Office of
Medical
Assistance Programs

Worker Guides

Contains updates through 8/1/2004

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.

Revision Number	Date Inserted	Revision Number	Date Inserted
1	04/01/00	21	
2	07/01/00	22	
3	10/01/00	23	
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Office of Medical Assistance Programs Worker Guide

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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.
- Is responsible for Title XIX and Title XXI State Plans.
- Distributes OMAP provider information and administrative rules.
- Pays claims for medical assistance covered services.
- Contracts with managed health care plans for the Oregon Health Plan.

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:

- Ensure a client selects a medical and dental plan in mandatory enrollment areas.
- Provide choice counseling to clients when needed regarding the selection of managed care organizations available in their area.
- Enter eligibility data into the computer system.
- Issue a temporary OMAP Medical Care Identification if needed. Although this is usually called a medical card, it is actually a letter-sized sheet of paper. (See sample of the medical ID in Section 3.)
- Determine a client's eligibility.
- Prior authorize and arrange for 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 managed care plan. 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

AFS 148	CMU - CAF FAX to (503) 373-0357 or send as a Groupwise attachment to MAINTENANCE, Client
AFS 415H	HIG - CAF PO Box 14023 Salem, OR 97309 (also on-line SYSM)
AFS 451, 451NV	PIL - Admin. Svcs. PO Box 14512 Salem, OR 97309
OMAP 502, 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
AFS 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
OHP 3060	HMU/OMAP 500 Summer St. NE, E-44 Salem, OR 97301-1079 FAX: (503) 945-6873

OMAP Field Resources

AIS - Automated Information System (client eligibility info)	Provider Svcs Unit - OMAP	**1-800-522-2508**
Billing Questions (for the medical provider, not clients)	In State - HFO - OMAP Out-of-State - CMU - OMAP	**1-800-336-6016** **(503) 945-6522**
Buy-In (Medicare premium buy-in)	Buy-In Unit - CAF	**(503) 378-2220**
Client Complaints		
CAF (formerly AFS) clients	Local Branch Offices	**Operations Managers**
SPD clients	SPD Administration	**(503) 945-5811 / 1-800-282-8096**
Other DHS clients	Governor's Advocacy	**1-800-442-5238 / (503) 945-6904**
***Client Advisory Services Unit** (client calls with problems regarding billing or access, quality and limitations on care)	Client Advisory Svcs Unit OMAP	**1-800-273-0557**
Eligibility History (to correct information on eligibility files)	CMU - CAF	**(503) 378-4369**
Health Insurance Group	HIG - Admin Services	**(503- 378-2220**
Hearings & Expedited Hearings (medical service issues)	Program & Policy OMAP	**(503) 945-5785**
In-Home Services		
Payments	Local Branch Offices	
Policy	SPD In-Home Svcs 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** (for clients)	OHP Telecommunication Ctr	**1-800-359-9517**
OHP Benefits RNs	Medical Unit - OMAP	**1-800-393-9855 / (503) 945-5772**
OMAP Forms	Order through CICS	**Order on FBOS**
Out-of-State Medical		
Prior authorization	Medical Director-OMAP	**(503) 945-6488**
Emergency Claims	Claims Mgmt Unit-OMAP	**(503) 945-6522**
Premium Billing Questions	OHP Premium Billing Ofc	**1-800-922-7592**
Prepaid Health Plan (questions/ problems on MHC enrollment) or	Health Mgmt Unit	**(503) 945-6531 / (503) 945-6534**
Pharmacy Management Program	OMAP	**(503) 945-6535 / (503) 945-5796**
Transportation		
Policy	OMAP Policy Unit	**(503) 945-6493**
Authorization	Local Branch Offices	
Transplant Services	Medical Director-OMAP	**(503) 945-6488**
Personal Injury Liens	PIL - Admin Services	**(503) 373-0333**

*TTY: 1-800-621-5260

If you cannot find the number you need call OMAP Reception 1-800-527-5772 / (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. Sometimes workers need to issue a temporary OMAP Medical Care ID to a client. (Use screen MID1). Once information on a client is entered into the computer system, the system automatically issues an OMAP Medical Care ID to the client.

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

The OMAP Medical Care ID also shows the benefit package assigned for every 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 OMAP Medical Care ID is incorrect or if information changes (examples include: address change or someone leaves the household). Workers are then responsible for entering changes into the computer system.

A sample of the OMAP Medical Care ID (front and back) is shown on pages 2 and 3. A sample of the temporary ID is shown on page 4.

(1) (2)
5503 XX#### EF P2
P.O. BOX 14520
SALEM, OR (3)
97309-5044
DO NOT FORWARD: RETURN IN 3 DAYS

OMAP Medical Care Identification (ID)

(4) Branch Name: OHP Branch
Division: AFS
(5) Worker: EF
(6) Phone: (503) 378-2666
1-800-699-9075

John Doe
Street Name

City State Zip

(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 OMAP MEDICAL PLAN
MEDICAL PLAN NAME
PH # 1-800-555-1234
GRP #

B OMAP DENTAL PLAN
DENTAL PLAN NAME
PH # 1-800-555-1234
GRP #

C OMAP MENTAL HEALTH PLAN
MENTAL HEALTH PLAN NAME
PH # 1-800-555-1234
GRP #

D PRIVATE MAJOR MED/DRUGS
MEDICAL PLAN NAME
PH # 1-800-555-1234
GRP #

E PRIVATE VISION COVERAGE
VISION PLAN NAME
PH # 1-800-555-1234
GRP #

F

G

H

I

(9a) Benefit Package

A – OHP Plus	**C – Qualified Medicare Beneficiary (QMB)**	**D – Limited Medicaid**
B – OHP Standard		**E – CAWEM Emergency Medical**

All non-emergency care must be approved by applicable Managed Care/TPR shown in field 8a. See OMAP General Rules OAR 410-120-1200 for specific benefit package limitations. All OMAP administrative rules can be found on the OMAP website at: www.dhs.state.or.us/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
DOE, JOHN SSN ###-##-####	XX#####X	10/13/62	3/01-3/31/03	B	A	A
DOE, JANIE SSN ###-##-####	XX#####X	08/10/94	3/01-3/31/03	NO COPAYS	BCDE	B

IMPORTANT:

(14)

- **This is your new OMAP Medical Care ID. Issued on:** 6/25/04
- **Show this ID to all providers, even if you have a Managed Care Plan card.**
- **Not valid outside the United States or US Territories.**

Message Box:

A monthly DHS message will appear in this space.

