DHS Oregon Department of Human Services

Health Services
Office of Medical Assistance Programs

Policy Transmittal

Allison Knight, Acting Manager
OMAP Program and Policy Section
Authorized Signature

Number: OMAP PT-06-002
Issue Date: 8/10/2006

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:	Revision 22 of the OMAP Worker Guides		
Policy/Rule Number(s):	Medical Benefits	Release No:	OMAP-WG-22
Effective Date:	10/01/06	Expiration:	
References:			
Web Address:	www.oregon.gov/DHS/healthplan/data_pubs/wguide/main.shtml		

Discussion/Interpretation:

As of July 1, 2006, clients at or below 10% of the Federal Poverty Level are not required to pay OHP premiums. We have updated the OMAP worker guides with this policy change, as well as making many housekeeping changes and language clarifications. We have updated contractors' names, phone numbers and addresses; added chemical dependency organization information; and a list of contracted transportation brokerages by county.

The OMAP changes are all valid as of July 1, 2006, and will be included in the Family Services Manual Revision 43, dated October 1, 2006.

Revision 22 includes ten of the 14 guides:

- Worker Guide I: Updated phone contacts and where to send forms

- Worker Guide II: Delete and redirect for history of the Oregon Health Plan
- Worker Guide IV: Premium change for clients at or below 10% FPL
- Worker Guide V: Changed Managed Care section to include Chemical Dependency Organizations materials and added clarifying language to many instructions.
- Worker Guide VII: Clarification on how to complete forms for private insurance
- Worker Guide IX: Updated contacts list for Prior Authorization
- Worker Guide X: Updated service denial codes to match online versions
- Worker Guide XI: Corrected some of the OAR citations
- Worker Guide XII: Added list of transportation brokerages and updated

Implementation/Transition Instructions:

Training/Communication Plan:

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

Central Office Action Required:

Field/Stakeholder review: ☒ Yes ☐ No

If yes, reviewed by: OMAP Worker Guide review list of DHS stakeholders

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Filing Instructions:

Replace Guides I, II, IV, V, VII, IX, X, XI, XII and XIV with the attached versions and mark the date in your revision record.

If you have any questions about this policy, contact:

Contact(s):	Mary Gail Jones		
Phone:	503-947-5484		
E-mail:	mary.gail.jones@state.or.us		

OMAP Worker Guide I
OMAP/Medicaid Overview

- Where to send information
- OMAP field resources

A. OMAP/Medicaid Overview

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

- Determines policy and rules for medical assistance programs 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 covered health care services.
- Contracts with managed care organizations (MCOs) for OHP.

Children, Adults and Families (CAF), Seniors and People with Disabilities (SPD), and the Oregon Youth Authority (OYA) are the direct links 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 medical and dental plans in mandatory enrollment areas.
- Provide choice counseling to clients when needed regarding the selection of MCOs available in their area.
- Enter eligibility data into the computer system.
- Order replacement Medical Care Identifications (IDs) on ELGH, or issue temporary Medical IDs on MID1, when needed.
- In areas without contracted medical transportation brokerages, arrange for and prior authorize clients' transportation, when needed, to access health care services.

When health services are delivered to clients not enrolled in an MCO, the provider submits either a paper or electronic claim to OMAP. Then OMAP sends claims through the Medicaid Management Information System (MMIS), a computerized claims processing system. We issue provider checks weekly, accompanied by a remittance advice (RA), 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.

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B.Where to Send Information

Forms Mailing Addresses		
Any form used in conjunction with Death with Dignity	Death with Dignity claims	OMAP, PO Box 992 Salem, OR 97308-0992
AFS 148	Request for Medical eligibility	CMU FAX to (503) 373-0357 or send as a GroupWise attachment to MAINTENANCE, Client
DHS 415 H	Medical Resource Report	HIG PO Box 14023 Salem, OR 97309 or SYSM
DHS 443	Hearing requests (medical)	OMAP Hearings Unit 500 Summer St., E-49 Salem, OR 97301
DHS 451 or 451 NV	Personal injury (vehicle and non-vehicle related)	PIL—Admin Services PO Box 14512 Salem, OR 97309
OMAP 505	Medicare/Medicaid claims	OMAP, PO Box 14015 Salem, OR 97309
Administrative exams (OMAP 729 series)	Exams requested by DHS offices. Send reports to requesting DHS office; mail claims to OMAP	OMAP, PO Box 14165 Salem, OR 97309
OMAP 741 OMAP 742	Consent to hysterectomy Consent to sterilization	OMAP, PO Box 14958 Salem, OR 97309
OMAP 1036 – Individual adjustment request	To use if you have received an incorrect payment (overpayment or underpayment) for a claim	OMAP, PO Box 14952 Salem, OR 97309
OMAP 3073	Private health insurance premium referral	OMAP HFO 500 Summer St., E-44 Salem, OR 97301
ADA 2000 or 2002/2004	Dental claims	OMAP, PO Box 14953 Salem, OR 97309
CMS 1500	All medical provider claims	OMAP, PO Box 14955 Salem, OR 97309
	Speech/language pathology, audiology & hearing services; private duty nursing claims	OMAP, PO Box 14018 Salem, OR 97309
	Contract RN claims	OMAP, PO Box 14957 Salem, OR 97309
TADS	Long-term nursing home care claims	OMAP, PO Box 14954 Salem, OR 97309
UB 92	Hospital, Home Health, Hospice claims	OMAP, PO Box 14956 Salem, OR 97309
UCF 5.1 (Universal Claim Form)	Drug claims	OMAP, PO Box 14951 Salem, OR 97309
Out-of-state claims (all claim types)	For providers more than 75 miles beyond the Oregon border. If within 75 miles, use previous instructions for each form type	OMAP Claims Management PO Box 14016 Salem, OR 97309
OMAP/DHS forms	To order OMAP or DHS forms	DHS Distribution Center 550 Airport Rd Salem, OR 97310

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: Provider Services – OMAP....................1-800-336-6016

Out-of-State: CMU – OMAP....................(503) 945-6522

OMAP.prov-callcenter@state.or.us

Buy-In (Medicare premium buy-in)

Buy-In Unit –OPAR....................(503) 378-2220

Client Complaints

CAF clients – Local Branch Offices....................Operations Managers

SPD clients – SPD Administration....................(503) 945-5811 or

....................1-800-282-8096

Medicaid Fraud Hotline....................1-888-372-8301(888fraud01)

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 – OPAR....................(503) 378-4369

Health Insurance Group

HIG – OPAR....................(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) 945-6106/(503) 947-5129/(503) 945-6072

Private Health Insurance (premium referral) – OMAP....................(503) 945-6562

SSP-Policy, Medical in GroupWise

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

Managed Care Enrollment (questions/problems on plan enrollment)
OMAP – Health Management Unit (HMU) .... (503) 945-5772 or 1-800-527-5772
OMAP.HMU@state.or.us, or HMU, OMAP in GroupWise

Medical Payment Recovery
MPR – OPAR .... (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

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 – Contracted medical transportation brokerages or local branch offices in areas without a brokerage (see a list of brokerages by county in OMAP Worker Guide 12)

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 II

The Oregon Health Plan History

A. The Oregon Health Plan

An historical overview of the Oregon Health Plan is available online at <http://egov.oregon.gov/DHS/healthplan/data_pubs/ohpoverview0706.pdf>.

OMAP Worker Guide IV
Benefit Packages

- What's covered and what's not
- Eligibility, copay, premium requirements
- Other DHS medical assistance programs

A. Benefit Packages General Rules 410-120-1160 through 410-120-1230

OHP Rule 410-141-0480

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

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

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

** The OHP Standard benefit package closed to **new** enrollment July 1, 2004.*

B. What's Covered

1. The OHP Plus Benefit Package
BEN Code – BMH

The Oregon Health Services Commission (HSC) developed a list of 730 medical conditions and treatments in order of effectiveness. Currently, covered services are lines 1-530 on the Prioritized List of Health Services.

OHP Plus Benefit Package – Covered Services

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

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

- Medically Appropriate Ancillary Services – when provided as part of treatment for covered medical conditions
  - Hospital care, including emergency care
  - Home health services
  - Private duty nursing
  - Physical and occupational therapy evaluations and treatment
  - Speech and language therapy evaluations and treatment
  - Medical equipment and supplies
  - Vision and hearing services including exams, evaluations, treatment, materials and fitting for glasses and hearing aids
  - Prescription drugs and some over-the-counter drugs
  - Transportation to health care for clients who have no other transportation available to them, including ambulance and other methods of transport
- Dental Services
- Outpatient Chemical Dependency Services
- Comfort Care – this includes hospice care and other comfort care measures for the terminally ill, and death with dignity services
- Mental health services

2. The OHP Standard Benefit Package*
BEN Code – KIT

This benefit package is similar to private insurance with premiums and benefit limitations. The Prioritized List also applies to the OHP Standard benefit package.

** The OHP Standard benefit package closed to **new** enrollment July 1, 2004.*

OHP Standard Benefit Package – Covered Services

- Physician services
- Ambulance
- Prescription drugs
- Laboratory and x-ray services

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

OHP Standard Benefit Package – Excluded Services

- Acupuncture, except for treatment of chemical dependency
- Chiropractic and osteopathic manipulation
- Nutritional supplements taken by mouth
- Home health care
- Hospital services that are not for urgent or emergency care
- Occupational therapy
- Physical therapy
- Private duty nursing
- Speech therapy

3. QMB Benefit Package
BEN Code – MED

The QMB benefit package pays for Medicare premiums, co-payments and deductibles for services covered by Medicare. This does not include any cost sharing for Medicare Part D coverage or prescriptions.

Providers are not allowed to bill clients with QMB benefit package coverage for deductible and co-insurance amounts for services covered by Medicare (except for Medicare Part D prescriptions). However, providers may bill these clients for services that are not covered by Medicare and for Medicare Part D prescriptions.

4. QMB + OHP with Limited Drug Benefit Package
BEN Code – BMM

This is a combination of the OHP with Limited Drug and QMB benefit packages. To be eligible for this benefit package, clients must meet the eligibility requirements for both

benefit packages. See the QMB and OHP with Limited Drug benefit package descriptions for coverage information.

5. OHP with Limited Drug Benefit Package BEN Code – BMD

The OHP with Limited Drug benefit package covers the same medical, dental and mental health services as the OHP Plus benefit package. However, the OHP with Limited Drug benefit package does not cover drugs covered by Medicare Part D.

6. CAWEM - Citizen/Alien-Waived Emergency Medical BEN Code – CWM

These clients are only eligible for treatment of emergency medical conditions. Labor and delivery services for pregnant women are considered an emergency.

