DHS Oregon Department of Human Services

Health Services
Office of Medical Assistance Programs

Policy Transmittal

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OMAP Program and Policy Section
Authorized Signature

Number: OMAP PT 05-002
Issue Date: 7/27/05

Topic: Medical Benefits

Transmitting (check the box that best applies):

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

Applies to (check all that apply):

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

Policy/Rule Title:	OMAP Worker Guide Revision 20		
Policy/Rule Number(s):	Medical Benefits	Release No:	OMAP-WG-20
Effective Date:	August 1, 2005	Expiration:	
References:			
Web Address:	www.oregon.gov/DHS/healthplan/data_pubs/wguide/main.shtml		

Discussion/Interpretation:

Effective August 1, 2005, OMAP Worker Guides 1 and 3-8 have been revised. This revision will be included in the October 2005, release of the CAF Family Services Manual.

In this revision, the terms “managed care plan” and “managed care organization” have been changed to prepaid health plan (PHP) and many of the guides have been reorganized and reformatted to make them more user-friendly. Major changes include:

Worker Guide #3 – Medical Care Identification

- Added information about how and when to use the OMAP Temporary Medical Care ID (OMAP 1086) and a sample of the ID

Worker Guide #5 – Managed Health Care

A. *Managed Health Care Systems*
- ♦ Defined prepaid health plan (PHP)
- ♦ Added Medical Case Management (MCM) and Disease Case Management (DCM) program information
- ♦ Added physician care organization (PCO) information

B. *Enrollment Process*
- ♦ Simplified managed care enrollment instructions
- ♦ Clarified auto-enrollment information

C. *Effective Date of PHP Coverage*
- ♦ Broke into two sections – “existing clients” and “new clients”
- ♦ Created instructions for changes to “existing clients”
- ♦ Clarified the “new clients” information

D. *Disenrollment/Changes in Managed Care*
- ♦ Added an allowable reason for clients who are auto-enrolled to change their PHP

E. *Exemptions from Managed Care*
- ♦ Added new codes (MMC and RIF) and clarified existing codes
- ♦ Added information to help workers determine:
  - ♦ The appropriate code
  - ♦ The documentation necessary
  - ♦ How to enter the code or request the code - some codes are restricted and can only be entered by HMU

G. *Dual-Eligible Medical Plan Enrollment Requirements*
- ♦ New section – enrollment requirements for clients who have both Medicaid and Medicare coverage. Includes:
  - ♦ Enrollment requirements for OMAP Medical Plans with corresponding Medicare Advantage Plans (MAP)
  - ♦ Reasons clients may be exempt from enrollment
  - ♦ Instructions on when and how to complete the Medicare Advantage Election (OHP 7208M) form
  - ♦ Information about how clients can disenroll from their MAP

J. *Managed Health Care Issues*
- ♦ Corrected phone numbers in table

Worker Guide #6 – Other Medical Resources

B. Family Health Insurance Assistance Program (FHIAP)

- Updated federal poverty level information
- Added FHIAP contact information – phone numbers and website address

Worker Guide #7 – Payment of Private Health Insurance Premiums

- Clarified existing information
- Changed to reflect HIPAA requirement – referrals must be sent to OMAP only through the mail or by shuttle
- New documentation requirement – a signed and dated original Authorization for Use and Disclosure of Health Information (DHS 2099) must be included with referrals
- Replaced the old Premium Referral (OMAP 3073) form with the new one

Worker Guide #8 – Administrative Examinations and Reports

A. Administrative Medical Examinations and Reports

- Added information on how to set up a client's case electronically
- In section 2. Selecting the Appropriate Examination, the worker is instructed to obtain the last 12 months of the client's medical records, instead of 2

Implementation/Transition Instructions:

Training/Communication Plan:

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:

Replace the table of contents and sections 1 and 3-8 with this revision

If you have any questions about this policy, contact:

Contact(s):	Tanya Allen		
Phone:	(503) 945-6599	**Fax:**	(503) 945-6873
E-mail:	tanya.s.allen@state.or.us		

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OMAP Worker Guide #1

OMAP/Medicaid Overview

A. OMAP/Medicaid Overview

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

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

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

- Determine a client's eligibility.
- Ensure clients select PHPs in mandatory enrollment areas.
- Provide choice counseling to clients when needed regarding the selection of PHPs available in their area.
- Enter eligibility data into the computer system.
- Order replacement Medical Care Identifications (ID) on ELGH, or issue temporary Medical IDs on MID1, when needed. Although this is usually called a medical card, it is actually a letter-sized sheet of paper. See samples of the Medical ID in Worker Guide #3.
- Arrange for and prior authorize transportation, when needed, to access health care services.

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

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

B. Where to Send Information

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

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

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

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

OMAP 505
OMAP Claims
PO Box 14015
Salem, OR 97309

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

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

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

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

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

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

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

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

C. OMAP Field Resources

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

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

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

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

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

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

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

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

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

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

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

Medical Payment Recovery
MPR – Admin Services ....(503) 947-4250

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

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

OMAP Forms
Order through CICS .... Order on FBOS

Out-of-State Medical
Prior authorization – OMAP Medical Director ....(503) 945-6488
Emergency Claims – OMAP Claims Mgmt Unit ....(503) 945-6522

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

Prepaid Health Plan (questions/problems on managed care enrollment)
OMAP – Health Management Unit (HMU) .... (503) 945-5772 or
OMAP.HMU@state.or.us, or *HMU, OMAP* in Groupwise

Pharmacy Management Program
OMAP – HMU.. (503) 945-5772 or
OMAP.HMU@state.or.us, or *HMU, OMAP* in Groupwise

Transportation
Policy – OMAP Policy Unit ....(503) 945-6493
Authorization – Local Branch Offices

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

Personal Injury Liens
PIL – Admin Services..(503) 947-9970

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

OMAP Worker Guide #3

Medical Care Identification

A. Medical Care Identification

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

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

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

Issuing a Replacement Medical Care ID

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

Issuing a Temporary Medical Care ID

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

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

(1) (2) (3)

OMAP Medical Care Identification (ID)

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

(7a) Copy Requirements
A $3 for outpatient services not paid for by your Plan (listed in 8a)
B $2 Generic/$3 Brand – for drugs not paid for by your Medical Plan (listed in 8a)

(8a) Managed Care/TPR
A
B
C
D
E
F
G
H
I

(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

IMPORTANT:

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

(14)

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

OMAP 1417 (Rev 6/04)

Clients

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

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

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

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

For questions about:

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

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

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

Your OMAP Medical Care ID shows:

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.