State of Oregon Department of Human Services Office of Medical Assistance Programs OMAP 1417 (Rev 6/04)

The first OMAP Medical Care ID may not have the managed care plans listed. Some plans will not provide service until listed on the OMAP Medical Care ID. Until the plans are listed, clients can go to any provider who will accept the OMAP Medical Care ID on a fee-for-service or open card basis.

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 Advocate 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:

⑤ Your worker's code.

⑥ Your worker's phone number.

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

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

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

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

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

⑪ Health care providers use the recipient ID number to bill OMAP.

⑬ 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).

⑭ Message Box. A monthly message from the Department of Human Services.

OMAP Client materials can be found on the OMAP website at: www.dhs.state.or.us/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.dhs.state.or.us/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 6/04)

TEMPORARY MEDICAL CARE IDENTIFICATION
Valid for services
Provided from 06/25/2004 through 06/30/2004

Case SCD : XX#### Prog Elig : 4

Benefit Package: A-OHP PLUS B-OHP STANDARD D-LIMITED MEDICAID C-QUALIFIED MEDICARE BENEFICIARY (QMB) E-CAWEM EMERGENCY MEDICAL

Copay: A-OUTPATIENT B-PHARMACY

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

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

Authorized Signature _____ Date _____

ATTENTION PROVIDERS

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

All OMAP administrative rules, guidelines and applications to become an enrol-led 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

Who Gets What? *General Rules 410-120-1160 through 410-120-1230*
OHP Rule 410-141-0480

Clients may get different medical services depending upon which public assistance program they are eligible to receive. The DHS Medical Assistance Programs chart in this section shows which benefit package goes with which public assistance program.

There are five benefit packages:

- OHP Plus Benefit Package
- OHP Standard Benefit Package
- Qualified Medicare Beneficiary (QMB)
- QMB + OHP Plus Benefit Package
- Citizen/Alien-Waived Emergency Medical (CAWEM)

The tables in this section show the DHS Medical Assistance Programs and their corresponding benefit packages, as well as services available under each benefit package and copayment information.

B. What's Covered *OHP Rule 410-141-0480*

1. The OHP Plus Benefit Package

The Oregon Health Services Commission (HSC) developed a list of 745 medical conditions and treatments in order of effectiveness. Currently, covered services are lines 1-546 on the Prioritized List of Health and Dental Services. This includes some mental health conditions/treatments and alcohol/drug dependency conditions/treatments.

Covered services under the OHP Plus Benefit Package include:

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, whether or not the treatment for the condition is covered
- Laboratory, X-ray and other appropriate testing

Medical and Surgical Care

- Family planning services and supplies including birth control pills, condoms, Norplant, and Depo-Provera; sterilizations and abortions
- Medically appropriate treatments for conditions that are expected to get better with treatment. Some examples of problems that might get treatment include, but are not limited to:

Appendicitis	Diabetes
Infections	Asthma
Ear Infections	Kidney stones
Broken bones	Epilepsy
Pneumonia	Burns
Eye diseases	Rheumatic fever
Cancer	Head injuries
Stomach ulcers	Heart disease

The following 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 persons having no other transportation available to them, including ambulance and other methods of transport

Dental services

Outpatient chemical dependency services

Comfort care

- Hospice care and other comfort care measures for the terminally ill, including death with dignity services

Mental health services

2. The OHP Standard Benefit Package

These clients receive the same health care coverage as the OHP Plus Benefit Package, with some exceptions. 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 Standard Benefit Package coverage changes are effective August 1, 2004.**

As directed by the 2003 Legislature under House Bill 2511, the OHP Standard Benefit Package will consist of the following core set of services (overlaid by Oregon's Prioritized List):

- physician services
- ambulance
- prescription drugs
- laboratory and x-ray services
- limited durable medical equipment and supplies
- outpatient mental health
- outpatient chemical dependency services
- emergency dental services

Although not part of the core set of services, the Standard Benefit Package will also include:

- hospice
- limited hospital benefit

In brief, the limited hospital benefit will include:

1. evaluation, lab, x-ray and other diagnostics to determine diagnosis (line zero on the Prioritized List);
2. hospital treatment for all emergency services;
3. urgent conditions for which prompt treatment will prevent life threatening health deterioration;
4. a subset of number three that will require prior authorization.

Services dropped:

The following services are **removed** from the OHP Standard Benefit Package:

- 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

Services added:

The following services are **added** to the OHP Standard Benefit Package:

- outpatient mental health and chemical dependency services
- some 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
  - urgent and emergency dental services (teeth cleaning, orthodontia, fillings, and other routine services are **not** covered)

Excluded Services - Both Plus and Standard *OHP Rule 410-141-0500*

Services for conditions that the Health Services Commission ranks of lower priority are generally not covered. The Health Services Commission report contains a complete listing of conditions/treatments that are not covered. There may be other limitations depending on the eligibility category to which the client is assigned. The OHP Plus and OHP Standard Benefit Packages **do not** cover **treatments** for the following conditions that have no other complicating diagnosis:

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

Excluded Services - Both Plus and Standard (continued) -

Conditions where a "home" treatment is effective, such as applying an ointment, resting a painful joint, drinking plenty of fluids, 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

3. QMB - Qualified Medicare Beneficiary Package

QMB-only clients are Medicare beneficiaries who have limited income but do not meet the income or resource standard for full medical assistance coverage. QMB clients have medical and hospital coverage through Medicare Parts A and B. The QMB medical assistance program pays for Medicare premiums, co-payments and deductibles only for services Medicare covers up to the amount Medicare pays.

Clients may NOT be billed by the provider for the deductible and co-insurance amounts which are covered by the medical assistance program for Medicare covered services. The provider may bill QMB patients for services not covered by Medicare.

4. QMB + OHP Plus Benefit Package

These clients are Medicare beneficiaries who receive the same services as the OHP Plus Benefit Package. Service coverage is based on the Prioritized List of Health Services. Their coverage also includes any service covered by Medicare.

5. CAWEM - Citizen/Alien-Waived Emergency Medical

These clients are only eligible for treatment of emergency medical conditions. Labor and delivery services for pregnant women **are** considered an emergency. **CAWEM clients do not pay premiums or copayments.**

The following services are **NOT covered for CAWEM clients:**

- 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

This list is not all inclusive but can be used as an illustration to identify some services that are not covered for CAWEM clients.

CAUTION: CAWEM clients are **NOT COVERED** for services that are ongoing, require prior authorization, payment authorization or that can be scheduled in advance.