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

The following list is not all-inclusive but can be used as an illustration to identify services that are **NOT covered for clients on the CAWEM benefit package:**

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

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

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

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

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

D. Benefit Package Overview

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

OHP Plus – BMH	
Physician, lab and X-ray services	Hospice services
Pharmacy services	Home health services
Physical therapy/occupational therapy	Dental services
Reasonable diagnostic services	Medical transportation
Durable medical equipment and supplies	Some over-the-counter drugs
Vision, glasses	Chemical dependency services
Hearing, speech services	Mental health services
Hospital services (inpatient and outpatient)	Preventive services (for example: tobacco cessation services)
OHP Standard – KIT	
Physician, lab and X-ray services	Some over-the-counter drugs
Pharmacy services	Outpatient mental health services
Hospice services	Outpatient chemical dependency services
Reasonable diagnostic services	Emergency medical transportation
Limited durable medical equipment (see OAR 410-122-0055)	Limited emergency dental (see OAR 410-123-1670)
Limited hospital services (see OAR 410-125-0047)	Preventive services (for example: tobacco cessation services)
Qualified Medicare Beneficiary (QMB) – MED	
Medicare premiums, deductibles and copays for Medicare covered services	
QMB + OHP with Limited Drug – BMM	
See QMB and OHP with Limited Drug benefit packages	
OHP with Limited Drug – BMD	
The OHP with Limited Drug benefit package covers the same medical, dental and mental health services as the OHP Plus benefit package. However, the OHP with Limited Drug benefit package does not cover drugs covered by Medicare Part D.	
Citizen/Alien-Waived Emergency Medical (CAWEM) – CWM	
Emergency medical services	Labor and delivery
Senior Prescription Drug Assistance Program (SPDAP) – PDA	
Prescription drug assistance for elderly – this is not a Medicaid program (see OMAP Worker Guide #6 for detailed information)	

E. OHP Plus Benefit Package Eligibility and Copay Requirements

This page does not list all requirements or exceptions.

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

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

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

F. OHP Standard Benefit Package Eligibility and Copay Requirements

This page does not list all requirements or exceptions.

This benefit package closed to **new** enrollment July 1, 2004.

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

Copays
None

Premiums
Premiums are charged per member/per month
American Indians/Alaska Natives are not required to pay premiums
Clients who are eligible for benefits through Indian Health Services are not required to pay premiums
Clients with income of 10 percent or less of the Federal Poverty Level are not required to pay premiums
Clients must pay all required premiums before their coverage can be renewed for another enrollment period

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 G & 3-L	OHP Plus, OHP with Limited Drug, QMB with 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 G & 3-L	OHP Plus, OHP with Limited Drug, QMB with OHP Plus
4, D4	Aid to the Disabled	See Computer Guide section 3 G & 3-L	OHP Plus, OHP with Limited Drug, QMB with 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	Comp Guide 3G & 3I	OHP with Limited Drug, OHP Plus
P2	Qualified Medicare Beneficiary (QMB)	QMB	QMB
Any Program	QMB + Any Program	QMM	QMB + OHP with Limited Drug
P2, M5, 2, 82	OHP Medical	OPC, OP6, OPP	OHP Plus
P2, M5, 2, 82	OHP Medical	OPU	OHP Standard
P2, M5, 2, 82	Breast and Cervical Cancer Program	BCP	OHP Plus
P2, M5, 2, 82	Senior Prescription Drug Assistance	PDA	N/A
Any Program	CAWEM	CWM	Emergency Medical

OMAP Worker Guide V
Managed Care Information

- Types of MCOs
- Enrollment process, disenrollment,
- Effective dates, exemptions
- Dual-eligibles, choice counseling
- Educating clients

A. Managed Health Care Systems

OMAP contracts with managed care organizations (MCOs) (MCO 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 MCOs:

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

When the client has been enrolled into an MCO, the MCO 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 in 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 MCO. A comparison chart is included in the OHP application packet (not included in reapplication packets) and describes the MCOs 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 are fee-for-service(FFS) clients who have health conditions such as asthma, diabetes, COPD and heart failure) . OMAP determines if a FFS client with these types of conditions should be enrolled in MCM or DCM Field 8a of the Medical Care ID lists the MCM or DCM contractors., 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. Questions regarding either of these programs should be directed to OMAP.*

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 many medications. FCHPs provide an Exceptional Needs Care Coordinator (ENCC) for clients with special needs. Clients 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 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 can also be enrolled with a PCM. 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. Chemical Dependency Organizations (CDO)

Chemical Dependency Organizations (CDO) are prepaid chemical dependency plans that provide chemical dependency services to qualified medical assistance clients. OMAP pays the CDO a monthly capitation fee to provide comprehensive services and to manage each enrolled client's chemical dependency care. At this time there is only one CDO, which is located in Deschutes County.

6. 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 (only if a medical plan is not available), and
- An OMAP Dental Plan (DCO), and
- An OMAP Chemical Dependency Plan (CDO) if the client resides in Deschutes County.
- 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*.

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

The KSEL screen gives the following information (based on the zip code for the clients home address):

- The types of managed care coverage available (i.e., medical plans, dental plans)
- The specific MCOs and/or PCMs available where the client lives
- The PCM's specialty
- The MCO's enrollment status:
  - Open or closed for enrollment
  - If they are accepting re-enrollments
  - The time limits are for re-enrollment (for example 30 days)
  - Whether or not they take Standard clients

Sometimes a managed care plan must close enrollment to new members. When doing an enrollment if a plan is closed, check KSEL to see if there is a re-enrollment period. These are usually 30 days but can be longer. If the clients break in enrollment was less than the number of re-enrollment days the client may be able to get back into the plan. Workers should contact HMU to see if the client can be re-enrolled. If a case already has someone enrolled in a plan that is closed, any new or returning family members can also be enrolled.

1. Selection Process

The MCO and PCM selection process is based on whether the client lives in a mandatory or voluntary enrollment area and how many MCO's are available. An area

can be mandatory for one type of MCO (for example FCHP) and at the same time be voluntary for another type of MCO (for example DCO). Whether or not a plan is open for new enrollment and whether an area is voluntary or mandatory is determined by OMAP.

Clients who live in a mandatory area must select a medical plan (FCHP or PCO) if one is available. If one is not they may enroll with a PCM.. They must also enroll with a dental plan (DCO). The date of enrollment in an FCHP or DCO depend on when the enrollment action is taken.

Clients are auto-enrolled into an MHO based on their medical plan or PCM enrollment and are therefore not required to choose a MHO. MHO enrollments begin on the first of the month.

If the client was auto-enrolled by the system or their worker choose for them they have 30 days to notify their worker to request an enrollment change. Clients who were enrolled into the MCO 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*."

Enrollment Process—Mandatory area, Multiple MCOs

Use this process for clients who:

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

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

Enrollment Process—Mandatory area, Single MCO

Use this process for clients who:

- Live in a mandatory area, and
- Have only one MCO available, and
- Either did not choose a MCO or the MCO they chose was not available. S*ee "Client Notification Requirement" below.*

The worker must enroll the client in the available MCO.

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

Enrollment Process—Mandatory area, No MCO available

Use this process for clients who:

- Live in a mandatory area, and
- Have no MCO available, and
- Either did not choose a MCO or the MCO 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 MCO when one becomes available. *See "3. Auto-Enrollment" for more information.*

Enrollment Process—Voluntary area

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

Clients who are not enrolled in a MCO 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 MCO and/or PCM until they reapply.
- Voluntary to Mandatory—The client will be auto enrolled or enrolled at redetermination by OMAP Systems. *See "3. Auto-Enrollment" for more information.*

3. Auto Enrollment

This information does not apply to clients who have been approved for an exemption or are in certain categories (for example Native Americans, clients with Third Party Resource (TPR) or have Medicare). 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 MCO if there are other

MCOs 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 MCO Coverage *OHP Rule 410-141-0060*

1. Existing Clients

When an existing client has moved out of their MCO and/or PCM's service area, it's very important to enter their address change as follows:

- Day 1 – Enter the client's new address their existing FCHP and DCO enrollments will end that night. DO NOT DO THE NEW ENROLLMENTS.
- Day 2 – Enter the client's new managed care enrollment choices. The client will be enrolled at the next weekly enrollment

Important - If the new address and managed care enrollment changes are made on the same day, the client's current managed care enrollments will not end until the last day of the month. This will cause their new enrollment to be delayed until the following month and could also affect their ability to receive care.

	Date	Worker enters	Address change effective	Managed Care Enrollment Existing ends	Managed Care Enrollment New begins
Correct	8/7/06	Address change	8/7/06	8/7/06	
	8/8/06	New managed care information			8/14/06
Incorrect	8/7/06	Address change **and** new managed care enrollment information	8/7/06	8/31/06	9/1/06

2. New Clients

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

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

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

Newborns are retroactively enrolled back to their date of birth as long as their birth mother was enrolled in a MCO 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-enroll clients into MHOs each month, with the first of the next month as an effective date.

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

Clients may change their MCO or PCM:

- When they reapply or,
- If they move and their existing MCO or PCM does not provide service at their new address, or
- Within 30 days of an auto-enrollment in an area with multiple MCOs or,
- When approved by OMAP

Contact HMU for assistance with managed care enrollment issues. **E-mail questions 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 a PHP Coordinator at OMAP.

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

Exemption Codes

Clients may temporarily or permanently be exempt from enrolling in a MCO if they are approved for an exemption.. Some codes are restricted and must be entered by HMU. **All** exemptions require a specific start and end date (other than 999999) except the code “PIH”.

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

Do not use an exemption code when the client has private comprehensive medical insurance to prevent auto enrollment or while waiting for ELGX to be updated.

Only use an exemption code in a voluntary enrollment area if the client has a situation that matches the criteria of an existing code. Otherwise, it is not necessary to use an exemption code if not enrolling in managed care.

Use exemptions codes for the reasons listed in this table.

ACC	**Access to Care –** Use in the rare instance when the client receives the majority of their care from a very unique specialist who is out of the client’s service area. For example, the client has a complicated seizure disorder and lives in Medford, however, they receive the majority of their care from a specialist in Portland.
CNT	**Continuity of Care –** Use when MCO 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 MCO. 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 MCO 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– Has not enrolled in a MCO during the past three months, and 3 – Is under the care of a provider who is not contracted with an available MCO.
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. All SPD field staff that want to use this code must make a referral to the SPD Medical Director's Office.
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 MCO 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 MCO. Documentation must be kept in the case file.
SUR	Use when the client has surgery scheduled and the current provider is not part of one of the available MCOs

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 MCO and/or PCM. The Health Insurance Group (HIG) verifies what the insurance covers and determines if the private insurance will be the primary payor. Depending on the type of insurance clients may or may not be required to enroll in an MCO.

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 in an MCO

Note: Clients in mandatory areas with dental private health insurance are still required to enroll in a DCO if one is available where they live.

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. In cases where a client's health requires immediate care, workers can contact HIG by phone and ask for expedited processing of the 415H.

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 the client's case or submit a 415H to HIG. HIG also researches the discrepancy report and requests additional information from branch workers or will requests that the client case be updated.

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

Type of Managed Care Enrollment for Clients with TPR

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

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

1 First preference is to enroll with a medical plan. If an MCO is not available, enroll with a PCM. New clients or clients with a break in enrollment who have End-Stage Renal Disease (ESRD) 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 may be enrolled with PCMs rather than MCOs. If the TPR is specialized, such as 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" was changed to "Medicare Advantage Plan."

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 a 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.. Clients not completing this form may be disenrolled from their MCO. 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 client must complete the Request to Terminate Insurance form (OHP 7209) and send it to the Medicare Advantage Plan they are disenrolling from.