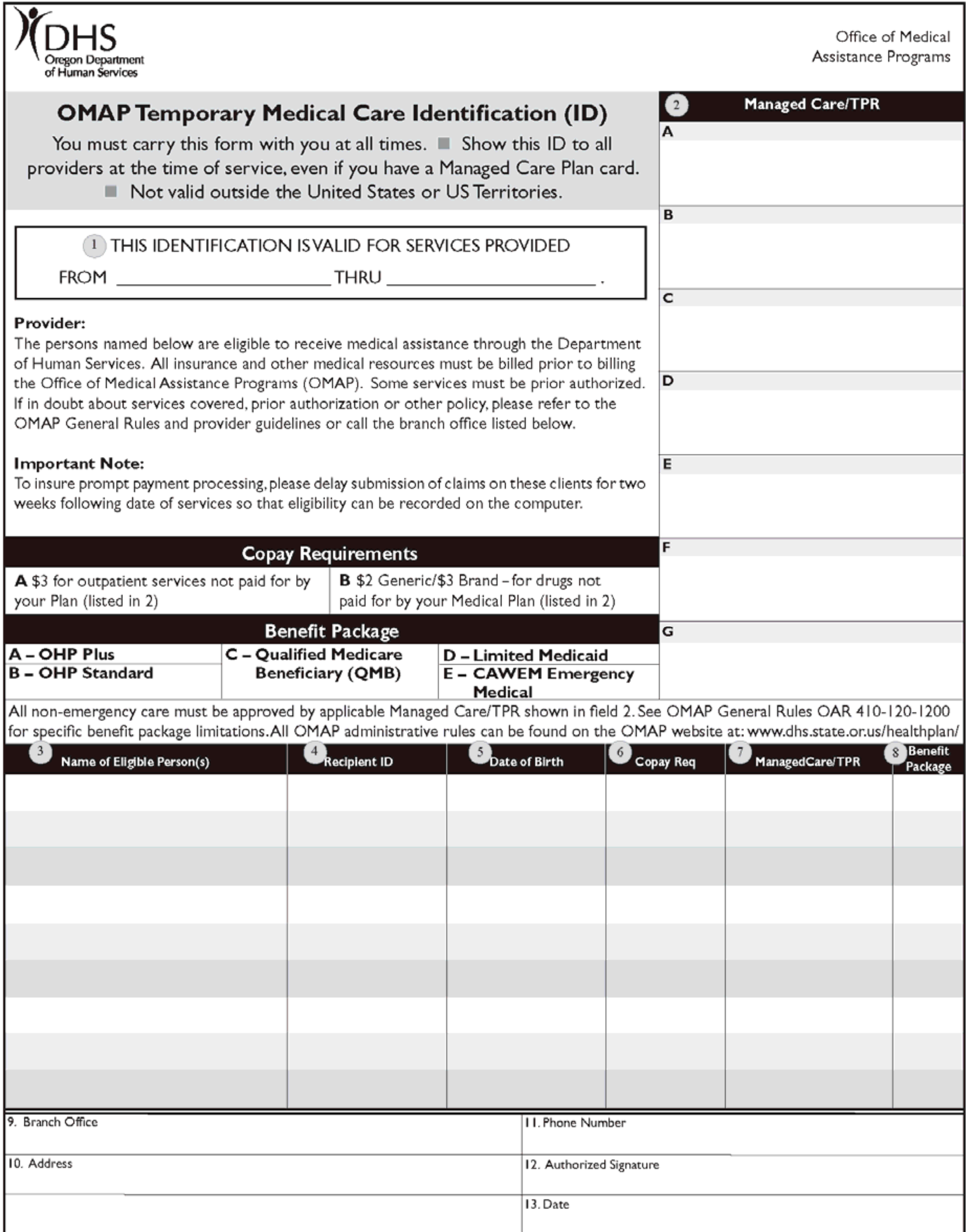
OMAP will only make payment to enrolled providers.

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.



DHS Oregon Department of Human Services

Office of Medical Assistance Programs

OMAP Temporary Medical Care Identification (ID)

You must carry this form with you at all times. ■ Show this ID to all providers at the time of service, even if you have a Managed Care Plan card. ■ Not valid outside the United States or US Territories.

(1) THIS IDENTIFICATION IS VALID FOR SERVICES PROVIDED

FROM ____________________ THRU ____________________ .

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

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

(2) **Managed Care/TPR**

A

B

C

D

E

F

G

Copay Requirements

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

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 2. 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/

(3) Name of Eligible Person(s)	(4) Recipient ID	(5) Date of Birth	(6) Copay Req	(7) ManagedCare/TPR	(8) Benefit Package

9. Branch Office	11. Phone Number
10. Address	12. Authorized Signature
	13. Date

Distribution: White - Client Copy; Canary - Branch Copy

OMAP 1086 (Rev 1/05)

Instructions for Temporary Medical Care Identification (OMAP 1086)

1. **Valid Dates** — Enter the days this identification is valid.

2. **Managed Care/TPR** — Enter all medical resources which must be billed before OMAP *(1 resource per letter).*

   Private Insurance
   Enter all insurance or other medical resources which must be billed before OMAP.

   OMAP Capitated Plan(s)
   Enter name of the OMAP Managed Care Plan (FCHP, PCO, DCO or MHO) if client is currently enrolled.