Medical Assistance Benefit Packages

Neither all benefits nor all limitations are listed. See General Rules, Oregon Health Plan, and individual provider Administrative Rules for complete information.

Benefit Packages	Identifier (BEN on ELGR)

OHP Plus — BMH

- Physician, lab, and X-ray services
- Pharmacy services
- Hospital services (inpatient & outpatient)
- Physical therapy/occupational therapy
- Reasonable diagnostic services
- Durable medical equipment and supplies
- Vision, glasses
- Hearing, speech services
- Hospice services
- Home health services
- Dental services
- Medical transportation
- Preventive services (for example: tobacco cessation services)
- Some over-the-counter drugs
- Chemical dependency services
- Mental health services

OHP Standard — KIT

- Physician, lab, and X-ray services
- Pharmacy services
- Reasonable diagnostic services
- Hospice services
- Preventive services (for example: tobacco cessation services)
- Some over-the-counter drugs
- Emergency medical transportation
- Outpatient mental health services
- Outpatient chemical dependency services
- Limited hospital services (see OAR 410-125-0047)
- Limited durable medical equipment (see OAR 410-122-0055)
- Limited emergency dental (see OAR 410-123-1670)

QMB - Qualified Medicare Beneficiary — MED

Medicaid pays for only:

- Medicare premiums, deductibles and copayments for Medicare covered services

QMB + OHP Plus — BMM

CAWEM - Citizen/Alien-Waived Emergency Medical — CWM

Medicaid pays for only:

- Emergency medical services
- Labor and delivery

Senior Prescription Drug Assistance Program — PDA

Prescription drug assistance for elderly (NOT a Medicaid Program)
See OMAP Worker Guide 6 for detailed information.

OHP Plus Benefit Package

This benefit package replaced the Basic Benefit Package on February 1, 2003.

Neither all benefits nor all limitations are listed. See General Rules, Oregon Health Plan, and individual provider Administrative Rules for complete information.

ELIGIBLE CLIENTS:

- Pregnant Women – up to 185% Federal Poverty Level
- Children under age 19 – up to 185% Federal Poverty Level
- 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
- Getting Medical Assistance under Temporary Assistance to Needy Families (TANF) or General Assistance
- Presumptive eligibility prior to disability determination
- Children in Foster Care or in Adoptive Assistance

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.

CLIENTS AND SERVICES EXEMPT FROM COPAYMENTS:

- Clients in Managed Care Plans (for services covered by their plans)
- Pregnant Women
- Children under Age 19
- American Indians/Alaska Natives
- Clients who are 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)
- Family Planning Services
- Emergency Services, as defined in OAR 410-120-0000
- Prescription drugs ordered through OMAP's home delivery (mail order) vendor

For information on benefits and exemptions for QMB and CAWEM clients, see pages 5 and 6.

OHP Standard Benefit Package

This benefit package was redefined on August 1, 2004.

Neither all benefits nor all limitations are listed. See General Rules, Oregon Health Plan, and individual provider Administrative Rules for complete information.

ELIGIBLE CLIENTS:

- Adult clients who do not meet eligibility for OHP Plus Benefit Package - up to 100% Federal Poverty Level
- Do not currently have commercial insurance and have not had coverage during the past 6 months
- If client has employer sponsored insurance they must be evaluated for FHIAP

COPAYMENTS:

- OHP Standard copayments eliminated effective June 19, 2004.

PREMIUMS:

- Premium charge is per member/per month
- No waivers from premiums incurred after February 1, 2003
- Failure to pay premiums will result in 6 months disqualification from program for every household member required to pay premiums
- The following clients are exempt from paying premiums:
  - American Indians/Alaska Natives who are enrolled in a tribe
  - Clients who are eligible for benefits through Indian Health Services

BENEFIT EXCLUSIONS:

- Hospital services that are not for emergency or urgent care (see OAR 410-125-0047)
- Therapy services (physical therapy, speech therapy, occupational therapy)
- 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

For information on benefits and exemptions for QMB and CAWEM clients, see pages 5 and 6.

Family Health Insurance Assistance Program (FHIAP)

Health Insurance Premium Assistance

ELIGIBLE CLIENTS:

Low-income Oregonians with the ability to obtain employer-sponsored insurance (ESI) or individual insurance.

ELIGIBILITY CRITERIA:

- Reside in Oregon
- Be a US Citizen or a Qualified Non-Citizen
- Have Investments and Savings less than $10,000
- Be uninsured for the previous six months, except for those leaving the OHP/Medicaid program
- Family income less than 185% Federal Poverty Level

DHS Medical Assistance Programs			
Program Code	Program Title	Case Descriptor	Benefit Package
1, A1	Aid to the Aged	See Computer Guide Section 3-L	OHP Plus
2, 82	Temporary Assistance for Needy Families (TANF)	MAA, MAF	OHP Plus
V2	Refugee Assistance		OHP Plus
3, B3	Aid to the Blind	See Computer Guide Section 3-L	OHP Plus
4, D4	Aid to the Disabled	See Computer Guide Section 3-L	OHP Plus
19, 62	DHS Foster Care		OHP Plus
C5	Substitute/Adoptive Care	SAC, SCP	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 Plus
P2	Qualified Medicare Beneficiary (QMB)	QMB	QMB
Any Program except P2	QMB + Any Program	QMM	QMB + OHP Plus
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 & 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. Overview

Clients covered by the Oregon Health Plan (OHP) receive health care services through managed care plans in areas where they are available. The client chooses a managed care plan or primary care manager (PCM) to coordinate their health care. The managed care plan will ask the client to choose a primary care provider (PCP) from that plan's panel of providers. In areas where available and open to enrollment, clients may choose a dental plan to coordinate his or her dental care. When a client chooses a medical plan they may be automatically enrolled into the mental health organization (MHO) that contracts with the medical plan or with their local county's MHO. In Deschutes County a chemical dependency organization (CDO) provides alcohol and drug services.

This section on managed health care contains information on the following:

- Who Needs to Enroll?
- Enrollment Process
- Effective Date of Coverage
- Disenrollment/Changes in Managed Care
- Exemptions from Managed Care
- Third Party Resources (TPR)
- Dental Care
- Mental Health Care
- Choice Counseling
- Be a Good User

1. Managed Health Care Systems

In managed care, medical services are coordinated through one primary care provider or clinic that manages the patient's health care. The primary care provider then manages referrals to specialty services paid by the managed care plan. A comparison chart is included in the OHP application packet and describes the managed care plans available in the area the client lives and what coverage each plan will provide.