H. Choice Counseling

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

If the client is unable to choose a MCO 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 MCO 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 MCO or enrolled as a PCM?
- ❒ Do the client's children have a PCP? Is the PCP part of an available MCO?
- ❒ 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 MCO 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—***		
MCO enrollment and eligibility/billing questions No MCO message or wrong MCO 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
MCO claim problems, available services, physicians, etc.	Contracted MCO	Contact MCO listed on client Medical ID
ELGC/ELGR and/or coding problems	Client Maintenance Unit (CMU)—OPAR	(503) 378-4369
Private health insurance or third party resource (TPR)	Health Insurance Group (HIG)—OPAR	(503) 378-2220
Unresolved client/MCO problems	Client Advisory Services Unit (CASU)—OMAP	Clients can call: (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	PHP Coordinator in the Delivery Systems Unit (DSU)—OMAP See DSU assignment list or call	(503) 945-5772

OMAP Worker Guide VII
Payment of Private Health Insurance Premiums

- Excluded groups
- Referral to OMAP
- Determining cost-effectiveness
- Hearings
- Forms

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 form (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. OMAP will return incomplete referrals to the branch office.

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). If employer-sponsored insurance, OMAP needs a completed DHS 2099 for both the employer and the insurer. When completing the DHS 2099, remember: Sections A & B require the **policy holder**'s information.
  - ♦ Section B—Include either individual or employer-sponsored insurance companies here (including COBRA) and the insurance company's address

- Section C should always list the OMAP PHI Coordinator's name and address as shown above
- Section D should be signed by the **policy holder** (or rep); add branch worker's name, agency and location

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.

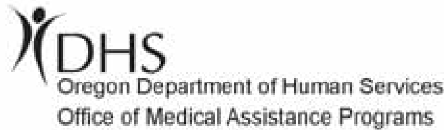
4. Hearings

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: ________ When are premiums due? monthly ☐ quarterly ☐

Policy/Group # ________ Premium Amount $ ________

Date next premium due? ________

Name and address of health insurance company: ________

Name, address, phone number of sponsoring employer: ________

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

ATTACH the following:

A copy of the private health insurance ID card.

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)

Print Clear Form

Authorization for Use & Disclosure of Information

This form is available in alternative formats including Braille, computer disk, and oral presentation.

Section A	Legal Last Name	First	MI	Date of Birth
	Other Names Used By Client/Applicant			Case ID#

By signing this form, I authorize the following record holder (individual, school, employer, agency, or medical or other provider) to disclose the following specific confidential information about me:

Section B	Release From	Specific Information to be Disclosed	Mutual Exchange: Yes / No

If the information contains any of the types of records or information listed below, additional laws relating to use and disclosure may apply. I understand that this information will not be disclosed unless I place my initials in the space next to the information:

HIV/AIDS _______ Mental Health _______ Alcohol/Drug diagnoses, treatment, referral _______ Genetic Testing _______

Section C	Release To (address required if mailed) If releasing to a team, list members	Purpose	Expiration Date or Event*

I can cancel this authorization at any time. The cancellation will not affect any information that was already disclosed. I understand that state and federal law protects information about my case. I understand what this agreement means and I approve of the disclosures listed. I am signing this authorization of my own free will.

I understand that the information used and disclosed as stated in this authorization may be subject to re-disclosure and no longer protected under federal or state law. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS, mental health, and drug/alcohol diagnosis, treatment, or referral information.

Section D	Full Legal Signature of Individual OR Authorized Personal Representative		Relationship to Client	Date
	Name of Staff Person (print)	Initiating Agency Name/Location		Date

*** The authorization is valid for one year from the date of signing unless otherwise specified.**

Full Legal Signature of Agency Staff Person Making Copies	**This is a true copy of the original Authorization document.**
Print Staff Name	

See Important Information on Page 2 of This Form →

Important Information for the Client

To provide or pay for health services: If the Department of Human Services (DHS) is acting as a **provider** of your health care services or paying for those services under the Oregon Health Plan or Medicaid Program, you may choose not to sign this form. That choice **will not** adversely affect your ability to receive health services, *unless* the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure. (Examples of this would be assessments, tests or evaluations.) Your choice not to sign **may affect** payment for your services if this authorization is necessary for reimbursement by private insurers or other non-governmental agencies.

This authorization for use and disclosure of information **may also be necessary** under the following situations:

- To determine if you are eligible to enroll in some medical programs that pay for your health care
- To determine if you qualify for another DHS program or service not acting as a health care provider

This is a Voluntary Form. DHS cannot condition the provision of treatment, payment, or enrollment in publicly funded health care programs on signing this authorization, except as described above. However, you should be given accurate information on how refusal to authorize the release of information may adversely affect eligibility determination or coordination of services. If you decide not to sign, you may be referred to a single service that may be able to help you and your family without an exchange of information.

Using This Form

1. **Terms Used: Mutual exchange:** A "yes" allows information to go back and forth between the record holder and the people or programs listed on the authorization. **Team:** A number of individuals or agencies working together regularly. The members of the team must be identified on this form.
2. **Assistance:** Whenever possible, a DHS staff person should fill out this form with you. **Be sure you understand the form before signing.** Feel free to ask questions about the form and what it allows. You may substitute a signature with making a mark or by asking an **authorized** person to sign on your behalf.
3. **Guardianship/Custody:** If the person signing this form is a personal representative, such as a guardian, a copy of the legal documents that verify the representative's authority to sign the authorization must be attached to this form. Similarly, if an agency has custody, and their representative signs, their custody authority must be attached to this form.
4. **Cancel:** If you later want to cancel this authorization, contact your DHS staff person. You can remove a team member from the form. You may be asked to put the cancellation request in writing. Federal regulations do not require that the cancellation be in writing for the Drug and Alcohol Programs. No more information can be disclosed or requested after authorization is cancelled. DHS can continue to use information obtained prior to cancellation.
5. **Minors:** If you are a minor, you may authorize the disclosure of mental health or substance abuse information if you are age 14 or older; for the disclosure of any information about sexually transmitted diseases or birth control regardless of your age; for the disclosure of general medical information if you are age 15 or older.
6. **Special Attention:** For information about **HIV/AIDS, mental health, genetic testing or alcohol/drug abuse treatment**, the authorization must clearly identify the specific information that may be disclosed.

Re-disclosure: Federal regulations (42 CFR Part 2) prohibit making any further disclosure of Alcohol and Drug information; state law prohibits further disclosure of HIV/AIDS information (ORS 433.045, OAR 333-12-0270); and state law prohibits further disclosure of mental health, substance abuse treatment, vocational rehabilitation and developmental disability treatment information from publicly funded programs (ORS 179.505, ORS 344.600) without specific written authorization.

OMAP Worker Guide IX
Prior Authorization

- PA authorities and contact numbers
- Authorizing services on the computer system
- MMIS screens

A. Prior Authorization

Some medical services and equipment require prior authorization (PA) by various DHS agencies or the client's managed care plan before they can be delivered to a client. These services and equipment include:

- Non-emergency medical transportation (including client mileage, meals and lodging)
- Some durable medical equipment and medical supplies
- Most physical therapy and occupational therapy
- Private duty nursing
- Most home health
- Most speech and hearing
- Some visual services
- Some home enteral/parenteral IV
- Some dental services
- Some transplants
- Out-of-state services
- Some surgeries

The chart on the next page lists services requiring prior authorization and who can authorize those services. Procedures for processing PAs are the same for all benefit packages, except when a client is in a managed care organization (MCO) that covers the service.

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

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

Prior Authorization Authority		
Responsible Authority	**Client Groups**	**Services Authorized**
Managed Care Organization (MCO)	All clients enrolled in an MCO when the service is included in the plan's contract	All services for which the plan receives a capitation payment
Local contracted transportation brokerage or DHS branch staff in counties where no brokerage is contracted	DHS clients for non-emergency medical transportation (for clients enrolled in an FCHP or PCO, the plan is responsible for all ambulance, including non-emergency)	Transportation
OMAP Claims Management	Children in subsidized adoption	Medical Transportation; Administrative Exams
SPD branch staff	SPD clients not enrolled in an MHCP	Medical Transportation
First Health Services 1-800-344-9180	All clients not enrolled in an FCHP Any client receiving a therapeutic class 7 or 11 drug	Drugs related to National Drug Codes (NDCs); Oral nutritional supplements
OMAP Medical Unit	CAF and SPD clients not enrolled in an MHCP except Medically Fragile Children[1] and High cost/High risk clients[2]	Durable Medical Equipment (DME) and Supplies (for specific items, see OAR 410-125); Physical/Occupational Therapy (OAR 410-131);Private Duty Nursing Home Health (OAR 410-132); Speech and Hearing (for specific items see OAR 410 Division 129); Visual Services (OAR 410-140); Home Eneral/Parenteral IV (OAR 410-148)
OMAP Dental Coordinator	DHS clients not enrolled in a Dental Care Organization or an MCO which covers dental	Dental services
Transplant/Out-of-state RNs	DHS clients not enrolled in an MCO	Transplants and out-of-state services
Acumentra (formerly OMPRO)	DHS clients not enrolled in an MCO	Surgeries and services listed in OAR 410 Division 130 and/or supplements as requiring Acumentra prior authorization
[1] Medically Fragile Children's Unit	Children case managed by the MFCU and identified with a case descriptor MFC	All medical services requiring prior authorization, except transportation, transplants, out-of-state services, dental and visual services
[2] Innovative Care Management (ICM)	DHS fee-for-service High cost/high risk clients	All medical services requiring prior authorization

Prior Authorization Contacts **or services not covered by a Managed Care Organization** **(i.e., fee-for-service, FFS or open card)**		
Dental	OMAP Dental Coordinator	800-527-5772 or 503-945-6506
Durable Medical Equipment (DME) & Supplies	OMAP Medical Unit*	800-642-8635 or 503-945-6821
Medically Fragile Children (MFC)	MFC Unit	971-673-2985 or 971-673-3000
FFS high cost/high risk	Innovative Care Management (ICM)	800-862-3338
Drugs/Pharmacy	First Health	800-344-9180
Managed Access Program (MAP)	First Health	800-250-6950
Hearing Aid Services	OMAP Medical Unit*	800-642-8635 or 503-945-6821
Medically Fragile Children (MFC)	MFC Unit	971-673-2985 or 971-673-3000
FFS high cost/high risk	ICM	800-862-3338
Home Health (nursing only)	OMAP Medical Unit*	800-642-8635 or 503-945-6821
Medically Fragile Children (MFC)	MFC Unit	971-673-2985 or 971-673-3000
FFS high cost/high risk	ICM	800-862-3338
Home Enteral/Parenteral IV	OMAP Medical Unit*	800-642-8635 or 503-945-6821
Medically Fragile Children (MFC)	MFC Unit	971-673-2985 or 971-673-3000
FFS high cost/high risk	ICM	800-862-3338
Oral nutritional supplements	First Health	800-344-9180
Physical/Occupational Therapy		800-642-8635 or 503-945-6821
Medically Fragile Children (MFC)	MFC Unit	971-673-2985 or 971-673-3000
FFS high cost/high risk	ICM	800-862-3338
Private Duty Nursing	OMAP Medical Unit *	800-642-8635 or 503-945-6821
Medically Fragile Children (MFC)	MFC Unit	971-673-2985 or 971-673-3000
FFS high cost/high risk	ICM	800-862-3338
Speech/Hearing/Audiology	OMAP Medical Unit*	800-642-8635 or 503-945-6821
Surgical Procedures	Acumentra Health (*formerly OMPRO*) 2020 SW Fourth Ave., Ste. 520, Portland 97201	800-452-1250 or 503-279-0159 from outside Oregon: 800-325-8933
FFS high cost/high risk	ICM	800-862-3338

Transplants	OMAP Medical Director's Unit	800-527-5772 or 503-945-6488
FFS high cost/high risk	ICM	800-862-3338
Transportation	Local brokerage	See Worker Guide 12
Visual Services	OMAP Medical Unit*	800-642-8635 or 503-945-6821
FFS high cost/high risk	ICM	800-862-3338
Out-of-State Services	OMAP Medical Director's Unit	800-527-5772 or 503-945-6488
FFS high cost/high risk	ICM	800-862-3338
* OMAP Medical Unit	FAX	503-378-5814

B.Authorizing Services on Computer System

For medical services branch staff must:

- Determine if the client is eligible.
- Determine the client's benefit package.
- Determine if the client is in a managed health care plan and, if so, which plan (ELGX and KON1 screens).
- Determine if procedure codes and diagnosis codes are valid; (LVL3-DIAG screen).
- Check the list to find out where the diagnosis/treatment pair is in relation to the OHP Prioritized List cutoff line (HSCX screen).