   Doctor - Pharmacy
   Enter name of doctor and pharmacy if client is GAMMP or Medical Management (if doctor and pharmacy have been selected).

3. **Name of Eligible Person(s)** — Enter only the family members who need medical services.

4. **Recipient ID** — Enter the prime number; not the case number.

5. **Date of Birth** — Enter only the family members who need medical services.

6. **Copay Requirements** — For OHP Plus clients who are required to pay copayments, enter "AB." For clients in all other benefit packages, enter "NO COPAYS."

7. Enter the appropriate Managed Care/TPR code letter from the choices you listed in section 2.

8. Enter the appropriate Benefit Package code letter from the codes listed.

9. Branch office name.

10. Branch office address.

11. Branch office telephone number.

12. Branch worker authorized signature.

13. Date this identification is issued.

Branches

Staff should use this form for immediate medical needs only when the MID1 screen cannot be used. Staff should also issue a replacement Medical Care ID using the ELGH screen as soon as possible after completing this form.

OMAP 1086 (Rev 1/05)

```
               TEMPORARY MEDICAL CARE IDENTIFICATION
                        Valid for services
             Provided from 08/25/2004 through 08/31/2004

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

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




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

Authorized Signature _______________________________     Date _______________
                              ATTENTION PROVIDERS
```

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

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

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

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

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

OMAP Worker Guide #4

Benefit Packages

A. Benefit Packages

General Rules 410-120-1160 through 410-120-1230

OHP Rule 410-141-0480

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

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

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

** The OHP Standard benefit package closed to* ***new*** *enrollment July 1, 2004. Coverage for clients who were enrolled in OHP Standard prior to July 1, 2004, may continue as long as the client continues to meet all eligibility requirements.*

B. What's Covered

1. The OHP Plus Benefit Package

The Oregon Health Services Commission (HSC) developed a list of 730 medical conditions and treatments in order of effectiveness. Currently, covered services are lines 1-546 on the Prioritized List of Health Services.

OHP Plus Benefit Package – Covered Services

- Preventive Services:
  - Maternity and newborn care
  - Well-child exams and immunizations
  - Routine physical exams and immunizations for children and adults
  - Maternity case management, including nutritional counseling
- Diagnostic services:
  - Medical examinations to tell what is wrong, even if the treatment for the condition is not covered
  - Laboratory, X-ray and other appropriate testing
- Medical and Surgical Care
- Family Planning Services and Supplies – including birth control pills, condoms, contraceptive implants, and Depo-Provera; sterilizations
- Medically appropriate treatments for conditions expected to get better with treatment – includes, but is not limited to:
  - Appendicitis
  - Infections
  - Ear Infections

  - ♦ Broken bones
  - ♦ Pneumonia
  - ♦ Eye diseases
  - ♦ Cancer
  - ♦ Stomach ulcers
  - ♦ Diabetes
  - ♦ Asthma
  - ♦ Kidney stones
  - ♦ Epilepsy
  - ♦ Burns
  - ♦ Rheumatic fever
  - ♦ Head injuries
  - ♦ Heart disease
- Medically Appropriate Ancillary Services – when provided as part of treatment for covered medical conditions
  - ♦ Hospital care, including emergency care
  - ♦ Home health services
  - ♦ Private duty nursing
  - ♦ Physical and occupational therapy evaluations and treatment
  - ♦ Speech and language therapy evaluations and treatment
  - ♦ Medical equipment and supplies
  - ♦ Vision and hearing services including exams, evaluations, treatment, materials and fitting for glasses and hearing aids
  - ♦ Prescription drugs and some over-the-counter drugs
  - ♦ Transportation to health care for clients who have no other transportation available to them, including ambulance and other methods of transport
- Dental Services
- Outpatient Chemical Dependency Services
- Comfort Care – this includes hospice care and other comfort care measures for the terminally ill, and death with dignity services
- Mental health services

2. The OHP Standard Benefit Package*

These clients receive the same health care coverage as clients on 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 OHP Standard benefit package closed to* ***new*** *enrollment July 1, 2004. Coverage for clients who were enrolled in OHP Standard prior to July 1, 2004, may continue as long as the client continues to meet all eligibility requirements.*

OHP Standard Benefit Package – Covered Services

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

OHP Standard Benefit Package – Excluded Services

Acupuncture, except for treatment of chemical dependency

Chiropractic and osteopathic manipulation

Nutritional supplements taken by mouth

Home health care

Hospital services that are not for urgent or emergency care

Occupational therapy

Physical therapy

Private duty nursing

Speech therapy

3. QMB – Qualified Medicare Beneficiary Benefit Package

Clients who are on the QMB benefit package:

- Are Medicare beneficiaries who have limited income but do not meet the income or resource standard for the OHP Plus benefit package coverage, and
- Have medical and hospital coverage through Medicare Parts A and B

The QMB benefit package pays for Medicare premiums, co-payments and deductibles only for services Medicare covers.

Clients on the QMB benefit package may **not** be billed by the provider for the deductible and co-insurance amounts for Medicare covered services. The provider may bill clients on the QMB benefit package for services not covered by Medicare.

4. QMB + OHP Plus Benefit Package

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

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.

Clients on the CAWEM benefit package do not pay premiums or copays.

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

The following services are **NOT covered for clients on the CAWEM benefit package:**

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

- Medical equipment and supplies
- Home health services

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

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

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

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

- Weight loss programs
- Infertility services

D. Benefit Package Overview

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

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

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

Qualified Medicare Beneficiary (QMB) – MED
Medicare premiums, deductibles and copays for Medicare covered services

QMB + OHP Plus – BMM
See OHP Plus and QMB benefit packages

Citizen/Alien-Waived Emergency Medical (CAWEM) – CWM	
Emergency medical services	Labor and delivery

Senior Prescription Drug Assistance Program (SPDAP) – PDA
Prescription drug assistance for elderly – this is not a Medicaid program (see OMAP Worker Guide #6 for detailed information)

E. OHP Plus Benefit Package Eligibility and Copay Requirements

This page does not list all requirements or exceptions.