OMAP contracts with managed care plans and certain medical providers to provide services to Medicaid clients in exchange for a monthly capitation payment for each enrolled client. The managed care plan 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 the clinics to be managed care. When discussing managed care enrollment options for American Indian and Alaska Native clients, specify OHP managed care.

2. Fully Capitated Health Plans

The most common delivery system is the fully capitated health plan (FCHP). OMAP pays these organizations a set monthly capitation fee to provide comprehensive services for each enrolled client and to manage the 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 Oregon Health Plan. Clients in the adults/couples category may be exempt from enrollment in FCHPs if they are hospitalized at the time they are enrolled in managed care. Hospital holds are submitted to the OHP Application Center by the admitting hospital. The exemption period for a hospital hold is six months. These clients would continue to be enrolled in MHOs and dental care organizations (DCOs). See *Exemptions from Managed Care* in this section for further information.

3. Primary Care Managers

In areas where there are not enough medical plans to provide coverage for all clients, OMAP contracts with providers to be primary care managers (PCMs). 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, who manage a client's health care for a nominal monthly case management payment. They bill fee-for-service to OMAP for actual health care services provided to the client. 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 also refer clients to specialty services. Clients are not enrolled in PCMs if there is a managed care plan available in their area.

4. Dental Care Organizations

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

5. Mental Health Organizations

Mental health organizations (MHOs) provide mental health services to qualified medical assistance clients. A client's mental health plan enrollment is determined by the medical plan the client chooses. OMAP pays these organizations a set monthly capitation fee to provide comprehensive services for each enrolled client and to manage the client's mental health care.

B. Who Needs to Enroll? *OHP Rule 410-141-0060*

All medical assistance clients are required to enroll in managed health care either through a plan or a PCM unless they are determined eligible for an approved exemption. Refer to the DHS Medical Assistance Programs chart in Section 4 for detailed information.

C. Enrollment Process

1. Managed Health Care Plan

Clients should be enrolled in a managed care plan. However, some clients may be exempt from managed care because they have private health insurance. You should make this determination **before** you enroll a client into managed care. (See sections on *Exemptions and Private Insurance/ Third Party Resources*).

Once you have determined that a client is not exempt from managed care, you must determine what managed care plans are available to the client. Enrollment in managed care is determined by the client's address and county of residence.

The KSEL screen gives the following information on managed care plans:

- What types of managed health care coverage are available in the client's geographic area
- Which plans are available to the client by residence zip code
- Categories of service the plan covers
- Whether a plan is open for enrollment
- Whether a plan is accepting re-enrollments
- What the time limits are for re-enrollment
- The specialty of the PCM

When KSEL shows a plan is closed, but a client was previously enrolled in that plan, the Health Management Unit (HMU) of OMAP can assist in enrolling the client under certain conditions.

Clients may live in a mandatory or voluntary service area depending on the plans available. The ENRC screen will show if the client is in a mandatory or voluntary enrollment area. If a client is exempt from managed health care because of private third-party resource or allowable exemption, they may be enrolled in an MHO or DCO where available.

2. Selection of Managed Care Process

HPN (Health Plan New/Noncategorical) applicants must select a managed health care plan (FCHP) and dental plan (DCO). The mental health care plan is part of an auto enrollment process done by OMAP, therefore the applicant is not required to select a MHO.

- **Health Plan New/Noncategorical (HPN) -** *A person who is age 19 or over and is not pregnant is referred to as an HPN person.*

<u>For mandatory enrollment areas:</u>

They must select both a managed health care plan and dental care plan.

Single Plan Area:

If the HPN person has not selected both a managed health care plan and dental care plan, the worker will enroll the HPN person in the health plan available in that area. For a dental plan assignment the worker will follow the same procedure depending on whether the dental plan available is in a single or multiple plan area.

Multiple Plan Area:

If the HPN person has not selected both a managed health care plan and dental care plan, the worker will do an assignment based on a random alphabetical selection. For example: for the first application processed for that particular area, the worker would select a plan based on the first letter (A-Z) of the plan choice or PCM choice in that area. For the second application processed for that particular area, the worker would select the next plan choice or PCM choice, based on alphabetical selection.

The worker will then enroll the HPN person in the health plan randomly selected, sending a notice to the HPN person informing the client of the assignment(s) and their right to change the health and/or dental plan within 30 days of the assignment.

For a dental plan assignment the worker will follow the same procedure depending on whether the dental plan available is in a single or multiple plan area.

In mandatory enrollment counties, if the worker does not enroll the client, and the client does not have an approved exemption, OMAP Systems will auto-enroll the client in a managed care plan. The client will have 30 days to contact their worker to request a plan change.

In some mandatory areas, there may be no managed care plans available, however PCMs are available. In that instance, HPN persons are required to select a PCM. If they have not indicated on their application a PCM selection, the worker will need to follow the steps listed above for mandatory enrollment areas. **Do not enroll a client in a PCM if a managed care plan is available.**

For voluntary enrollment areas:

- Enrollment is not an eligibility requirement, unless the area changes to mandatory.
- Client has the option of enrollment - if client does not select a plan, the client will receive their health care on a fee-for-service (open card) basis.

♦ **Non-HPN(s)/Categorical Eligibles -** *applicants who are under age 19 or pregnant.*

For mandatory enrollment areas:

- Enrollment is not an eligibility requirement.
- Applicant should select a plan for enrollment - if applicant does not select, the worker will select a plan and notify applicant of plan selection.

If a Non-HPN (Categorical Eligible) does not select a plan, the worker will enroll the Non-HPN(s) in the plan available in that area. If more than one plan exists in that area, the worker will randomly assign applicants to the plans available.

The worker will do an assignment based on a random alphabetical selection. For example: for the first application processed for that particular area, the worker would select a plan based on the first letter (A-Z) of the plan choice or PCM choice in that area. For the second application processed for that particular area, the worker would select the next plan choice or PCM choice, based on alphabetical selection.

For voluntary enrollment areas:

- Enrollment is not an eligibility requirement, unless the area changes to mandatory.
- Client has the option of enrollment - if client does not select a plan, the client will receive their health care on a fee-for-service (open card) basis.

Non-HPN persons are not required to select a managed health care plan and dental care plan as a condition of eligibility. However, workers are advised to encourage Non-HPN(s) to select a managed care plan and a dental care plan, as this could increase their access to health and dental care.

HPN and Non-HPN persons still have the option of selecting fee-for-service if they meet the exception criteria provided in OAR 410-141-0060. The HPN person must select a managed health and dental plan on their application or provide information for an exception to enrollment into health and dental plans. Requests for exemption are submitted to Health Management Unit (HMU).