How It Works

Step 1 – Is the client medically eligible and does the client's Benefit Package include the service being requested? (ELGR)

No – Deny the request using the appropriate denial code. (See Section 10-denial codes)

Yes – Go to Step 2.

Step 2 – Is the client enrolled in a managed care plan? (ELGX)

No – Go the step 3.

Yes – Deny the request using the appropriate denial code. (See Section 10-denial codes)

Step 3 – Is the client in a long-term care facility? (ELGF)

No – Go to Step 4.

Yes – Review the provider guide to determine if the service is in the all inclusive rate. If it is in the all inclusive rate, deny the request. (See Section 10-denial codes) If it is not all inclusive, proceed to step 4.

Step 4 – Is the procedure code valid? (LVL3)

No – Deny the request using the appropriate denial code. (See Section 10-denial codes)

Yes – Go to step 5.

Step 5 – Is the diagnosis code valid? (DIAG)

No – Deny the request using the appropriate denial code. (See Section 10-denial codes)

Yes – Go to step 6.

Step 6 – Is the service covered by the Oregon Health Plan prioritized list and included in the client's benefit package? (Use HSCX to determine if diagnosis/treatment pairing is a benefit according to the Health Services Commission Prioritized List. Prioritized List reflects diagnosis and procedures that may not be a covered benefit for OMAP.)

No – Deny the request using the appropriate denial code. (See Section 10-denial codes)

Yes – Go to step 7.

Step 7 – Process the request using the appropriate MMIS screen (ELGP) and provider rules.

C. MMIS Screens

The following screens are used in prior authorizing services for OHP clients. Please refer to the *CAF Computer Guide*, Chapter XXII, for specific screen information.

- OHPS – A menu of OHP screens.
- HSCX – Entering a diagnosis and procedure code for the date of service identifies whether a treatment is above or below the line. However, the diagnosis and procedure code must be verified on the DIAG and LVL3 screens and indicate an active status for MMIS payment.
- ELGR – To verify Medicaid eligibility and benefit package.
- ELGX – Indicates whether a client is enrolled or is being enrolled in a plan or has private insurance.
- KON1 – The names and pertinent information on plans.
- ELGP – Prior authorization screen. The computer will automatically furnish the PA number and generate a notice of approval or denial to the client, provider, and branch.
- DIAG – Indicates if this diagnosis code has an active status for MMIS payment.
- LVL3 – Indicates if this procedure code has an active status for MMIS payment.
- XREF – To locate a client by name or Social Security number.
- ELGF – Long Term Care indicates current and historical information about a client's stay in a nursing facility.
- MEDC – Indicates medical criteria that affect the adjudication of claims.
- PRVX – To locate a provider by name.
- PRV1 – Used to identify provider eligibility.

OMAP Worker Guide X
Service Denial Codes

A. Service Denial Codes

When you deny a medical service, including medical transportation, you can use the ELGP screen to send the denial. These are the codes used to send the denial.

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

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

R03 – The service for which you billed is not covered by OMAP. (General Rules 410-120-1200; 410-120-1160, 410-120-1210)

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

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

R06 – OMAP does not pay for services that were not properly prescribed by a licensed practitioner practicing within his/her scope of practice or licensure. (General Rules 410-120-1200)

R07 - removed

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

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

R10 – OMAP does not cover medical expenses incurred by a client, regardless of age, who is in the custody of a law enforcement agency or an inmate of a non-medical public institution. (General Rules 410-120-1200)

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

R12 – OMAP will not pay for purchase, repair or replacement of materials or equipment when loss or damage is due to the adverse action of the client. (General Rules 410-120-1200)

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

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

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

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

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

R18 – For clients whose medical care is managed by a primary care practitioner, a referral is required before non-emergency care is covered by the health plan or OMAP. (General Rules 410-120-0000, 410-120-1210)

R19 - *Removed*

R20 – This service/item is not covered due to age limitations. (General Rules 410-120-1200, 410-120-1160)

R21 – OMAP will not pay for dental services when the client is enrolled in a DCO. Please contact the client's plan. (OHP Administrative Rule 410-141-0420).

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

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

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

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

R26 – OMAP will not pay for services when the client is enrolled in a prepaid health plan that covers the service. Please contact the client's plan. (OHP Administrative Rules 410-141-0420; General Rules 410-120-0250).

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

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

R29 – Information submitted does not substantiate the medical appropriateness for the service provided/requested. (General Rules 410-120-0000, 410-120-1230)

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

R31 – This service/item requires authorization of payment before it can be provided. (General Rule 410-120-1320, Dental 410-123-1160, FQHC 410-147-0060, Home Health 410-127-0080, PT/OT 410-131-0160, Speech 410-129-0080, Vision 410-140-0040).

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

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

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

R35 – This service/item requires authorization of payment before it can be provided. (General Rules 410-120-1320; Durable Medical Equipment 410-122-0040; Medical-Surgical Services 410-130-0200; Private Duty Nursing 410-132-0100; Transplant Services 410-124-0020; American Indian/Alaska Native 410-146-0060).

R36 – Items and/or serv (i.e., PT, OT, etc.) included in the nursing facility all-inclusive per-diem rate are the responsibility of the nursing home facility. (General Rules 410-120-1340; DME 410-122-0180; Home Enteral/Parenteral Nutrition and IV 410-148-0120; Pharmaceutical 410-121-0920; SPD 411-070-0085)

R37 – Diag & clinical evidence submitted do not meet the criteria for approval. (OHP Admin Rule 410-141-0480, 410—141-0520; General Rules 410-120-1320; Speech 410-129-0080; PT/OT 410-131-0080; HH 410-127-0080; Vision 410-140-0040; EPIV 410-128-0020; DME 410-122-0080; Priv Duty Nurs 410-132-0080; Dental 410-123-1100)

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

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

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

R41 – Written documentation has not been received to justify authorization for medically necessary service and/or supplies. (General Rules 410-120-1320, 410-120-0000, 410-120-1200; Speech/Hearing 410-129-0080; Vision 410-140-0040; EPIV 410-148-0060, 410-148-0260; Pvt Duty Nurse 410-132-0080; Dental 410-123-1100)

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

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

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

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

R46 – OMAP will not pay for srv/item which are similar or identical to srv/item that achieve the same purpose at a lower cost & for which the anticipated outcome will be essentially the same, (DME 410-122-0080; General Rules 410-120-1200; Med Transport 410-136-0300; Prvt Duty Nurs 410-132-0080; HH Care 410-127-0060).

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

R48 – Written documentation has not been received to justify authorization for medically necessary serv and/or supplies. (General Rules 410-120-1320, 410-120-0000, 410-120-1200; DME 410-122-0040, 410-122-0080; Home Health 410-127-0080; PT/OT 410-131-0080).

R49 – This service is not covered by OMAP for clients with only QMB coverage. Coverage is only for those services which are covered by Medicare. (General Rule 410 120-1210)

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

R41 - Removed

R52 – OMAP only pays for stainless steel crowns on posterior teeth. (OHP Dental/Denturist Svcs 410-123-1260).

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

R54 – Replacement of dentures and cast metal partials is limited to once every five years. (OHP Dental/Denturist Svcs 410-123-1260).

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

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

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

R58 – This service requires payment authorization. (General Rules 410-120-0000, 410-120-1320; HH Care 410-127-0080, PT/OT 410-131-0160; Speech/Language,, Audio/Hearing Aid 410-129-0070; Home Enteral/Parenteral Nutrition & IV 410-148-0060; DME 410-122-0202, 410-122-0210; Vision 410-140-0040).

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

R60 – OMAP does not pay for services listed as not covered. (General Rules 410-120-0000, 410-120-1210; Durable Medical Equipment 410-122-0080).

R61 – This service is not covered by OMAP for clients with Citizen/Alien-Waived Emergency Medical (CAWEM) coverage. (General Rules 140-120-0000, 140-120-1210; Durable Medical Equipment 410-122-0080).

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

R63 – Theorder must be dated, legible & specify the exact medical item or service required, the primary ICD-9diagnosis code, number of units and length of time needed. (Durable Medical Equipment 410-122-0020)

R64 – Limited to 220 units/month, based on medical appropriateness, of any combination of products (i.e., adult briefs and liners) unless documentation supporting a higher utilization is submitted to OMAP Medical Unit for review & Prior Authorization. (Durable Medical Equipment 410-122-0190, 410-122-0630)

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

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

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

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

R69 – Prior Authorization is not required.

R70 – Considered to be paid after 16 consecutive months of rental by the same provider or when purchase price is reached. (Durable Medical Equipment 410-122-0182)

R71 – PA not required for Medicare covered services. DME 410-122-0040 (3); PT/OT 410-131-0160 (7); EPIV 410-148-0160 (1); Speech/Hearing 410-120-0100 (6); Home Health 410-127-0080).

R72 – Limited to 220 units per month of any combination of Category I incontinence supplies, unless documetnation submitted supports why the higher amount is medcally appropriate. (Durable Medical Equipment/Supplies 410-122-0190. 410-122-0630).

R73 – Limited to 100 units per month of any combination of Category II incontinence supplies, and required documentation must be submitted supporting the medically appropriate reasons for incontinence. (Durable Medical Equipment/Supplies 410-122-0190, 410-122-0630).

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

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

OMAP Worker Guide XI
Client Rights and Responsibilities

- Billing of clients
- Health care complaint process
- Hearings
- Form

A. Client Rights and Responsibilities

Clients who receive Medical Assistance programs have specific rights and responsibilities:

- Rights and Responsibilities is part of a client's application for medical assistance. Clients are asked to sign this form to be sure they are aware of their rights.
- Part of a client's rights involve billing. OMAP has very specific rules for billing clients.
- Clients also have grievance rights and rights to a hearing under administrative rules.
- Plans must have a complaint process for clients.

B. Billing of Clients *General Rules 410-120-1280 and 410-141-0420*

A provider must not seek payment from a Medical Assistance client or any financially responsible relative or representative of that individual for any service covered by Medicaid except under the circumstances described below.

- The health service or item is not covered by the Medical Assistance program. The client must be informed in writing in advance of the receipt of the specific service that is not covered, the estimated cost of the service, and that the client or the client's family is or may be financially responsible for payment for the specific services.
- The client is not eligible for Medical Assistance at the time the service(s) or item(s) were provided, and is not made eligible retroactively.
- The charge is for a copayment when a client is required to make a copayment as outlined in OMAP General Rules 410-120-1230.
- The client did not tell the provider that he/she had Medical Assistance Program coverage either at the time the service was provided or subsequent to the provision of the service and, as a result, the provider could not bill the Medical Assistance Program in accordance with the Timely Submission of Claims rule. The provider must document attempts to obtain information from the client on potential Medical Assistance Program coverage.
- The client did not tell the provider that he/she had Medical Assistance Program coverage prior to the delivery of the service, the service required authorization prior to the delivery of the service, and Medical Assistance Program staff will not retroactively authorize.
- The client did not tell the provider that he/she had other insurance coverage and the third party insurer will not make payment because of lack of timeliness or lack of prior authorization. The Medical Assistance Program will not make payment on a service which would have been covered by another insurer if the client had informed the provider in a timely manner of the other insurance.