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

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

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

F. OHP Standard Benefit Package Eligibility and Copay Requirements

This page does not list all requirements or exceptions.

This benefit package closed to **new** enrollment July 1, 2004. Coverage for clients who were enrolled in OHP Standard prior to July 1, 2004, may continue as long as the client continues to meet all eligibility requirements.

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

Copays
None

Premiums
Premiums are charged per member/per month
Waivers for premiums incurred after February 1, 2003, are not allowed
American Indians/Alaska Natives are not required to pay premiums
Clients who are eligible for benefits through Indian Health Services are not required to pay premiums
If premiums are not paid on time, the client may lose coverage before the end of their six month enrollment.

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

G. DHS Medical Assistance Programs

Program Code	Program Title	Case Descriptor	Benefit Package
1, A 1	Aid to the Aged	See Computer Guide section 3-L	OHP 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, SFC	OHP Plus
GA (CSD)	Non-title XIX Foster Care		OHP Plus
P2, M5, 2, 82	Children's Health Insurance Program (CHIP)	CHP	OHP Plus
P2, M5, 2, 82	Extended Medical Program	EXT	OHP Plus
5	OSIPM-PRS	NCP	OHP 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 and Cervical Cancer Program	BCP	OHP Plus
P2, M5, 2, 82	Senior Prescription Drug Assistance	PDA	N/A
Any Program	CAWEM	CWM	Emergency Medical

OMAP Worker Guide #5

Managed Health Care

A. Managed Health Care Systems

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

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

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

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

In managed care, services are coordinated through one primary care provider or clinic that manages the client's health care. When necessary, the primary care provider makes referrals to specialty services which are paid for by the PHP. A comparison chart is included in the OHP application packet (not included in reapplication packets) and describes the PHPs available in the area where the client lives and what coverage each plan will provide.

**Important –Medical Case Management (MCM) and Disease Case Management (DCM) are not types of managed care. The clients who are part of the MCM and DCM programs have certain health conditions (i.e., athsma, diabetes). MCM or DCM contractors are listed in field 8a "Managed Care/TPR" of the Medical ID, however, MCM and DCM clients receive services on a fee-for-service (open card) basis. MCM and DCM are not payers or third party resources and do not affect claim submissions or payments.*

1. Fully Capitated Health Plans (FCHP)

The most common delivery system is the fully capitated health plan (FCHP). OMAP pays the FCHP a monthly capitation fee to provide comprehensive services and to manage each enrolled client's health care. FCHPs provide medical services ranging from physician and hospital inpatient care to physical therapy and drugs. FCHPs provide exceptional needs care coordination (ENCC) for the special needs of the aged and disabled populations in the OHP. Clients in the adults/couples category may be exempt from enrollment in an FCHP either temporarily or permanently for various reasons. See section E – *Exemptions from Managed Care* in this worker guide for detailed information.

2. Physician Care Organization (PCO)

OMAP pays the physician care organization (PCO) a monthly capitation fee to provide comprehensive services and to manage each enrolled client's health care.

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

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

3. Primary Care Managers (PCM)

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

4. Dental Care Organizations (DCO)

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

5. Mental Health Organizations (MHO)

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

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

- Evaluation
- Case management
- Consultation
- Mental health related medication and medication management
- Individual, family, and group therapy
- Local acute inpatient care
- 24 hour urgent and emergency response
- For adults only:
  - Rehabilitation services
  - Skills training
  - Supported housing
  - Residential care

B. Enrollment Process

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

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

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

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

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

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

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

1. Selection Process

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

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

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

Clients can only change their enrollment (within 30 days) if they did **not** choose their PHP and/or PCM. Clients who were enrolled into the PHP and/or PCM of their choice can only change their enrollment for one of the reasons listed in section D. *Disenrollment/Changes in Managed Care*.

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

Mandatory – Multiple PHPs – Enrollment Process

Use this process for clients who:

- Live in a mandatory area, and
- Have more than one PHP available, and
- Either did not choose a PHP or the PHP they chose was not available – *see "Client Notification Requirement" below*

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

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

Mandatory – Single PHP – Enrollment Process

Use this process for clients who:

- Live in a mandatory area, and
- Have only one PHP available, and
- Either did not choose a PHP or the PHP they chose was not available – *see "Client Notification Requirement" below*

The worker must enroll the client in the available PHP.

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

Mandatory – No PHP Available – Enrollment Process

Use this process for clients who:

- Live in a mandatory area, and
- Have no PHP available, and
- Either did not choose a PHP or the PHP they chose was not available – *see "Client Notification Requirement" below*

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

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

Voluntary Enrollment Process

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

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

Client Notification

If the client was enrolled into a managed care plan or PCM other than the one they chose, the worker must send a notice to the client telling them:

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

2. Mandatory/Voluntary Service Area Changes

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

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

3. Auto Enrollment

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

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

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

1. Existing Clients

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

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

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

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

2. New Clients

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

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

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

Newborns are retroactively enrolled back to their date of birth as long as their birth mother was enrolled in a PHP at the time of the baby's birth. This retroactive enrollment pays capitation back to the baby's date of birth. The payment is made at end of month cutoff after the baby is added to the case.

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

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

Clients may change their PHP or PCM:

- When they reapply
- If they move out of the PHP or PCM service area
- Within 30 days of an auto-enrollment in an area with multiple PHPs
- When approved by OMAP

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

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

Exemption Codes

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

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

Use exemptions codes for the reasons listed in this table.