3. County (enrollment area) changes from Mandatory to Voluntary during the client's certification.

If a county changes from mandatory to voluntary during a client's certification, the client will remain enrolled with the plan selected for the remainder of their certification period, unless the client meets the criteria for exemption from managed care enrollment.

4. County (enrollment area) changes from Voluntary to Mandatory during the client's certification.

If a county changes from voluntary to mandatory during a client's certification, the worker will enroll the client at redetermination or as designated by OMAP.

5. Primary Care Managers

Clients will choose a primary care manager (PCM) if:

1. there are no managed care plans available where they live,
2. the client has other major medical insurance, or
3. the client was diagnosed with end stage renal disease (ESRD) prior to enrollment.

NOTE: In addition to a PCM, the client must also choose a dental plan.

6. Auto Enrollment

If a client is not enrolled in a mandatory enrollment county, OMAP Systems will auto-enroll the client unless they have an allowable exemption from managed care. Requests for exemptions are submitted to Health Management Unit (HMU).

See table below to determine when a client with private insurance may still be enrolled in managed care. In most cases, having Medicare does not exempt a client from enrollment in a medical plan.

Medicare and TPR Coding

Medical Insurance Benefits (MIB)	
MIB codes: 1 Medicare part B (physician benefits) 2 Medicare part A (hospital benefits)	
3 Both part A and B Medicare	Fill in after verifying the client has Medicare coverage - **if not**, leave blank (If ELGX is not updated, worker must contact HIG)
Private Health Insurance (PHI)	
PHI codes: **Y** - Yes, the client has private health insurance such as Blue Cross or Champus and an AFS 415H has been sent to the Health Insurance Group. **N** - No, the client does not have private health insurance such as Blue Cross or Champus. **Use "N" if the client has no insurance or has medical coverage such as Medicare or Veterans coverage which does not usually disqualify a client from managed care.**	

After the worker has entered the MIB and PHI codes on the PCMS screen, enter the enrollment information on the ENRC screen. Enter the ID number of the selected managed care provider (KSEL screen has this information) in the PHP field. The system will automatically enter the beginning and ending dates of coverage.

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

Managed care coverage does not take effect until the coverage information appears on the Medical Care ID. Client enrollment in managed care is now done on a weekly basis. (Weekly enrollment does not include newborns or MHOs). Here's how it works:

If the managed care information is entered into the CMS system before **5:00 p.m. Wednesday**, the client's managed care coverage will be effective the **following Monday**.

The client will receive a Medical Care ID within a few days of enrollment showing a date range during which the client is fee-for-service and a date range for managed care. If the information is entered into the system **after Wednesday**, the client's managed care coverage will be effective **a week from the following Monday**

Newborns are retroactively enrolled back to their date of birth when they are added to the grant **if the mother was enrolled 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 are enrolled monthly. The computer automatically enrolls eligible clients, depending on whether or not they are enrolled in a medical plan that has a corresponding MHO. Between the date of application and the time a plan is listed on the Medical Care ID, clients may get medical care on a fee-for-service (open card) basis from any provider who will take their Medical Care ID. See the ENRC screen for the client's managed care coverage effective date. Clients remain covered in managed care until the information no longer appears on the Medical Care ID.

To arrange exemptions, mid-month disenrollment or retroactive enrollments, contact HMU. See chart at the end of this section for contact numbers. Some requests may be forwarded to an OMAP Pre-Paid Health Plan Coordinator for review.

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

Clients may change their plan or PCM at the following times:

- When they reapply
- If they move out of the managed care plan or PCM service area
- Other reason approved by OMAP

Clients are instructed to call their worker if circumstances change that will affect their managed care coverage. Workers should contact HMU when enrollment changes are indicated.

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

Clients should be enrolled in a managed care plan, but there are exemptions. Some reasons for exemption:

- A woman in the third trimester of pregnancy who is under the care of a provider not in one of the available plans, and has not been enrolled in a plan during the three months preceding redetermination
- The client needs continuity of care for a current health condition and the treating provider is not in one of the available plans.
- The client has surgery scheduled and the current provider is not in one of the available plans.
- The client has proof of American Indian/Alaska Native (AI/AN) tribal membership or is eligible for benefits through an Indian Health Program. 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 the OMAP Medical Care ID.

- Client has been diagnosed with end stage renal disease (ESRD), as defined in rule.
- Other major medical insurance.
- The client is hospitalized at the time of enrollment choice.
- Clients determined eligible through the hospital hold process. The exemption period for a hospital hold is six months. Clients would still be enrolled in MHOs and DCOs.
- Women eligible under the Breast and Cervical Cancer Medical (BCCM) Program.

Exemption Codes

Some clients may either be delayed or are exempt from managed care enrollment if they meet the eligibility for exemption criteria for the reasons below. Some of the following codes are restricted based on staff level of responsibility. **ALL** exemptions below require an end date (other than 999999) except "PIH".

ACC Access to Care - unique circumstances that prevent the client from receiving/ accessing the medical services from the available plan.

CNT Continuity of Care - the client needs continuity of care for a current health condition and the treating provider is not in one of the available plans.

EXL The client's managed care plan requested, with good cause, to have client disenrolled and excluded from enrollment.

FRP Used by Child Welfare only.

HOS The client is enrolled in a managed care plan **during** hospital stay. Enrolled into plan choice after hospital discharge, OR

HOS Adults and couples without children identified through the hospital hold process, exempt from enrollment into a FCHP during OHP certification period. Clients would still be enrolled in MHOs and DCOs.

HRG Hearing scheduled - enrollment delayed until after results of hearing.

PIH The client has proof of American Indian/Alaska Native (AI/AN) tribal membership or is eligible for benefits through an Indian Health Program. (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 the OMAP Medical Care ID.) Must have an HNA case descriptor.

PRG A woman in the third trimester of pregnancy who is under the care of a provider not in one of the available plans, and has not been enrolled in a plan during the three months preceding redetermination.

LNG Language barrier - plan locating interpreter.

MED A client's medical condition or medical care requires special handling by OMAP. Also, clients with end stage renal disease (ESRD).

OTH Other reason.

REL Religious consideration.

SUR The client has surgery scheduled and the current provider is not in one of the available plans.

Some continuity of care and access to care exemptions must be approved by the OMAP Medical Director. For questions regarding exemptions, contact HMU (see page 14).

