Policy Transmittal

Oregon Department of Human Services

Originating Cluster:

OMAP, Health Services

Transmittal No. 510

Authorized by: Joan M. Kapowich
Signature

Date: December 1, 2003

Transmitting: ☑ Policy Change

Applies to: ☑ All DHS employees

Policy Title: OMAP Worker Guides, Revision #15

Topic Area: Medical Assistance

Effective Date: January 1, 2004

Release No: FSML-30, OMAP-15

Web Address: www.dhs.state.or.us/healthplan/data_pubs/wguide.html

Discussion/Interpretation:

The Office of Medical Assistance Programs (OMAP) has revised the OMAP Worker Guides. The attached revision will also be included with the January 1, 2004, release of the CAF Family Services Manual, FSML-30.

This revision contains changes to the following guides:

- Worker Guide 4 - Benefit Packages
  - Added Admin Rule references for client copayments 410-120-1230 to OHP Plus and OHP Standard Benefit Package charts.
  - Removed Admin Rule references to repealed rule 410-120-1235.
  - Added General Assistance to list of OHP Plus categorical eligibles.
- Worker Guide 5 - Managed Health Care
  - Expanded description of American Indian/Alaska Native clients related to managed care enrollment/exemption.
- Worker Guide 8 - Administrative Examinations and Reports
  - Revised Guidelines for Filling Out OMAP 729 related to Procedure Code 99080.

- ♦ Worker Guide 11 - Client Rights and Responsibilities
  - Removed Admin Rule references to repealed rule 410-120-1235.
- ♦ Worker Guide 14 - Premiums, Copayments and Special Requirements
  - Removed Admin Rule references to repealed rule 410-120-1235.
  - Added a contact phone number for workers with questions about premiums.
  - Expanded description of American Indian/Alaska Native clients related to exemption from premium requirement.

Field/Stakeholder review: ☑ Yes, reviewed by OMAP Worker Guide review list

Local/Branch/
Action Required: Read and become familiar with policy and procedure changes

Central Office/
Action Required: Read and become familiar with policy and procedure changes

Filing Instructions: File this material, dated 1/1/04, in your OMAP Worker Guides. Record the insertion date on the transmittal record on the inside of the front cover.

Remove	Insert
Worker Guide 4, pp 1/2, 5-8	Worker Guide 4, pp 1/2, 5-8
Worker Guide 5, pp 7/8	Worker Guide 5, pp 7/8
Worker Guide 8, pp 9/10	Worker Guide 8, pp 9/10
Worker Guide 11, pp 1/2	Worker Guide 11, pp 1/2
Worker Guide 14, pp 1/2	Worker Guide 14, pp 1/2

A. Benefit Packages

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

The medical services clients receive depend on which public assistance program they are eligible for. 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 developed a list of 745 medical conditions and treatments in order of effectiveness. Currently, covered services are lines 1-558 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:

a. Preventive Services
- Maternity and newborn care
- Well-child exams and immunizations
- Routine physical exams and immunizations for children and adults
- Maternity management, including nutritional counseling

b. 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

c. 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

d. **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

e. **Dental services**

f. **Outpatient chemical dependency services**

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

h. **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 some cost sharing and benefit limitations. The Health Services Commission's Prioritized List also applies to the OHP Standard Benefit Package. The Standard Benefit Package **does not** cover the following:

a. **Non-emergency medical transportation**
b. **Vision services and supplies (frames, contacts, corrective devices, eye exams for the sole purpose of prescribing glasses or contacts, glasses following cataract surgery)**
c. **Durable medical equipment, prosthetics, orthotics and supplies (DMEPOS)**
d. **Dental services**
e. **Outpatient chemical dependency**
f. **Outpatient mental health**
g. **Hearing aids and hearing aid exams**

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)
- Over-the-counter drugs
- Chemical dependency services
- Mental health services

OHP Standard — KIT

- Physician, lab, and X-ray services
- Pharmacy services
- Hospital services (inpatient & outpatient)
- Physical therapy/occupational therapy
- Reasonable diagnostic services
- Hearing, speech services (excludes hearing aids and hearing aid exams)
- Hospice services
- Home health services
- Preventive services (for example: tobacco cessation services)
- Over-the-counter drugs
- Emergency medical transportation

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.

ELIGIBLE CLIENTS:

Categoricals:

- Pregnant Women – up to 185% Federal Poverty Level
- Children under 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: *See General Rule 410-120-1230*

- $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
- 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 mail order vendor

COVERAGE BEGINS:

Plus benefit package will begin on the date of request. (Some clients may be eligible for up to three months retroactive OHP Plus coverage.)

For information on benefits and exemptions for QMB and CAWEM clients, see pages 3 and 4.

OHP Standard Benefit Package

This reduced benefit package began on February 1, 2003.

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: *See General Rule 410-120-1230*

- $3.00 up to $250.00 - see detailed list of copayments in Section 14, page 5

PREMIUMS:

- Premium charge is per member/per month
- No waivers from premiums allowed
- 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

BENEFIT EXCLUSIONS:

- Non-Emergency Transportation
- Routine Vision Services
- Hearing Aids and Related Services
- Alcohol and Drug Outpatient Services
- Mental Health Outpatient Services
- Dental Services
- Durable Medical Equipment and Supplies

COVERAGE BEGINS:

Initial month Standard benefit package benefits will begin the first of the month following eligibility determination.

For information on benefits and exemptions for QMB and CAWEM clients, see pages 3 and 4.

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

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.

OMAP's Health Management Unit (HMU) is the contact for arranging exemptions, mid-month disenrollment or retroactive enrollments. See chart at the end of this section for contact numbers.

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

Clients are instructed to call their worker if circumstances change that will affect their managed care coverage. You may need to enter changes or disenroll a client from managed care. (PCM enrollment does not close when client moves to another area. Branch offices need to disenroll or call HMU if retroactive changes are required.)

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

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. The medical start date depends on which benefit package the client is eligible to receive. 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 new plan choice **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.

Guidelines to Filling Out OMAP 729 (cont.)

Procedure	Section	Details
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	Section	Details
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.

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.

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?

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 Indian/Alaska Native
- CAWEM

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. 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. Non-payment of Premiums

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 also pay premium arrearages before becoming eligible again. Any OHP Plus 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. 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.

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 Indian/Alaska Native clients
- 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