Code	Description
ACC	**Access to Care –** Use in the rare instance when the client receives the majority of their care from a very unique specialist who is out of the client's service area. For example, the client has a complicated seizure disorder and lives in Medford, however, they receive the majority of their care from a specialist in Portland.
CNT	**Continuity of Care –** Use when PHP enrollment could harm the client's health. For example, the client is receiving care for a chronic or long-term condition from a provider who is not part of an available PHP. The worker must have documentation from the client's medical provider before using this code. Documentation must be kept in the client's casefile.
EXL	Use when the client's PHP requested, with good cause, to have client disenrolled and excluded from enrollment
HOS	This code can be used for two different reasons, read both descriptions to determine the appropriate code. This code is restricted and must be entered by HMU. 1 – Use when the client is an inpatient in a hospital on the day their managed care enrollment was to begin. Enroll the client after hospital discharge) 2 – Use for clients (adults and couples without children) who applied through the hospital hold process. These clients are exempt from medical plan enrollment for six months. These client would still be enrolled in a DCO and MHO
HRG	**Hearing scheduled –** Use when enrollment is delayed until after a hearing

MMC	Use only for clients who are dual-eligible (Medicare and Medicaid) **and** live in an area where the only medical plans available have corresponding Medicare Advantage Plans that the client does not want to enroll in.
PIH	Use when the client has proof of American Indian/Alaska Native (AI/AN) tribal membership or is eligible for benefits through an Indian Health Program – the client must have an HNA case descriptor. AI/AN clients can choose to enroll in a managed care organization **and** continue to receive care at an AI/AN facility OR remain fee-for-service and go to any provider who will accept their OMAP Medical Care ID
PRG	Use this code for a pregnant woman when she: 1 – Is in the third trimester of pregnancy, and 2 – Is under the care of a provider who is not contracted with an available PHP, and 3 – Has not enrolled in a PHP during the past three months
MED	Use when a client's medical condition or medical care requires special handling by OMAP, or the client has end stage renal disease (ESRD). Contact HMU to use this exemption. These clients show an end date of 2049.
OTH	**Other reason** – Not to be used in local offices – All requests for this code require authorization by DHS and will include a review of physician notes.
REL	**Religious consideration** - This is used in the rare instance when religious beliefs would prevent the client from accessing a covered service (i.e., a woman needed to see a woman doctor and the PHP did not have female doctors)
RIF	**Rehabilitation/Inpatient/Nursing Facility** – Use for clients in Eastern Oregon Training Center, Eastern Oregon Psychiatric Center, Oregon State Hospital and for clients in a nursing facility when the client needs to use the in-house physician of the facility, and the physician is not part of an available PHP. Documentation must be kept in the casefile.
SUR	Use when the client has surgery scheduled and the current provider is not part of one of the available PHPs

F. Third Party Resources (TPR)

Private health insurance does not automatically exempt a client from managed care. Depending on the type of private health insurance, a client may still be eligible for enrollment in a PHP and/or PCM.Client's who are exempt from managed care because of private health insurance are not allowed to be enrolled into managed care. Their private health insurance must remain the private payor.

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

Enrollment Codes for Private Health Insurance					
Private Coverage Type	**Code**	**FCHP/ PCO**	**PCM[1]**	**DCO**	**MHO**
Accident	AI	X	X	X	X
Champ VA	CA	X	X	X	
Cancer	CI	X	X	X	X
Champus	CS		X	X	X
Major	H12		X	X	
Hospital	H13	X	X	X	X
Surgery	H14	X	X	X	X
Drugs	H15		X	X	X
Dental	H16	X	X	X	X
Visual	H17	X	X	X	X
Private Medical	HM			X	
Medicare Supp.	MS			X	
Medicare HMO[2]	MAB			X	
Nursing Home	NH	X	X	X	X

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

[2] System will allow clients with Medicare HMOs to be enrolled in a medical plan. However, workers are ***not*** to enroll Medicare HMO members in medical plans (unless the HMO is also an OHP medical plan), or with PCMs. They may be enrolled in DCOs.

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

A case is listed on a discrepancy report if there is a difference between the PHI code and the TPR file, (example: PHI code is "Y" and there is no private health insurance on ELGX, or the PHI code

is "N" and there is private health insurance on ELGX). Discrepancy reports are sent to branch offices and HIG. Branch offices should research the discrepancies and update PCMS or submit 415H's to HIG. HIG also researches the discrepancy report and requests additional information from branch workers or requests that PCMS be updated.

Caution: The PHI flag **does not** stop enrollment into managed care, even if that enrollment is inappropriate because of a client's private health insurance. The table below may help. For more information, contact HIG.

Type of Managed Care Enrollment for Clients with TPR

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

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

1 First preference is to enroll with a medical plan. If that is not possible, enroll with a PCM. Clients who have end-stage renal disease or are in Medicare hospice cannot be enrolled with plans, but should be enrolled with PCMs if possible.

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

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

G. Dual-Eligible Medical Plan Enrollment Requirements

OHP Rule 410-141-0060

Effective January 1, 2006, "Medicare + Choice 65" will be changed to "Medicare Advantage Plan." We have started using this name now.

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

1. Medical Plan Enrollment Requirements

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

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

OMAP Medical Plan with Corresponding Medicare Advantage Plan

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

- Medicaid services – through their OMAP Medical Plan
- Medicare services – through their Medicare Advantage Plan

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

Important: *Clients who have End Stage Renal Disease (ESRD) or receive routine dialysis treatment, or have received a kidney transplant within the last 36 months cannot enroll in a Medicare Advantage Plan unless they were already enrolled in the plan as a commercial member before developing ESRD.*

OMAP Medical Plan without a Corresponding Medicare Advantage Plan

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

- Medicaid services – through their OMAP Medical Plan
- Medicare services – on a fee-for-service basis

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

Clients who are enrolling in their OMAP Medical Plan's corresponding Medicare Advantage Plan must complete the OHP 7208M. The following information is needed to complete the OHP 7208M:

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

3. Disenrollment Requirements

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

H. Choice Counseling

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

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

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

Choice Counseling Checklist

- ❒ Does the client reside in a mandatory or voluntary plan area?
- ❒ Is the client's doctor (PCP) in a PHP or enrolled as a PCM?
- ❒ Do the client's children have a PCP? Is the PCP part of an available PHP?
- ❒ Is the medical or dental office near the client's home or on a bus line? Can they get to their appointments easily?
- ❒ Are the PCP's office hours convenient for the client?
- ❒ Where will they go for medicine? Is there a pharmacy near their home?
- ❒ Which hospital does the plan require the client to use? Is it near their home?
- ❒ Does the family have special medical, mental health, or chemical dependency needs to be considered?
- ❒ Is the client elderly or disabled, requiring Exceptional Needs Care Coordination (ENCC)?
- ❒ What transportation is available to the client to access medical services?