G. Third Party Resources (TPR)

Private insurance does not automatically exempt a client from managed care. Depending on the type of private insurance, a client may still be eligible for enrollment in a prepaid health plan, with a PCM, in an MHO or with a DCO. (See tables next page).

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

Valid Enrollment Codes for Private Insurance

Enrollment Codes for Private Insurance					
Private Coverage Type	**Code**	**PHP**	**PCCM**	**DCO**	**MHO**
Accident	AI	X	X	X	X
Champ VA	CA		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 PHP	HM			X	
Medicare Supp.	MS			X	
Medicare HMO*	MAB			X	
Nursing Home	NH	X	X	X	X

* 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 PCCMs. They may be enrolled in DCOs.

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). Branch offices and HIG receive the discrepancy report. 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.

A word of caution: The PHI flag DOES NOT stop enrollment into managed care, even if that enrollment is inappropriate because of a client's private insurance. The table below may help. If you have further questions, 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:			
	PHP	PCCM	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 areas of the state.

[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, hospital policy, or school insurance, enroll clients as if they had no TPR. Complete the AFS 415H and forward it to HIG.

H. Dental Care

Depending on where the client lives and which benefit package they are eligible to receive, he or she may get dental care through managed care or as fee-for-service.

Dental care is included for clients who receive the OHP Plus benefit package. The OHP Standard benefit package provides emergency dental services only. Clients can access dental care several ways:

- Enroll in a dental plan. The client should call their dental plan for a list of dentists in their area. The client contacts the dentist directly to make an appointment. It may take from one to three months for a routine appointment.
- If there are no dental plans in the area, clients may go to any dentist who will take their OMAP Medical Care ID on a fee-for-service or open card basis.
- Clients who cannot obtain dental care in their local area qualify for travel reimbursement assistance to allow them to access these services.

I. Mental Health Care

The Health Services Commission identified 50 mental health diagnoses affecting children and adults to be included on the list of conditions/treatments under the Oregon Health Plan. The 1993 Legislature approved funding to pay for treating 42 of these conditions, including schizophrenia, bipolar disorder, depression, post-traumatic stress, eating disorders, and attention deficit disorders.

Clients who are eligible for mental health benefits will receive services through MHOs, which may be fully capitated health plans, community mental health programs, or private mental health organizations.

Mandatory services for MHOs include:

- Evaluation
- Case management
- Consultation
- 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

J. Choice Counseling

Choice counseling helps a client choose the managed care plans that best meet his or her needs. Most of the time, clients make their own decisions about which health plans to choose. Clients receive a comparison chart to help them make their choice.

Some clients are unable to make their own health plan choices. For clients who are incapable of choosing their own health plan, one may be selected by a holder of a power of attorney, guardian, spouse, family member, a team of people, or an agency caseworker.

Workers who help a client choose a managed care plan may find the checklist in this section helpful. It lists major discussion areas to cover with the client.

During the discussion, workers provide the client with:

- The OHP Application (OHP 7210), which covers the client's rights and responsibilities in the Medical Assistance Program.
- *Oregon Health Plan Comparison Charts*, (OHP 9031), which lists the plans in the area and compares their benefits.
- The worker will also discuss any private insurance resources available to the client.

Choice Counseling Checklist

- ❒ Does the client reside in a mandatory or voluntary plan area?
- ❒ Is the client's doctor (PCP) in a managed care plan or enrolled as a PCM?
- ❒ Do the client's children have a PCP? Which managed care plan does the PCP belong to?
- ❒ 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?

K. Educating Clients About Health Care

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

- Define truly emergent care. (Services that are needed immediately because of a serious injury or illness. Some examples are: broken bones, bleeding profusely, suspected heart attack and loss of consciousness.) OHP 9035, *Managed Care Information*, explains this.
- Advise clients to cancel appointments at least 24 hours in advance if they can't make it to the appointment.
- Help clients to understand 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 OMAP Medical Care ID and managed care plan card to all medical 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.
- Remind clients to read the *Managed Care Handbook* and the "Rights and Responsibilities" section of the application.
- Remind clients to review their Medical Care ID each time they receive one to ensure it contains accurate information.
- Explain how to resolve billing problems.
- Explain how to resolve provider care problems.
- Explain how the appeal and grievance process works.
- Remind clients to notify workers 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 *Managed Care Handbook* "Your Rights and Responsibilities" section 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.

Managed Health Care Issues Who Can You Call? (FOR DHS STAFF ONLY)		
Health Plan Enrollment and Eligibility/Billing Questions No MHC message or wrong MHC on Medical ID AI/AN Exemptions Medical Exemptions	Health Management Unit (HMU) OMAP	(503) 945-6534 (503) 945-6535 (503) 945-5796
MHC Claim Problems	Contracted Health Plan	Contact Plan listed on client Medical ID
ELGC/ELGR and/or Coding problems	Client Maintenance Unit (CMU) CAF	(503) 378-4369
Private Health Insurance or TPR (Third Party Resource)	Health Insurance Group (HIG) CAF	(503) 378-2220
Unresolved Client/ MHC Problems	Client Advisory Services Unit (CASU) OMAP	Client number: 1-800-273-0557
Expedited Hearing Requests	Medical Director's Unit, OMAP	(503) 945-5785
Managed Health Care Available Services, Physicians, etc.	Contracted Health Plans	Contact Plan listed on client Medical ID
Problems with Mental Health Organizations (MHOs)	Office of Mental Health and Addiction Services (OMHAS)	(503) 945-9447
Problems with Fully Capitated Health Plans	Delivery Systems Unit (DSU) See OMAP 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 currently is implementing the first portion of the statute (the discount portion). The discount program was rolled out in phases beginning late 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 $1,964 a month for a family of four (based on 2004 Federal Proverty 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

A FHIAP applicant must meet the following criteria:

- Reside in Oregon
- Be a U.S. citizen or a qualified non-citizen
- Have investments and savings less than $10,000
- Have a three month average income of less than 185% of the Federal Poverty Level
- Be uninsured for the previous six months, except for those leaving OHP/Medicaid
- Must not be eligible for or receiving Medicare
- No individual may be receiving both OHP and FHIAP benefits at the same time

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. Current waiting period to receive an application is six months, although that could vary.

2. OHP Standard, OHP Plus, TANF, employer sponsored insurance and FHIAP

Some people who apply for OHP/Medicaid must get coverage through FHIAP. This applies only to adults who qualify for the OHP Standard benefit package and have access to employer-sponsored insurance (ESI). OHP Standard clients with ESI available will have their OHP application and a group insurance form forwarded to FHIAP to determine eligibility. If found eligible, they must enroll in FHIAP and disenroll from OHP Standard. OHP Plus clients with access to ESI will have the choice of remaining in OHP Plus or applying for FHIAP. TANF clients may receive cash assistance only (no medical coverage) and use a FHIAP subsidy to purchase health insurance.

