DHS Oregon Department of Human Services

Health Services
Office of Medical Assistance Programs

Policy Transmittal

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Authorized Signature

Number: OMAP-PT-04-001
Issue Date: 07/01/2004

Topic: Medical Benefits

Transmitting (check the box that best applies):

☐ New Policy ☐ Policy Change ☐ Policy Clarification ☐ Executive Letter

☐ Administrative Rule ☒ Manual Update ☐ Other: (Specify other group here)

Applies to (check all that apply):

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

Policy Title:	OMAP Worker Guide Revision 17		
Topic Area:	Medical Benefits		
Policy Number(s):		Release No:	OMAP-WG-17
Effective Date:	July 1, 2004	Expiration:	
References:			
Web Address:	http://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. This revision will also be included with the July 1, 2004, release of the CAF Family Services Manual, FSML-32.

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.

Field/Stakeholder review: [X] Yes [ ] No

If yes, reviewed by: Worker Guide review list

Filing Instructions:

File this material, dated 7/1/04, in your OMAP Worker Guides. Record the insertion date on the transmittal record on the inside of the front cover.

Remove	Insert
TOC, pp 3/4	TOC, pp 3/4
Worker Guide 4, pp 1/2, 5/6	Worker Guide 4, pp 1/2, 5/6
Worker Guide 7, pp 1/2	Worker Guide 7, pp 1/2
Worker Guide 8, pp 7/8, 11/12	Worker Guide 8, pp 7/8, 11/12
Worker Guide 12, pp 3/4, 17/18	Worker Guide 12, pp 3/4, 17/18
Worker Guide 14, pp 3-6	Worker Guide 14, pp 3-6

If you have any questions about this information, contact:

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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 premiums, copayments, 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 home delivery (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.

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.

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: **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.

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

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)

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

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

Clients on OHP Standard have a higher copayment than those on the OHP Plus benefit package. They also make copayments on more services.

Health care providers have a complete list of all services and items which require a copayment and the amount of the copayment. The provider may collect the copayment at the time of service or bill the client for it later.

If the client does not make the required copayment, the provider **may refuse** service to the client. The client will also owe a debt to the provider for any unpaid copayments.

A client may be charged more than one copayment per provider per day.

OHP Standard does not require copayments for the following services:

- Family Planning services and supplies, like birth control pills
- Pap smears
- Mammograms (breast x-rays)
- Fecal occult blood test
- Diagnostic sigmoidoscopy (over age 50)

- Total blood cholesterol screenings
  for men ages 35-64
  for women ages 45-64
- Rubella serology or vaccinations for women of childbearing age
- Tetanus Diphtheria (Td) boosters
- Influenza Immunizations
- Hospice services
- Administrative Medical Exams - medical examinations required by DHS staff to assist in determining eligibility
- Venipuncture
- Women's annual health exams
- Pneumococcal vaccinations

OHP Standard requires copayments for the following services:

Hospital:

Inpatient Care (per admission) $250
Outpatient Surgery and Ambulatory Surgical Centers $20
Other Outpatient Hospital Services $5
Emergency Services (waived if admitted) $50

Professional visits for:

Primary and Specialty Care, including urgent care $5
Office, medical procedures $5
Surgical procedures $5
Occupational Therapy, Physical Therapy, or Speech Therapy $5

Prescription Drugs:

Generic prescription drugs $2
Brand name mental health, cancer and HIV drugs $3
All other brand name drugs $15

Home visits for:

Home Health, Private Duty Nursing, or Enteral/Parenteral Nutrition and IV services $5

Other services and procedures:

Chemical Dependency Services/Mental Health Services (no copayment for medication services or case management services) $5

Emergency Ambulance Services $50

Laboratory and Radiology Test and Diagnostic Procedures $3

Radiology treatments $5

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.