I. Educating Clients About Health Care

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

- Define truly emergent care – These are services that are needed immediately because of a serious injury or illness. Some examples are: broken bones, bleeding profusely, a tooth that has been knocked out, suspected heart attack and loss of consciousness. Refer to the Client Handbook (OHP 9035), for more information.
- Advise clients to cancel appointments at least 24 hours in advance if they can't make it to the appointment.
- Explain that there may be a wait for a routine appointment, especially with a dentist (usually from one to three months).
- Primary care providers (PCPs) are an essential feature of managed care. The PCP manages the client's health care needs. The PCP works with the client to keep him or her healthy.
- If the client needs a specialist, their PCP can refer them to one.
- Clients need to bring both their Medical ID and PHP card to all appointments.
- Advise clients that some providers are not taking new patients.
- Explain that clients need to follow the rules of their plan and respect doctors and their staff.
- Tell clients to read the *Client Handbook* (OHP 9035), and give a description of some of the information in the handbook. For example:
  - ♦ How to resolve billing problems.
  - ♦ How to resolve provider care problems.
  - ♦ How the appeal and grievance process works.
- Remind clients to review their Medical ID each time they receive one to ensure it contains accurate information.
- Remind clients to notify their worker of changes, i.e., pregnancy, change of address, change of household composition.

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

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

J. Managed Health Care Issues

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

OMAP Worker Guide #6

Other Medical Resources

A. Senior Prescription Drug Assistance Program

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

This program has two main provisions:

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

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

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

1. Eligibility requirements for enrollees

Applicants must:

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

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

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

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

B. Family Health Insurance Assistance Program (FHIAP)

FHIAP was created by the 1997 Oregon Legislature to help low-income Oregonians afford private health insurance. The program subsidizes or pays for a significant portion of a member's health insurance premium — 95% of the premium for members earning less than 125% of the federal poverty level (FPL) or $2,016 a month for a family of four (based on 2005 Federal Poverty Guidelines), a 90% subsidy for those earning up to 150% FPL, a 70% subsidy for those earning up to 170% FPL, and a 50% subsidy for those earning up to 185% FPL.

FHIAP is a subsidy program, not an insurance plan. FHIAP will subsidize the medical portion of the premium only – not vision or dental coverage. FHIAP members must pay deductibles, co-pays or any other coinsurance associated with their health insurance plan.

1. Eligibility Criteria and Enrollment

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

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

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

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

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

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

2. FHIAP Expansion, Federal Funding and Program Information

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

The Insurance Pool Governing Board (IPGB) administers the FHIAP program. Applicants should be directed to call FHIAP at 1-888-564-9669 or TTY 1-800-433-6313, Monday through Friday, 9 am to 5 pm. Additional FHIAP information can be found on the IPGB web site at:

www.oregon.gov/IPGB/index.shtml

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

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

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

- Inform applicants about the EPSDT Program. Repeat this information at each redetermination of medical eligibility.
- If the child or teen is covered by other insurance, inform him or her that EPSDT may cover more services (e.g., well child exams, immunizations, dental services).
- Follow the branch procedure to help the client find a doctor or to obtain transportation.
- For CAF, help the applicant check the appropriate box under “You have a right to:” in the **Rights and Responsibilities** form and the EPSDT section of the **AFS 415A** application.
- For SPD, document in the case record that EPSDT information was given to the client.

OMAP Worker Guide #7

OMAP Payment of Private Health Insurance Premium

A. OMAP Payment of Private Health Insurance Premiums

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

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

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

1. Excluded Groups

OMAP will not pay PHI premiums for clients who are:

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

2. Referral to OMAP

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

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

PHI Coordinator – CMU
OMAP – HFO
500 Summer St NE E44
Salem OR 97301-1079

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

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

- Premium amount
- Type of coverage (major medical, drugs, etc.)
- Name and address of insurance company
- Policy holder's name, group and policy number
- Who the checks are made out to (insurance company, employer, etc.), and the name and address where the checks should be sent
- Client information (name, case number, etc.)
- Medical documentation/information to justify continuing premium payment
- A signed and dated original of the Authorization for Use and Disclosure of Health Information (DHS 2099)

3. Determining Cost-Effectiveness

OMAP determines PHI premium payment cost-effectiveness by:

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

4. Hearings

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

All hearings comply with DHS hearings rules and procedures.

Workers schedule pre-hearing conferences for OMAP.

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

PREMIUM REFERRAL FOR PRIVATE HEALTH INSURANCE (PHI)

Todays Date:

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

Client Information:

Program: ______ Branch: ______ Case Number: ______

Case Name: ______ Recipient Name: ______

Worker's Name and Phone Number: ______

Insurance Information:

Policy holder's name: ______

Policy/Group # ______

When are premiums due? monthly ☐ quarterly ☐

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.
- An original signed/dated "Authorization for Use and Disclosure of Health Information" (DHS 2099), allowing DHS to obtain applicant's information from the employer/health insurance carrier.
- A copy of the COBRA approval letter, if premium request is for COBRA coverage.

OMAP 3073 (REV 5/05)

OMAP Worker Guide #8

Administrative Medical Examinations and Reports

A. Administrative Medical Examinations and Reports

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

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

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

This section will help you:

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

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

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

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

Important

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

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

1. Client Medical Documentation

Client medical documentation is needed to:

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

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

2. Selecting the Appropriate Examination

Determine if the case is initial or ongoing.

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

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

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

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

3. Selecting a Provider

Obtain the name of the client's medical provider.

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

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

Order services only from authorized providers using the guideline tables.