American Indian/Alaska Native clients, who would otherwise be eligible for FHIAP, have the option of accepting enrollment in FHIAP or enrolling in OHP-OPU.

3. FHIAP Expansion, Federal Funding and Program Information

The 2001 Oregon Legislature passed House Bill 2519 which, among other things, directed the state to seek a waiver to get federal matching funds for FHIAP and expand the program. The program implemented the expansion 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 Monday through Friday from 9 am to 5 pm. Additional FHIAP information can be found on the IPGB web site at **www.ipgb.state.or.us.**

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

Payment of Private

Health Insurance Premiums

A. OMAP Payment of Private Health Insurance Premiums

For some clients, OMAP will pay the cost of health insurance premiums if that cost is less than the estimated cost of paying medical providers on a fee-for-service basis. This section tells you:

- What medical coverage information to consider.
- What groups of clients are eligible for this program.
- What information to include on the OMAP 3073, Premium Referral form.

For MAA, MAF GAM, OHP, OSIPM and REFM clients, OMAP may consider paying health insurance premiums on behalf of individuals on a selective basis when the net cost for payment of the premiums is less than the estimated cost of paying medical providers on a fee-for-service basis.

1. Excluded Groups

Excluded groups are:

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

2. Referral to OMAP

Send referrals for private health insurance premium payment consideration to OMAP using the OMAP 3073 form (see page 3). The case must be opened on the computer system prior to sending in the form 3073. Referrals must include the following information:

- Premium amount.
- Extent of coverage (major medical, drugs, etc.)
- Name and address of insurance company
- Policy holders name, group number, and policy insurance number
- Who the checks are made out to (insurance company, employer, etc.), and the name and address where the checks should be sent
- Recipient information (name, case number, etc.)
- Medical documentation/information to justify continuing premium payment
- A copy of the signature page of the clients application
- A signed and dated copy of the Release of Information

Forward the referrals to: **OMAP, Premium Payment Referral Section.**

3. Determining Cost Effectiveness

Upon receiving a PHI referral, OMAP will determine the cost effectiveness by:

- Reviewing the clients past use of medical services under medical programs, third parties, and private insurance data.
- 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(s).
- When obtaining medical coverage information from the client, consider these sources:
  - Spouse or absent parent.
  - Private insurance policies.
  - Previous employer COBRA coverage, which may be available for 6 to 36 months after employment ends.
  - Employer medical coverage for maternity leave and medical leave that requires monthly premium payments.

4. Clients Right to Hearing

- Clients have the right to a hearing to dispute use of private health insurance. The hearing process will comply with DHS hearings rules and procedures.
- Workers will schedule pre-hearing conferences for OMAP.
- OMAP will handle hearings by telephone and prepare hearings summaries for parties in the hearing.

Oregon Department of Human Services
Office of Medical Assistance Programs

PREMIUM REFERRAL FOR PRIVATE HEALTH INSURANCE (PHI)

Date:_____

Return Referral 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 must 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.

A 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 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.

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 initial or ongoing case.
- 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 two 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 providers 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. An ancillary services can be:

- X-ray;
- Laboratory test;
- MRI;
- CAT scan; 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.

Matrix for Administrative Medical Examinations and Reports

Last updated 7/1/03		Procedure Codes		
		Physical	**Mental Health**	**Eye**
Eligibility Determination	**Initial or Ongoing**	229 500 99080 99455 or 99456 S9981	229 919 90801 & 90889 99080 S9981 96111	99172
	Follow-up	229 424 434 500 97750 99080 99455 or 99456 S9981	229 918 919 90801 & 90889 96100 96117 99080 S9981	99172
Casework Planning	**Initial or Ongoing**	229 500 99080 99455 or 99456 S9981	229 919 90801 & 90889 99080 S9981	99172
Referrals to agencies Child placement JOBS planning SPD service planning	**Follow-up**	229 424 434 500 97750 99080 99455 or 99456 S9981	229 918 919 90801 & 90889 96100 96117 99080 S9981	99172

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.

Guidelines to Filling Out OMAP 729

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 & 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 to Filling Out OMAP 729 (cont.)

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 to Filling Out OMAP 729 (cont.)

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 to Filling Out OMAP 729 (cont.)

Procedure Code: **97750** Amount to be Billed: **$20.24** 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: **$49.31** 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 to Filling Out OMAP 729 (cont.)

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.
	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 to Filling Out OMAP 729 (cont.)

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 to Filling Out OMAP 729 (cont.)

Procedure Code: **96117** Amount to be Billed: **$49.31** 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: **$94.46** 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 to Filling Out OMAP 729 (cont.)

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 to Filling Out OMAP 729 (cont.)

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 80101if 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.

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

Administrative Medical Examination/ Report Authorization

"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**

⑪

A Release of Information is Enclosed

⑩

Provider Number _____

This individual and the Division 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 HCFA-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 HCFA 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

Comprehensive Psychiatric or Psychological Evaluation

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

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

Medical Record Checklist

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

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 Services
Office of Medical Assistance Programs

Physical Residual Function Capacity Report

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**

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
   ❑ at least 2 hours in an 8-hour workday
   ❑ about 6 hours in an 8-hour workday
   ❑ medically required hand-held assistive device is necessary for ambulation

4. Sit (with normal breaks) for a total of:
   ❑ less than about 6 hours in an 8-hour workday
   ❑ about 6 hours in an 8-hour workday
   ❑ must periodically alternate sitting and 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 upper extremities
   ❑ limited in lower 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	❑	❑	❑

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 do not include 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.	❑	❑	❑	❑

Limitation	Not Significantly Limited	Moderately Limited	Markedly Limited	Unable to Determine
Sustained Concentration and Persistence				
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				
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				
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

Rating of Impairment Severity 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**

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.

OMAP Worker Guide 12

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 documentation in the branch record indicates ride sharing is not appropriate for a particular client. The written documentation will be made available for review upon request by 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 responsibility 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 prepared and mailed to the client or attendant. Or, the branch may decide to write the check in their branch (especially when there is no time to wait for the check to be issued from Salem) and then complete the information to reimburse the branch for that revolving fund check.