  NOTE: Indian Health Services or Tribal Health Clinics are not Third Party Resources and are the payor of last resort.

- A third party resource makes payments directly to the client for medical services.
- The provider is not enrolled with the Oregon Medical Assistance Program.
- The client entered into a payment arrangement before or at the time service was provided. The provider must document the payment terms and client acceptance of the terms under which treatment is being provided and payment responsibility before the service is provided.

  NOTE: If clients report that they are receiving bills for a covered Medicaid service, branch staff should ask the client if they have told the provider that they have Medicaid coverage.

If the provider is aware of the client's Medicaid coverage but still bills the client, fax copies of the bills to the OMAP Client Advisory Services Unit at (503) 945-6898 or mail the copies to OMAP, Attention: CASU Billing.

C. Health Care Complaint Processes

OHP Rules 410-141-0260 and 410-141-0261

There will be times when clients are not satisfied with a health care decision made by their providers or their managed health care plan.

All clients may seek assistance with health care concerns or complaints through OMAP's Client Advisory Services Unit. Clients may call the unit toll-free at 1-800-273-0557. Clients may also use the OHP 3001 Complaint Form to submit a complaint in writing to the Client Advisory Services Unit. This form is especially useful if the client wants to attach backup documentation such as a denial of service or bills from providers. A copy of the OHP 3001 form is contained in this section.

Clients in managed health care plans should be encouraged to use the complaint process outlined below:

1. Talk to the Primary Care Provider. The client should ask the physician or other provider to attempt to resolve the problem.

2. Contact the Plan's Customer Service Representative. The plan's telephone number is on the client's monthly Medical Identification Form. Clients may also use the OHP 3001 Complaint Form to register complaints with a managed care plan.

Clients over 65 and those with disabilities can also seek help from their plan's Exceptional Needs Care Coordinator (ENCC) who can be reached at the same telephone number.

3. Ask for a Review by the Plan. If the decision is unsatisfactory, the client can request a review of the decision by the managed care plan's board of directors, quality assurance committee, or other responsible party. The plan must respond in writing within 30 days.

D. Hearings

General Rule 410-120-1860
OHP Administrative Rule 410-141-0262 and 410-141-0264

Managed Care Plan Clients

Clients enrolled in a managed care plan who have been denied a service must first appeal the decision through their plan before they may request an administrative hearing through DHS. Clients should follow the instructions on the Notice of Action (initial denial notice) to complete the appeal process through their plan.

Once the managed care plan has completed the appeal process, the plan will send the client a Notice of Appeal Resolution stating the plan's decision. If the client is not satisfied with the outcome, they may then elect to follow the instructions on the Notice of Appeal Resolution to request an administrative hearing through DHS.

Please ensure that clients enrolled in a managed care plan have completed the appeal process through their plan before giving them a DHS 443 form and Notice of Hearings Rights form.

Fee-for-service Clients

Clients who are fee-for-service (also known as “open card”), may request an administrative hearing through DHS at the time they receive the Notice of Action (initial denial notice).

Submitting the DHS 443 to OMAP Hearings:

Managed Care Plan Clients

Please ensure that the client has fully completed the DHS 443. Please ask the client for a copy of the Notice of Appeal Resolution (decision notice) from the managed care plan to include with the DHS 443. If they do not have a copy, please forward the DHS 443 to OMAP.

Fee-for-service Clients

Please ensure that the client has fully completed the DHS 443. Please ask the client for a copy of the Notice of Action (denial notice) to include with the DHS 443. If they do not have a copy, please forward the DHS 443 to OMAP.

Forward all OMAP hearing requests, with attachments, to:

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

OMAP Worker Guide XII
Medical Transportation Reimbursement

- Authorizing transports
- Special circumstance transports
- Client reimbursed travel
- Place of service codes
- Volunteer transports
- Forms

A. Medical Transportation

Staff will find detailed instructions for the authorization process in this section of the manual. In addition, anyone who authorizes non-emergency medical transportation should be knowledgeable of Medical Transportation Services Administrative Rules. This section of the OMAP Worker Guide includes:

- State requirements and authority
- Covered transports
- Authorizing the transport, including:
  - Branch/agency standards
  - Using a brokerage
  - Eligibility screening
  - Procedures to complete OMAP 405T, Medical Transportation Order
  - After hours rides
- Special circumstance transports, including:
  - Out-of-state transports
  - Special transports within Oregon
  - Out-of-state transports to obtain OMAP approved medical services
  - Helpful hints for lodging and meals
  - Hospital to hospital, home or other facility transports
- Not covered transports and related services
- Client reimbursed travel, meals, lodging
  - Attendant meals and lodging
  - Fee schedule for client travel
  - Revolving fund procedures and instructions for completing CMS-1500 Form
- Place of service codes
- Volunteer transports
- Samples of forms Requirements/Authority

Federal regulations 42 CFR 431.53 requires the State to “assure necessary transportation to recipients to and from providers”.

Further, 42 CFR 440.170(3) states: “Travel expenses” include:

(i) The cost of transportation for the recipient by ambulance, taxicab, common carrier, or other appropriate means;

(ii) The cost of meals and lodging in route to and from medical care and while receiving medical care; and

(iii) The cost of an attendant to accompany the recipient, if necessary, and the cost of the attendant’s transportation, meals, and lodging.

In addition, Part 6 - General Program Administration of the Medical Assistance Manual concerning Transportation of Recipients (6-20-00) reads:

1. Administrative Controls

States have an obligation to assure that:

- Transportation will be available for recipients to and from medical care;
- Payment is made only where transportation is not otherwise available;
- Payment is made for the least expensive available means suitable to the recipient's medical needs; and
- Transportation is available only to get individuals to qualified providers who are generally available and used by other residents of the community.

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

- OMAP will not make payment for transportation to a specific provider based solely on client or client/family preference or convenience. For purposes of authorizing non-emergency medical transportation, the medical service or practitioner must be within the client's local area. Local area is defined as "in or nearest" the client's city or town of residence. If the service to be obtained is not available locally, transportation may be authorized to a practitioner within the accepted community standard or the nearest location where the service can be obtained or to a location deemed by OMAP to be cost-effective to OMAP.
- A Branch may not authorize and OMAP will not make payment for non-emergency medical transportation outside of a client's local area when the client has been noncompliant with treatment facility refusing to provide further service or treatment to the client. In the event supporting documentation is submitted to OMAP that demonstrates inadequate or inappropriate services are being (or have been) provided by the local treatment facility or practitioner, transportation outside of the client's local area may be authorized on a case-by-case basis.
- If a managed care client selects a Primary Care Physician (PCP) or Primary Care Manager (PCM) outside of the client's local area when a PCP or PCM is available in the client's local area, transportation to the PCP or PCM is the client's responsibility and is not a covered service.
- The client will be required to utilize the least expensive mode of transportation that meets their medical needs and/or condition. Ride-sharing by more than one client is considered to be cost effective and may be required unless written medical documentation in the branch record indicates ride sharing is not appropriate for a particular client. The written documentation will be made available for review upon request by OMAP. Mileage reimbursement will be made to one of the clients who are sharing a ride. Payment will not be made to more than one client for each ride.

2. Covered Transports

OMAP will reimburse for medical transportation, for eligible Title XIX and Title XXI (for exceptions see *Not Covered Transports* in this guide) and TANF eligible clients (unless non-emergent transportation is excluded from the client's benefit package), when the following occurs:

- It has been determined by the branch authority that the client has no other means of transportation available; and

- When a properly completed Medical Transportation Order (OMAP 405T) or its equivalent has been forwarded to the transportation provider; AND
- The transportation provider is actively enrolled with OMAP as a provider of Medical Transportation services and the service to be obtained is one of the following covered services:
  - ♦ Administrative Medical Exam (An open eligibility segment on ELGR must be present in order for the claim to be paid.)
  - ♦ Adult day care service, where medical services are provided
  - ♦ Ambulatory Surgical Center service
  - ♦ Chemotherapy
  - ♦ Chiropractic service
  - ♦ Day treatment for children (DARTS)
  - ♦ Dental/denturist service
  - ♦ Diabetic/self-monitoring training and related services
  - ♦ Family sex abuse therapy, when provided by a mental health clinic
  - ♦ Federally Qualified Health Care Center service
  - ♦ Hemodialysis
  - ♦ Hospital service. (Includes inpatient, outpatient, and emergency room.)
  - ♦ Maternity management service. (Reimbursement for transportation is for client transport only. These services are provided for pregnant women and are provided only at medical offices, hospitals, public health departments and other medical facilities.)
  - ♦ Mental health and alcohol and drug service. (When provided by mental health organizations, mental health clinics or other providers subcontracted with prepaid health plans to provide mental health and/or alcohol and drug services.)
  - ♦ Naturopathic service
  - ♦ Nurse practitioner service
  - ♦ Nursing facility service
  - ♦ Pharmaceutical service*
  - ♦ Physical and occupational therapy
  - ♦ Transports to swimming pool therapy will be reimbursed only if the therapist is providing therapy “one-on-one” in the pool with the client and the therapy has been prior authorized.
  - ♦ Physician service
  - ♦ Podiatrist service
  - ♦ Prosthetic/orthotic repair/adjustments
  - ♦ Special transports to obtain out-of-state services not available in Oregon. Must be authorized by the OMAP Out-of-State Services Coordinator and Medical Transportation Program Manager.
  - ♦ Speech/hearing/audiology service
  - ♦ Transplant. Must be authorized by the OMAP Transplant Coordinator or the client’s prepaid health plan.
  - ♦ Vision service (including ophthalmic services)

- ♦ Waivered service as follows: OMAP will reimburse for transportation from a nursing facility to a Title XIX waivered living situation (i.e., AFC, SLC, RCF, Group Home) or from one Title XIX waivered living situation to another Title XIX waivered living situation or nursing facility.
- ♦ Transports to Title XIX psych hospitals for inpatient or outpatient psych services (covered for clients of all ages)

Remember: Most pharmacies now provide free delivery of prescriptions. Also, the OHP contracted home delivery pharmacy services are available for those clients who are on maintenance medications and who can reasonably utilize home delivery services. OHP Home-Delivery includes a 3-month supply instead of a one-month supply on most medications, and shipping is free to the client's home or clinic.

Wellpartner is the contracted home delivery pharmacy for OMAP. Contact Wellpartner at 1-877-935-5797 for more information. Prescription order forms and additional information are available from the DHS Web site at

<http://www.oregon.gov/DHS/healthplan/clients/mailrx.shtml>

3. Covered Transports Provided by Volunteers

(These are Title XIX matchable.) OMAP will reimburse a DHS Volunteer for a transport provided to any of the above listed services and to the following services as well:

- Family sex abuse therapy
- Transportation to Shriners Hospital for Children or Doernbecher Children's Hospital
- Transportation to Stepping Stones A&D facility for outpatient treatment
- Transportation to Veterans Administration facilities. (Unless the transport is from one Veterans facility to another Veterans facility. Generally, the Veterans Administration contracts with taxi or ambulance providers to provide these rides.)