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

4. Scheduling Appointments

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

5. Completion of OMAP 729 series

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

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

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

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

6. Ordering OMAP Covered Ancillary Services

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

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

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

7. Processing the Provider Report

Determine if the report is as requested.

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

CMS 1500 (formerly HCFA 1500) or UB 92 (billing forms) are sent directly to OMAP by the provider using the addresses at the bottom of the OMAP 729.

B. Determining Which Exam to Order

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

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

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

C. Matrix for Administrative Medical Examinations and Reports

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 and 90889 99080 S9981 96111	99172
	Follow-up	229 424 434 500 97750 99080 99455 or 99456 S9981	229 918 919 90801 and 90889 96100 96117 99080 S9981	99172
Casework Planning Referrals to agencies Child placement Jobs planning SPD service planning	**Initial or Ongoing**	229 500 99080 99455 or 99456 S9981	229 919 90801 and 90889 99080 S9981	99172
	Follow-up	229 424 434 500 97750 99080 99455 or 99456 S9981	229 918 919 90801 and 90889 96100 96117 99080 S9981	99172

D. Guidelines for the OMAP 729 Series

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

Revenue Code 229 Amount to be Billed **Usual Charge** Provider Type: **Hospital (HO)**	Description	Medical records copying fee, administrative. Includes copies of Admitting History/ Physical, Admission Summary, Consultations, Operative and Other Reports, and Discharge Instruction Sheet and Discharge Summary for (date)_____ admission as checked on OMAP 729D.
	Guidelines	(1) Use for initial or ongoing eligibility for client with a hospital stay within the last 60 days. (2) Use for casework planning, if appropriate.
	Hints	Use of OMAP 729D is required.
Revenue Code 309 Amount to be Billed: **$22.00** Provider Type: **Hospital (HO)**	Description	Drug screen qualitative; multiple drug classes chromatographic method, each procedure or drug screen qualitative; single drug class method (e.g., immunoassay, enzyme assay), each drug class. Only for Child Welfare and OYA clients.
	Guidelines	(1) Use for drug screening for Child Welfare and OYA clients and parents.
	Hints	To be used when the chosen provider is an outpatient hospital laboratory.
Revenue Code 309 Amount to be Billed: **$45.00** Provider Type: **Hospital (HO)**	Description	Drug confirmation, each procedure. Only for Child Welfare and OYA clients.
	Guidelines	(1) Used if screen testing is positive.
	Hints	To be used when the chosen provider is an outpatient hospital laboratory.
Revenue Code 309 Amount to be Billed: **$15.00** Provider Type: **Hospital (HO)**	Description	Alcohol and/or other drug testing, collection and handling, only specimen other than blood. Only for Child Welfare and OYA clients.
	Guidelines	(1) Use for drug screening collection for Child Welfare and OYA clients only.
	Hints	To be used when the chosen provider is an outpatient hospital laboratory.

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

Guidelines for the OMAP 729 series – continued

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

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

Guidelines for the OMAP 729 series – continued

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

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

Guidelines for the OMAP 729 series – continued

Procedure	Field	Details
Procedure Code: 97750 Amount to be Billed: **$19.98** Provider Type: **Physical Therapists, Occupational Therapists, (PT, OT, PB, IH)**	Description	Physical performance test or measurement (e.g., musculoskeletal, functional capacity), with written report, each 15 minutes. Limited to 1 hour.
	Guidelines	(1) Use to determine physical functional impairments and/or limitations as a supplement to the medical evaluation (2) Use for casework planning, if appropriate.
	Hints	(1) Medical examination must also be obtained. (2) If no facility to perform PCE is available then see 99080. (3) Do not use OMAP 729E with this evaluation.
Procedure Code: 99172 Amount to be Billed: **$85.64** Provider Type: **Medical Doctors, Ophthalmologists, Optometrists (PB, OD, MD, IH)**	Description	Visual function screening, automated or semi-automated bilateral quantitative determination of visual acuity, ocular alignment, color vision by pseudoisochromatic plates, and field of vision, with completion of the report on eye examination (OMAP 729C). See current CPT for details.
	Guidelines	(1) Use for initial or ongoing eligibility for client with eye or vision problem. (2) Use for casework planning, if appropriate.
Procedure Code: 96100 Amount to be Billed: **$50.60** Provider Type: **Medical Doctors, Psychiatrists, Psychologists (PY, PB, MC, IH, MD w/specialty in PS, PN, CH)**	Description	Psychological testing with interpretation and report, per hour. See current CPT for details. Limited to 6 hours per day.
	Guidelines	(1) Use for initial or ongoing eligibility to determine mental retardation or ability to grasp facts and figures. (2) Use for casework planning, if appropriate.

Guidelines for the OMAP 729 series – continued

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

Guidelines for the OMAP 729 series – continued

Procedure Code: S9981 Amount to be Billed: **$18.00** Provider Types: **(PB, MD, CR, CP, SC, PY, MC)**	Description	Medical records copying fee, administrative. Include progress notes, laboratory reports, X-ray reports, and special study reports since (date)_______. Include recent hospital admission records if available.
	Guidelines	(1) Use for initial or ongoing eligibility when client has been in the hospital or has had a history and physical in the last 60 days.
	Hints	Use of OMAP 729D is optional.
Procedure Code: 99455 Amount to be Billed: **$151.02** Provider Types: **Medical Doctors, Osteopaths, Psychologists, Ophthalmologists, Optometrists (MD, PB, IH)**	Description	Work related or medical disability examination by the treating physician. See current CPT for details. May be paid in addition to 99080.
	Guidelines	(1) Use to determine initial or ongoing eligibility for client with medical problem. (2) Use for casework planning, if appropriate. (3) Use for referral to specialist for consultation.
	Hints	(1) Have the client make appointment with physician and notify worker. Or, if possible, make a doctors appointment at time of interview with client. (2) 99080 completion of Physical Residual Function Capacity Report form OMAP 729E can be billed at the same time.
Procedure Code: 99456 Amount to be Billed: **$151.02** Provider Types: **Medical Doctors, Osteopaths, Psychologists, Ophthalmologists, Optometrists (MD, PB, IH)**	Description	Work related or medical disability examination by other than the treating physician. See current CPT for details. May be paid in addition to 99080.
	Guidelines	(1) Use to determine initial or ongoing eligibility for client with medical problem. (2) Use for casework planning, if appropriate. (3) Use for referral to specialist for consultation.
	Hints	(1) Have the client make appointment with physician and notify worker. Or, if possible, make a doctors appointment at time of interview with client. (2) 99080 completion of Physical Residual Function Capacity Report form OMAP 729E can be billed at the same time.