The 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
Salem, Oregon 97309

Date: _____

From: _____ **Branch** **AFS Cost Center:** _____

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

For Administrative Payment Unit Use Only

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

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

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

APPROVED OMB-0938-0008

PLEASE DO NOT STAPLE IN THIS AREA

Prog: 2
Branch: 2801
Wkr ID: K9

Example

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE MEDICAID CHAMPUS CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER ☐ (Medicare#) ☒ (Medicaid#) ☐ (Sponsor's SSN) ☐ (VA File #) ☐ (SSN or ID) ☐ (SSN) ☐ (ID)		1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) 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☐ Employed☐ Full-Time Student☐ Part-Time Student☐	CITY / STATE
ZIP CODE / TELEPHONE (INCLUDE AREA CODE) ( )		ZIP CODE / TELEPHONE (INCLUDE AREA CODE) ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS) ☐ YES ☐ NO	a. INSURED'S DATE OF BIRTH MM DD YY SEX M☐ F☐
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M☐ F☐	b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? ☐ YES ☐ NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO ***If yes***, return to and complete item 9 a-d.
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____
14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM 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 MM DD YY FROM 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 FROM MM DD YY	TO MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1	09 02 00	09 08 00	X	D	A0200	(Attend. Lodging)		280 00	7				
2	09 02 00	09 08 00	X	D	A0210	(Attend. Meals)		84 00	7				
3	09 02 00		X	D	A0190	(Client Meals)		12 00	1				
4	09 02 00		X	D	A0190	(Client Meals)		12 00	1				
5	09 02 00		X	D	A0140	(Client Airfare)		75 00	1				
6													

25. FEDERAL TAX I.D. NUMBER SSN EIN ☐ ☐	26. PATIENT'S ACCOUNT NO. ############	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO	28. TOTAL CHARGE $ 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 #

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

MIF/N90-1B

(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.

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

OMAP 410 (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

Begin Date _____ End Date _____ *Circle days of week* 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)

OMAP Worker Guide 13

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.

If clients have questions about in-state billings, have them talk to their plan, Primary Care Manager (PCM), or other insurance. If they do not have a plan, PCM, or other insurance, the OMAP Client Advisory Services Unit (1-800-273-0557) is available to listen to their problem and identify possible solutions.

For out-of-state billings where a client does not have a plan, PCM, or other insurance, contact OMAP Claims Management Unit at (503) 945-6522. If you send the billing to Claims Management, be sure to include recipient name and prime number, and worker name and phone number.

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.

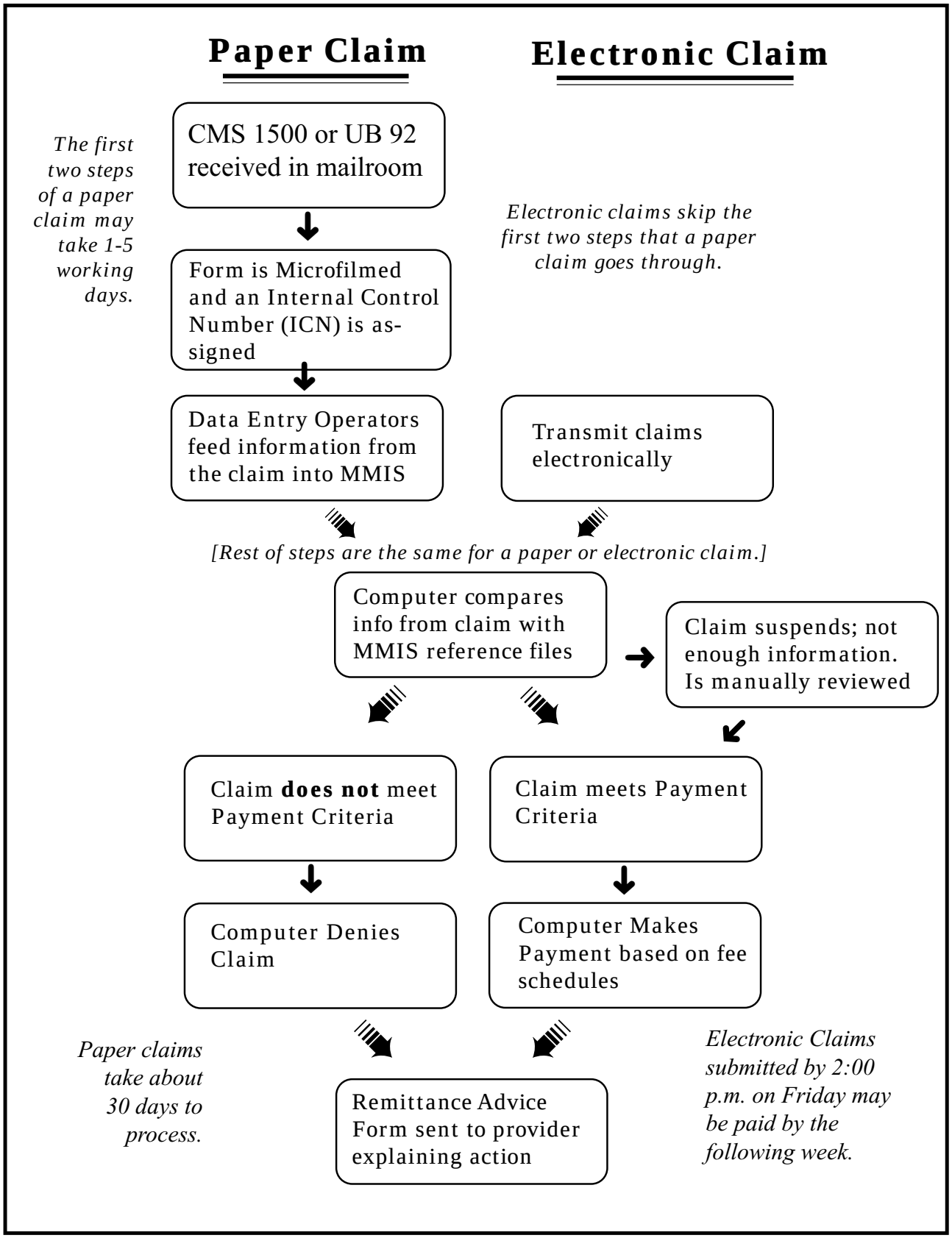
   Since eligibility is determined and updated at the local DHS branch level, OMAP depends on caseworkers to supply accurate and timely eligibility information to MMIS. If the claim has suspended for this reason, two weeks are allowed to pass. Then, if OMAP files still show "no eligibility for patient," 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.

OMAP Worker Guide 14
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