NOTE: *Volunteers may also be reimbursed for mileage expenses incurred when the client fails to keep the appointment. In addition, volunteers using State Motor Pool cars may be reimbursed for miles driven in their personal vehicle from home to the Motor Pool and from the Motor Pool to home.*

4. Miscellaneous

A client's family member may be reimbursed for mileage for medically necessary treatment or follow-up visits to Shriners, Doernbecher, or VA Hospitals. (Services provided by these are considered to be cost effective.)

Reimbursement for medical transportation is NOT included in spousal support payments. If a person receiving spousal support requests reimbursement for mileage, it may be approved.

OAR 410-136-0160, Medical Transportation Services, clearly states that client reimbursed travel requires authorization in advance. The rule also defines when retroactive authorization may be made. Once authorized initially, client reimbursement

for mileage may be approved for ongoing trips after the fact but only after the client has provided verification of all medical trips taken. Payment for such trips shall be at the rate calculated by the original authorization.

Do not authorize continuing trips beyond 30 days in advance.

B. Authorizing the Transport

1. Branch/Agency Standards

The branch or agency shall not deny an individual services based on grounds of race, color, sex, religion, national origin, creed, marital status, or the presence of any sensory, mental or physical disability.

Each branch or agency will designate a primary contact and backup person for the purpose of authorizing non-emergency medical transportation.

The branch or agency will inform clients regarding:

- The availability of non-emergency medical transportation, and
- The administrative rules regarding authorization of non-emergency medical transportation, and
- The procedures the client must follow to obtain non-emergency medical transportation.

The branch or agency will ensure that the client has actually received the services for which transportation has been authorized. Branch or agency should attempt to confirm with the medical provider that the client actually received services on the date of the transportation for each ride authorized or trip reimbursed.

The branch or agency will ensure that if any request for non-emergency medical transportation is denied, the client receives a written denial notice. Clients will also be informed about the fair hearing process.

The branch or agency should require the client to call with medical transportation requests as soon as medical appointments are made. Clients who call with "same day" requests may be asked to reschedule their appointment if the appointment is not urgent or not essential to maintaining continuity of care or monitoring of client medical condition.

2. Brokerage

Most regions in the state are within brokerage areas now. These brokerages are consolidated call centers that will verify client eligibility and provide the most cost-effective ride suitable to the client's needs. All requests for transportation originating within a brokerage region, except for ambulance services and client meals and lodging, should first go through the brokerage (this includes client mileage requests).

In some brokerage areas, the brokerage also has the authority to prior authorize mileage, meals, and lodging for clients, DHS volunteers and foster care parents. Check with the brokerage to ensure that the proper prior authorizations are requested.

Coordinate with the local brokerage, by phone, e-mail, etc. when providing client reimbursements in order to ensure that the client is not double dipping by getting a ride from the brokerage at the same time.

Clients who are sent into brokerage areas from non-brokerage areas and need return transportation must have their eligibility information provided by the branch to the appropriate brokerage so the brokerage can arrange for the transportation originating within their area. Clients from one brokerage area going to another brokerage area will be coordinated between the brokerages.

3. Brokerage locations

Broker/Call Center	Phone/Fax	Counties
Central Oregon Intergovernmental Council **Cascades East Ride Center**	**541-385-8680** 1-866-385-8680 Fax 541-548-9548 TDD 1-800-735-2900	Baker Crook Deschutes Grant Harney Jefferson Malheur Wallowa Union
Oregon Cascades West Council of Governments **Cascades West Ride Line**	**541-924-8738** 1-866-724-2975 Fax 541-791-4347 TDD 541-928-1775	Benton Linn Lincoln
Lane Transit District	Pending	Lane
Sunset Empire Transportation District **Northwest Ride Center**	**503-861-7433** 1-866-811-1001	Clatsop Columbia Tillamook
Rogue Valley Transportation District **TransLink**	**541-842-2060** 1-888-518-8160 Fax 541-618-6377	Coos Curry Douglas Jackson Josephine Klamath Lake
Mid-Columbia Council of Governments **Transportation Network**	**541-298-5345** 1-877-875-4657 Fax 541-296-5674 TDD 7-1-1 Relay Service	Gilliam Hood River Morrow Sherman Umatilla

		Wasco Wheeler
Salem Area Mass Transit District **Trip Link**	**530-315-5544** 1-888-315-5544 Fax 503-315-5144	Marion Polk Yamhill
Tri-Met **Transportation Services**	**503-802-8700** 1-800-889-8726 TDD 7-1-1 Relay Service	Clackamas Multnomah Washington

C. Authorization Process

The following information suggests minimal processes that must take place in the authorization of any non-emergency transport. Different client populations and their unique needs or circumstances mean that the process will vary. Certain procedures are required, however, regardless of the client or the specific level of need. This worker guide contains a recommended Medical Transportation Screening Form, which the branch may choose to adopt. Regardless of the form used, a "paper trail" clearly documenting the client's need for medical transportation services, including miles, meals and lodging, must be available for review by OMAP Quality Assurance Audit staff. If the branch is currently using the AFS 405M, that form is also appropriate.

1. Eligibility Screening

- Determine client eligibility for reimbursable transportation. The client must actually be eligible, not pending eligibility, for any non-emergent medical transportation, including client reimbursement. Rides associated with Administrative Examinations would be the exception.
- Has Transportation Screening or Rescreening interview been conducted?
- Is completed Transportation Screening form (or equivalent) in branch record? (The form only needs to be completed for those clients who have requested ongoing Medical Transportation Services.)
- Have all special needs of the client been identified on the form?
- Is the client requesting transport to an eligible (covered) Title XIX service?
- If the Transportation Screening form (or equivalent) indicates "other transportation resources are available," has the client attempted to find transportation other than through the branch?
- Is volunteer transportation available?

NOTE: re-screenings should be conducted at least semi-annually to ensure the client's transportation needs (or level of need) are ongoing.

In all instances, the branch has the responsibility to ensure that the least expensive mode of transportation (suitable to the client's needs) is authorized. It is also the branch responsibility to coordinate brokerage services outside of the resident location.

When a client requests transportation to medical services out of the client's local area, it is the branch's responsibility to determine medical appropriateness (i.e., has client been referred out of area by primary care physician rather than going to the provider of their

choice.). Written documentation supporting the authorization should be retained in the branch record for OMAP audit review.

2. Eligibility Screening - Children in the Care of DHS

Children in the care and custody of DHS are not considered to have familial, financial or other resources available to them for medical transportation. The monthly Foster Care Maintenance payment does not include moneys to cover the costs of transportation to medical appointments. Many children who are under the jurisdiction of DHS have a high volume of medical appointments for counseling, therapies, etc. More often than not, these children are extremely difficult to place. Refusal to make moneys available to the foster parent could potentially jeopardize the child's placement.

Keeping in mind that mileage reimbursement is nearly always the least expensive mode of medical transportation, OMAP's position is as follows:

- Where the foster parent has approached the caseworker and made a request for mileage reimbursement, the moneys should be provided in the same manner as described in the guidelines for client reimbursed mileage. It remains the caseworker's responsibility to ensure the appointment is a covered Title XIX service. In addition, there should be a written statement on the AFS 405M (or whatever screening form is used) to the effect that "Foster parent has requested reimbursement for medical transportation provided to (child's name and prime number). Child has no other resource available."
- If a DHS (or other) branch arranges the reimbursement aspect or otherwise arranges the transportation they should ensure that the caseworker has forwarded a written request containing the above (or similar) statement. All paper documentation is to be retained in the branch record. If DHS handles all aspects of the reimbursement, the paper documentation should be retained in the branch record.

IT IS IMPORTANT TO REMEMBER that while we are required to ensure client access to needed medical services, medical transportation moneys are not considered to be an "entitlement." If the foster parent is willing to provide the transportation and has not requested reimbursement for such, the foster parent is considered to be a resource. Requests for reimbursement on the part of the foster parent should not be encouraged or solicited.

Medical transportation for DHS children in subsidized adoptions should be arranged through OMAP's Claims Management Unit at (503) 945-6522.

3. Procedures for Completing the Medical Transportation Order

The Medical Transportation Order (OMAP 405T) or an equivalent form that includes all OMAP required information must be completed for ALL non-emergency provider transports. The branch is to initiate the order. The provider is only to initiate orders when the ride has been provided "after hours." The VP883 form is required for DHS volunteer transports.

The following information must be included on all Medical Transportation Orders for OMAP Quality Assurance Audit:

- Provider Name or Number

- Pickup Address
- Client Name and Prime Number
- Destination Name and Address
- Trip Information, indicate:
  - 1 way
  - Round trip
  - 3 way
- Mode of Transportation
  - Ambulance
  - Taxi
  - Stretcher Car
  - Wheelchair Van
  - Stretcher Car by Ambulance
  - Other (use for secured transports, ambulatory (able to walk) or other special transports - buses, trains, etc.)
- One Time Trip, indicate:
  - Appointment Date
  - Appointment Time
  - Pickup Time
- On-Going Trips (should not exceed a period of 30 days in advance), indicate:
  - Begin Date
  - End Date: Sun Mon Tues Wed Thurs Fri Sat
  - Appointment Time
- $ Authorized (if special, secured transport, or the total for an on-going period)
- Today's Date
- Branch Number
- Wkr/Clk ID

Each Branch will need to add specific instructions to the Medical Transportation Order that are unique to the needs of the individual client. If a Secured Transport is being authorized, then ensure this level of transport was medically appropriate and that the client was taken to a Title XIX facility. Indicate on the lower portion of the Order the reason secured level is required. The only acceptable reasons for secured transport are: a risk to self (suicidal) or others (assault). A flight risk is not considered appropriate for secured transport. Enter the name and phone number of the medical professional requesting the secured level.

The Medical Transportation Order should be faxed, mailed or routed at the end of each work day to the selected provider. If the branch currently batches and routes requests to providers on a weekly (or other) basis, that process can remain in place, but remember the provider cannot bill OMAP until the Order is received.

Urgent (same day) transports: A phone call to the selected provider should be made immediately, followed up by a completed Medical Transportation Order. A copy of all

Medical Transportation Orders (regardless of the form used) must be retained in the branch record for the period of time described in the General Rules.

4. Additional Client Transport – Same Ride

The fact that more than one OMAP client has been transported during the same ride is not always known to the branch. (Many nursing facilities, etc., contact providers directly to arrange rides.) When this happens the branch is required to verify client eligibility for the ride, etc., and forward a new (or changed) transportation order to the provider. (Administrative Rules require the provider to have branch authorization for EACH client transported. The rules also address those provider types that can bill OMAP for an additional client - same ride.)

5. After Hours Rides

Unless the client resides in a brokerage area, the provider will generally initiate the Transportation Order for "after hours" rides. (This is the only time a provider can initiate an order.) The rules instruct the provider to submit the partially completed order to the branch within 30 calendar days after the services was provided. After confirming the ride was appropriate, the branch is required to return the completed Order to the provider within 30 calendar days after receipt of the Order.