Guidelines for the OMAP 729 series – continued

Procedure Code: 96117 Amount to be Billed: **$50.60** Provider Types: **Psychologists (PY, PB, MC, IH)**	Description	Neuropsychological testing battery (e.g., Halstead-Reitan, Luria, WAIS-R) with interpretation and report, per hour. See current CPT for details. To be used in combination with 90801, 90889 if required. Limited to 3 hours.
	Guidelines	(1) Use to determine initial and ongoing eligibility to determine extent of brain damage in severely affected clients through neuropsychological testing. (2) Use for casework planning, if appropriate. (3) Paid in combination with 90801, 90889 if required.
Procedure Code: 96111 Amount to be Billed: **$99.91** Provider Types: **PY**	Description	Development testing, extended with interpretation and report, per hour, up to 5 hours. See current CPT for details.
	Guidelines	(1) Use for eligibility or casework planning to determine if an individual is a person with mental retardation. (2) Only for DD clients. (3) May be combined with 96100 (cognitive testing) only if needed to determine mental retardation, and only then when approved by the worker's supervisor or program policies. (4) Current results of both tests (96100 cognitive testing & 96111 adaptive testing) are needed for diagnosis of mental retardation, one or the other may have been completed by school, psychiatric hospital, or other providers of residential services. Request records.
Procedure Code: 90889 Amount to be Billed: **$50.00** Provider Types: **PY, MD, MC, IH, CR, CP**	Description	Preparation of report of patient's psychiatric status, history, treatment or progress. See current CPT for details. Use in conjunction with 90801 only.
	Guidelines	(1) Use for eligibility or casework planning. (2) Must request in conjunction with 90801 only.

Guidelines for the OMAP 729 series – continued

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

Guidelines for the OMAP 729 series – continued

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

"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**

Administrative Medical Examination/ Report Authorization

⑪

A Release of Information is Enclosed

⑩ **Provider Number** ______________________

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

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

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

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

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

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

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

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

Caseworker Instructions for Completion of OMAP 729

All blanks must be completed

1. Patient's Name........................Name of client to be seen by medical provider
2. Insured's ID/Prime No ....Eight alpha/numeric character field
3. SSN ....Client's Social Security Number
4. Date of Birth............................Patient's Date of Birth
5. Program ....Program (A1, 2, B3, D4, 5, P2, etc)
6. Branch ....Branch number (2401, etc)
7. Case Number ....Case number under which client is identified
8. Worker ID................................Worker Identification code
9. Case Name ....Case name under which client is identified
10. Provider Number ....Medical provider number assigned by OMAP, found on PRV1 (See Computer Guide for instructions on accessing PRV1)
11. Address Box ....Name and address of medical provider
12. Patient's Complaint Area ......List stated medical or mental conditions
13. Procedure Code......................Procedure code of selected exam or report
14. Description of Service...........Description for selected examination or report from guidelines
15. Amount to be Billed...............Amount to be billed for selected examination or report from guidelines
16. Needed Reports Boxes ....If other 729's are used, check the appropriate box
17. Branch Name and Address...Legible branch name and mailing address
18. Worker's Name.......................Legible name of worker requesting examination or report
19. Date Requested.......................Date 729 sent to medical provider
20. Telephone ....Legible telephone number of worker requesting report

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

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 Resources
Office of Medical Assistance Programs

Report on Eye Examination

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

Agency Use Only			
Progr0am	Branch	Case Number	Wkr ID
Case Name			Filing Sect 5

Diagnosis ____________________
____

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

1. Is the impairment of central visual acuity in the better eye after best correction to 20/200 or less? ☐ Yes ☐ No
2. Is the contraction of peripheral visual fields in the better eye to 10 degrees or less from the point of fixation; or ☐ Yes ☐ No
3. Is the contraction of peripheral visual fields in the better eye so the widest diameter subtends an angle no greater than 20 degrees; or ☐ Yes ☐ No
4. Is the contraction of peripheral visual fields in the better eye to 20 percent or less visual field efficiency? ☐ Yes ☐ No

What is the prognosis?

____
____

Is the condition progressive? ☐ Yes ☐ No

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

☐ Less than 60 days ☐ 60 days or longer

Will the condition deteriorate without treatment? ☐ Yes ☐ No

Is treatment indicated? ☐ Yes ☐ No

If "yes," what is the recommended treatment?

____
____
____

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

OMAP 729C (1/95)

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

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: ____________________

OMAP 729D (1/95)

State of Oregon
Department of Human Resources
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	☐	☐	☐

OMAP 729E (12/96)

Manipulative Limitations

☐ None established

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

Environmental Limitations

☐ None established

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

Diagnosis	**Prognosis**

How long do you expect this condition to last?

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

Would you recommend a psychological evaluation? ☐ **Yes** ☐ **No**

Additional Comments

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

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

Mental Residual Function Capacity Report

Patient's Name			Insured's ID (Prime No)	
SSN			Date of Birth	
Agency Use Only				
Program	Branch	Case Number		Wkr ID
Case Name			Date Completed	Filing Sec **5**

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

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

In responding to the ratings on this form, please 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.	❑	❑	❑	❑

Sustained Concentration and Persistence

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

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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: ______________________________

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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: ______________________________

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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: ______________________________

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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: ______________________________

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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 ______________________________

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Physician Name (Please type or print)	Address
Signature	Date