6. Helpful Hints for Completing the Medical Transportation Order

For Taxi, Wheelchair Van/Lift/Stretcher Car/Ambulance/Secured Transports and Other:

- Be sure to complete all required information.
- Be sure to fill in the client's prime number (not case number).
- Circle either: one-way, round trip or three-way in the Trip Info box. (Number of Base Rates and miles is no longer required on the order. The number of base rates and miles billed to OMAP will be reviewed by OMAP Audit staff at the time of provider audits.)
- Volunteers are usually authorized mileage only. On occasion, however, meals and/or lodging may be authorized in addition to mileage. Refer to the Client Reimbursed Travel in this worker guide for general guidelines and criteria.
- Special Instructions - Complete as needed based on client needs. Include on the order all information the volunteer or provider might need to know to provide the best transport possible for the client.
- The Medical Transportation Order must be retained in the branch record for audit purposes for the time described in General Rules.

NOTE: By ordinance, Stretcher Cars are not allowed to operate in all areas in Oregon. In the case where a client is required to travel in a supine position, arrangements can be made with an ambulance to provide the transport. Certain ambulance providers will provide these transports at Stretcher Car rates, and the Order should indicate Stretcher Car Ride. The provider should bill OMAP directly using the Stretcher Car Procedure Codes. If the ambulance provider is NOT willing to provide the stretcher car transport at stretcher car rates, the Order should indicate "Stretcher Car by Ambulance". The provider should be instructed to bill OMAP directly using the new procedure codes listed in the Guide.

D. Special Circumstances Transports

1. Out-Of-State Transfers

Occasionally, due to deteriorating condition/prognosis or other client circumstances, a client (or their family member) may request a transport to leave Oregon. These are generally nursing home clients with poor medical prognosis who want to relocate nearer to next of kin or other family members. It is often a reasonable request with obvious advantages for the client, their family and OMAP.

In order to facilitate a move of this nature OMAP has established basic protocol that must be adhered to in order to complete the successful transfer of a client to another state. That process consists of:

- The client or the client's family must express in writing a desire and a commitment to make the transfer. *
- The case manager must provide assurance that the receiving state has the necessary services the client requires.
- The family and case manager must make the appropriate contacts with the receiving state. Whenever possible, written confirmation from the receiving state is desirable. *
- Any necessary medical documents must be made available to the receiving state to assist that state in the determination of client eligibility.
- A written statement from the client's attending physician that the client is capable of making the transfer (traveling) without any detrimental effects to his/her medical status. *
- If going to a facility, written confirmation from the receiving facility acknowledging their willingness to accept the client and that a bed is available. *
- Determine the appropriate mode of transport, i.e., is the client bed-bound? If so, is ground transport more appropriate than air? If air transport is necessary, the appropriate ground transport must be arranged at the departure and destination points. Obtain written cost estimates from all providers contacted. *

* *Any of the above information with an asterisk (*) must be routed (or faxed) to the OMAP Medical Transportation Program Manager for final approval. Retain a copy of all information in the branch record.*

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

Remember: OMAP does not reimburse moving a client's personal belongings, furniture, medical equipment or for the services of an escort or an attendant. The client's family will be responsible for providing escort/attendant services, and moving of any medical equipment, furniture, etc.

2. Special Transports Within Oregon (Bid Rides)

Occasionally, due to client medical condition, circumstance or length of transport, an OMAP provider may be unwilling to provide a non-emergency transport at OMAP rates. When this happens, the following must occur:

- Determine the reason for the refusal. Is it simply OMAP rates are too low?
- Is there another reason? For example, is the patient extremely obese? Provider does not have vehicle or sufficient extra attendants to facilitate transport?
- Are other providers available in the area that would provide the transport at OMAP rates?
- Do staff in another branch (in the same area) know of any provider who might provide the service?

If at all possible, obtain the transport at OMAP rates. If absolutely no provider can be found who will accept OMAP rates, obtain three written estimates from various providers (if possible). Select the lowest estimate provider that can meet the client's medical need. Authorize as you would any other transport. (OMAP does not need to be contacted in advance for in-state transports.) Ensure the dollar amount authorized is entered in the lower right box of the Order if the OMAP 405T is used. If another form is used, ensure the authorized amount is indicated on the form. Also include the reason the special rate was authorized. Rides to services in the provider's local service area are not considered to be special transports, and shall not be authorized as such.

Retain a copy of all estimates, the billing and the Transport Order in the branch record.

NOTE: For clients residing in brokered areas, the broker will arrange for and provide these transports. Non-emergency ambulance transports will still be arranged by the branch, however.

3. Out-of-State Transportation to Obtain OMAP Approved Medical Services

a. Managed Care: If a Prepaid Health Plan subcontracts for services to be provided to a client out of state, and that service is available in-state, the Prepaid Health Plan is responsible for transportation and all associated costs (i.e., meals and lodging for both the client and any required attendant. (OMAP Administrative Rule 410-141-0420 (11)).

If a Managed Care Plan approves out-of-state services for a client because the services are not available in-state, the Managed Care Plan should send a copy of the approval to the branch for branch client records. Upon receipt of the letter of approval, the branch will be authorized to disburse non-emergency transportation funds (including per diem) as required.

If a client's Primary Care Case Manager or fee-for-service practitioner requests out-of-state services, the request must be submitted to the OMAP Out-of-State Coordinator for prior authorization.

If OMAP approves an out-of-state service, a letter of approval will be sent to the branch by the OMAP Out-of-State Coordinator. Upon receipt of the letter of approval, the branch will be authorized to disburse non-emergency transportation funds (including per diem) as required.

NOTE: Providers within 75 miles of the Oregon border are not considered out-of-state.

4. Secured Transports

If the branch is presented with a need for a secured transport, a 405T must be completed to indicate the reason for the need (e.g., suicidal tendencies; a flight risk is not considered appropriate for secured transport). A provider of secured transport is selected by calling three (if possible) available OMAP secured transport providers and accepting the most cost efficient bid for the transport. The 405T is sent to the provider and the transport of the client takes place.

Ensure that the client is Title XIX eligible, that the facility being transported to is a Title XIX provider (if in doubt call the facility and get the six digit Medicaid Provider Number), and that the client is not in the custody of the police/court.

5. Miscellaneous Information

The worker may be able to obtain free or reduced airfare for a client (usually a child) through one of the following resources:

- Air Life Lines (1-916-446-0995)
- American Airlines Miles For Kids
- Make a Wish Foundation (The Medical Social Worker at the receiving hospital may have this information.)
- Angel Flight (1-888-426-2643) or <www.angelflight.org> (Provides *free* non-emergency medical air transport.)

Often the receiving hospital (Medical Social Worker or Nurse Coordinator) has additional information regarding transportation and “special agreements” they have with various organizations for flight and lodging.

It will be the branch’s responsibility to determine the least costly mode of travel (i.e., the use of family vehicle, train, bus).

If the client is a child, OMAP may provide transportation for the child and one parent or escort. Most airlines will not charge for the escort, or will discount the escort’s rate, if the medical need is known.

6. Helpful Hints

- Lodging
  - Is there a Ronald McDonald house at the hospital?
  - Is there free (or reduced) lodging at or near the hospital that the hospital can recommend? Costs?
- Meals
  - Does the hospital provide a meal ticket (or card) or subsidized meals for clients being seen on an outpatient basis? For parents while the child is being hospitalized?
- Where the client/parent/escort will remain at the facility for a lengthy period of time, the branch may want to make arrangements to send incremental amounts of money to the client in the form of checks made payable to the client. This type of arrangement can be made through the Hospital Social Worker.

- Where the branch has a concern for the client or parent/escort's ability to budget funds over a period of time, arrangements can be made with the Hospital Social Worker to disburse incremental amounts as needed to the client, parent or escort.

Additional information for ordering out-of-state transports can be found in *Client Reimbursed Travel, Meals and Lodging* of this worker guide.

7. Hospital to Hospital, Home or Other Facility Transports

a. Hospital to Other Hospital and Return

Certain hospitals may have admitted a client but not have equipment for certain services, testing, or X-rays ordered by the client's attending physician. The client may have to be transported to another hospital where the testing or service can be provided. In these instances, and where the client is transported back to the admitting hospital within 24 hours, the provider must bill the hospital for the transports. No authorization by the branch is appropriate for these transports since the hospital reimburses the transportation provider directly.

b. Hospital to Hospital Transfer

An attending physician may transfer a client directly from one hospital to another hospital for further inpatient care. It is the responsibility of the transportation provider to determine from the hospital if the client has Medicaid coverage and to obtain prior authorization from the branch (or PHP) for these non-emergency transports.

c. Hospital Discharge to Home or Nursing Facility

As above, the Hospital Discharge Planner is responsible (per Hospital Rules) to contact the branch, or request the transportation provider contact the branch to let the branch know the client is being discharged and needs a transport. If the hospital chooses to pay the transport provider without obtaining authorization from the branch, no reimbursement will be made by OMAP to the hospital.

8. Not Covered Transports and Related Services

Following are examples of services/situations where OMAP will NOT reimburse for medical transportation:

- Transportation for a client whose benefit package excludes non-emergency transportation (e.g., OHP Standard).
- Transportation for a client who resides in a brokerage area without prior brokerage knowledge or authorization (this does not include ambulance transport).
- Transportation reimbursement for mileage and per diem in those brokerage areas that by contract are to be authorized solely by the brokerage (check with the brokerage in your area to ensure compliance).
- Secured transports to non-Title XIX facilities. Branch must research prior to completion of Transportation Order.
- Secured transports to return a client to their home or place of residence UNLESS written documentation stating the circumstances is signed and submitted by the treating physician. (OAR 410-136-0240) This written documentation must be retained in the branch record for OMAP review.

- Return a client from any foreign country to any location within the United States even though the medical care needed by the client is not available in the foreign country. (OAR 410-136-0300)
- Return a client to Oregon from another state unless the client was in another state for the purpose of obtaining OMAP approved services and/or treatment. (OAR 410-136-0300)
- Transportation for QMB clients
  - ♦ Program P2 or M5 clients where the only "Q" Case Descriptor on eligibility segment is "QMB". (OMAP only pays the Medicare premiums, coinsurance and deductible on services that Medicare covers. Medicare does not pay for any transportation other than emergency ambulance; rarely does Medicare cover non-emergency ambulance.)
- Transportation for SMB clients
  - ♦ Program P2 or M5 clients where the only Case Descriptor present on the eligibility segment is "SMB". (OMAP pays only the Medicare premium for these clients. They do not get a Medical Identification form and OMAP does not pay for any medical services.)
- Transportation to medical services before spend-down is met.
- Non-emergency medical transportation for undocumented non-citizens (CAWEMs).
- Out-of-state transportation to obtain services that are not covered by the client's benefit package, even though the client may have Medicare or other insurance that covers the service to be obtained.
- Transportation to a specific provider based solely on client preference or convenience, when the service to be obtained is available from a provider in or nearer the client's city (or town) of residence.
- Transportation to obtain primary care physician/case manager services in a service area outside of the client's local area when a primary care physician/case manager is available in or nearer the client's city (or town) of residence. (OAR 410-136-0160)
- Numerous transports to obtain services that could reasonably be scheduled on the same day for the same client or for more than one (1) family member.
- Transportation to recreational activities (e.g., asthma camp), even when doctor prescribed.
- Transports for court-ordered services of any kind (e.g., urinalysis for drug testing).
- Transports occurring while client in custody of law enforcement agency, juvenile detention center, or non-medical public institution.
- Transports to medical facilities where Title XIX dollars cannot be used to reimburse the facility for treatment or services.
- Non-emergency transports not authorized in advance by the client's branch office or brokerage, including client/attendant, private car mileage, meals and/or lodging (in non-brokerage areas and those areas where the brokerage does not by contract have authority to approve).
- Transports provided by a provider not enrolled with OMAP, or a provider who refuses to enroll with OMAP or is unwilling to accept OMAP scheduled or negotiated rates.

- "After hours" transports where the branch office was not notified within 30 days of the transport.
- Transports where no actual client transport occurred even though the transport may have been authorized by the local branch office.
- Transports to non-covered services, non-medical services, school or social activities, parenting classes or relief nurseries provided while parents are attending parenting classes, weight loss or anger management classes, WIC, Citizen's Review Board Hearings, YWCA, YMCA, Alcoholics Anonymous, Narcotics Anonymous, Pioneer Trails, etc. Transportation to Ponderosa Residential Facility or J Bar J Residential Facility in Bend may only be authorized if a client is going to or being returned from a covered medical service.
- Transports for visitation purposes.
- Transports for visits to the client's 'DD' caseworker for group or individual counseling or other sessions. (Transports for MH and A & D are allowed).
- Transportation of a client for the purpose of picking up purchased or repaired durable medical equipment. Administrative rules for DME stipulate that pick-up or delivery of purchased/repaired equipment is included in the purchase or repair price of the item. This does not include prosthetic/orthotic repair or adjustments.
- Additional paid transports should not be authorized for clients when the branch has already issued a monthly bus pass. (Note: change in client level of need or other circumstances would be an exception.)
- Transports to visit sick infant/child or critically ill/injured spouse with poor prognosis.
- Transport of Medicaid clients when those same transports are available at no cost to the general public or when the general public is being transported in the same vehicle at no cost.
- Transports provided to ineligible clients. Always verify client eligibility prior to authorizing transports.
- Transportation to obtain an exam ordered by Social Security, VRD, etc. For Title XIX purposes, these exams are not considered to be medically necessary. VRD has funding to pay for transports to exams required by VRD.
- Transports for the sole purpose of nursing facility "shopping"; i.e., client already in the nursing facility, is looking for another. Exceptions would be a "step-down" to a lower level of care, or "step-up" to a higher level of care with the prior approval of the OMAP Transportation Program Manager.
- Moving client's personal possessions, (e.g., TV or furniture) from home or facility to another facility, or transports for the purpose of picking up a deceased client's medical equipment purchased by OMAP. (This equipment becomes a part of the estate of the deceased.)
- Transports to obtain prescriptions from a pharmacy that offers free delivery.
  - ♦ See OMAP Worker Guide, Section 14, for information on the Home Delivery (Mail Order) Pharmacy Program.
- Transports of any nature after a client is deceased. The above list is not intended to be all inclusive but is provided for illustrative purposes only.

E. Client Reimbursed Travel, Meals, Lodging

1. Guidelines (If the branch lies within a brokerage area, the brokerage may have the authority for the following services. Coordinate with the local brokerage, by phone, e-mail, etc. when providing client reimbursements to ensure that the client is not double dipping by getting a ride from the brokerage at the same time.)

After verifying that appointments scheduled by clients are for covered medical services, and when the client has indicated and the branch has verified the need for financial assistance to access those services (see *Brokerages* section), the branch is authorized to issue a check payable directly to the client (or guardian, etc.) for travel expenditures. Occasionally, the client may need to travel away from their local area. In this case, it may be appropriate for the branch to provide financial assistance for meals and lodging. (See *Attendant* and *Meals [Client/Attendant]* sections.) In all instances, however, it remains the branch's responsibility to ensure the abuse of services does not occur, and to ensure the required screening documentation is completed for retention in the branch record. As with all non-emergency medical transportation, client mileage (including gas only), meals and lodging must be authorized in advance by the branch.

Reimbursements under the amount of $10.00 shall be accumulated until the minimum of $10.00 is reached.

2. Mileage/Gas Only (If the branch lies within a brokerage area, the brokerage may have the authority for the following services. Coordinate with the local brokerage, by phone, e-mail, etc. when providing client reimbursements to ensure that the client is not double dipping by getting a ride from the brokerage at the same time.)

All non-emergency medical transportation must be authorized by the DHS branch in advance of the transportation and the actual transportation should occur prior to reimbursement. DHS branches cannot retroactively reimburse clients for trips taken without prior authorization. However, once the DHS branch has authorized the reimbursement, if the client has no other means of making the trip prior to reimbursement, the DHS branch may provide the reimbursement in advance of the trip. Periodic checks by branch personnel should be made to ensure that non-emergency medical transportation disbursements are, in fact, for trips to and from covered medical services.

DHS branch offices may either issue gas vouchers/tickets or direct mileage reimbursement to clients seeking assistance. Any such reimbursement shall be based on the following formula: Total miles multiplied by $.25 per mile.

Exceptions to this reimbursement policy include:

- DHS Volunteers - will be reimbursed at the current rate of represented state employees
- Client Employed Providers - will be reimbursed at the current rate of their contract

For the purpose of calculating client reimbursed mileage, miles should ordinarily be calculated on a "city limit to city limit" basis. However, a client's destination may be to a service or facility 10-15 miles inside or beyond the city limit, particularly in the Tri-

County area, Salem, and Eugene. A client may also be required to travel additional miles to access a main highway or freeway in order to reach their destination. (Example: There is no direct route from Gold Beach to Sutherlin, so a client may be allowed additional mileage for having to travel an indirect route).

3. **Common Carrier Transportation** (If the branch lies within a brokerage area, the brokerage may have the authority for the following services.)

   When deemed cost effective and providing the client can safely travel by common carrier transportation, (e.g., inter/intra-city bus, train, commercial airline) reimbursement can be made either directly to the client for purchase of fare or the branch may purchase the fare directly and disburse the ticket (and other appropriate documents) directly to the client. (OAR 410-136-0840)

4. **Personal Care Attendant (PCA)** (If the branch lies within a brokerage area, the brokerage may have the authority for the following services.)

   If a PCA is required to accompany either an eligible child or an eligible adult who is unable to travel alone, payment is allowed for the PCA's **transportation***, and meals. Lodging for the PCA may be reimbursed if the PCA does not share the same room with the client. If the client and PCA share the same room, $40.00 per night is still the maximum payable. If the client is required to stay at the site of medical care, payment can be made for the PCA's return trip by the most appropriate mode available.

   ***Transportation** (if mileage) is payable to either the client or PCA, but not both. OMAP does not reimburse for escort or PCA services. As a rule, the branch should use the following criteria to determine if a PCA is necessary:

   - Client is a minor child.
   - Client is mentally/physically unable to get to medical appointment alone.
   - Client's attending physician has signed a statement indicating the need for a PCA because of the medical/mental condition of the client.
   - Client is unable to drive self home after treatment or service.

   NOTE: Reimbursement for meal allowances provided under the Medical Transportation program are to be treated as "extra expenses" and are not considered to be an expense paid by program benefits. These reimbursement moneys should therefore be excluded from calculation of the client food stamp benefit. (Refer to *FSM, Counting Client Assets*, OAR 461-145-0440).

5. **Meals (Client/Attendant)** (If the branch lies within a brokerage area, the brokerage may have the authority for the following services.)

   Client/attendant meals may be reimbursable when a client is required to travel for a minimum of four hours out of their local geographical area, and when the course of that travel spans the recognized "normal meal time". For reimbursement purposes meal allowance will be made when:

   - Breakfast (allowance) - travel begins before 6:00 a.m.
   - Lunch (allowance) - travel begins before 11:30 a.m. or ends after 1:30 p.m.
   - Dinner (allowance) - travel ends after 6:30 p.m.

The branch should monitor repeat requests for single day meal allowances closely to ensure the client is not requesting meal allowance excessively. Counseling on appointment scheduling should occur.

6. **Lodging (Client/Attendant)** (If the branch lies within a brokerage area, the brokerage may have the authority for the following services.)

   Occasionally a client's medical appointment may necessitate a overnight stay. Lodging is reimbursable for the client when the travel must begin before 5:00 a.m. in order to reach a scheduled appointment or when the travel from a scheduled appointment would end after 9:00 p.m. Again, lodging is payable for the attendant only when the shared room is not with the client.

   The branch should determine the actual lodging costs. Lodging may be available below OMAP's reimbursement rate (e.g., Ronald McDonald House is available for $10.00 per night.) When lodging is available below the allowance rate, the branch should only reimburse for the actual cost of the lodging. Reimbursement may only be authorized for one escort, attendant or parent.

   NOTE: If lodging is available closer to the facility where the medical service is being provided, it may be more cost effective to reimburse at the full allowance for lodging, if staying at Ronald McDonald House would necessitate an additional taxi ride to the service. The branch needs to look at these options closely.

7. **Miscellaneous**

   When ordering out-of-area/out-of-state transportation, remember that the client has to get to the airport, train depot, etc.

   Consider the least costly/most appropriate means of transportation; e.g., family, volunteers, bus, cab, stretcher car, etc. Determine from the client (or attendant) if there are special needs:

   - Oxygen
   - Wheelchair
   - Early loading
   - Reclining position
   - Any other condition which would be a problem for transportation provider

   If client is going out of state, work with local travel agents. They can get a better price on tickets, and travel agents are usually aware of the price of shuttles, taxi fares, etc., at the destination point.

   Make sure treatment has been approved by the OMAP out-of-state coordinator (if client is going out-of-state).

   Contact social work department at the medical facility to be used. They can help the client obtain a room(s) at local Ronald McDonald Houses or other low cost housing in the area.

In the case of a transplant, it is sometimes less expensive for the client/attendant to rent an apartment near the facility than to pay $40 a day for lodging. When renting an apartment on a weekly or monthly basis, the daily allowable amount for lodging is for one person. The allowable amount does not double because of the escort/parent.

Remember to make allowances for transportation to and from the hospital for the attendant.

If the client is released from the hospital, but must remain in the area for further treatment, food and lodging can be paid for the client as well as the attendant, if necessary.

An eligible client (or attendant) from another branch may need meals and/or lodging unexpectedly. (Example: The client may have had a medical evaluation and the attending physician is preparing to admit them to a hospital the following day.) When these situations occur, be prepared (after communication with the client's worker) to disburse moneys from your branch for meals and lodging. Always check with the client's local branch first, however, to ensure moneys have not already been provided to the client. In some cases, ongoing appointments are needed. Rather than providing mileage/food/ lodging moneys to the client on a piecemeal basis, and after initial branch approval the branch has the option to request the client to submit reimbursement requests on a monthly basis. When this situation occurs, the client is required to provide the following documentation:

- Date of appointment
- Time of appointment
- Actual miles traveled (odometer)
- Doctor/hospital/clinic name
- Lodging receipts (if stays were overnight)

All documentation must be retained in the branch record. The meals and lodging criteria defined above apply to DHS Volunteers also.

8. Fee Schedule - Client Travel

Procedure Code	**Allowance**	**Or**
A0090 – Private Car Mileage	$.25 per mile	Breakfast 3.00
A0190 – Client Meals	12.00 per day	Lunch 3.50
A0210 – Attendant Meals	12.00 per day	Dinner 5.50
A0180 – Client Lodging	40.00 per night	
A0200 – Attendant Lodging	40.00 per night (if staying in separate room)	
A0110 – Bus, i.e., Greyhound		
A0140 – Airplane (commercial)		

NOTE: Common carrier transportation such as bus, train or airplane, should be made for the least expensive mode suitable to the client's needs.

9. Revolving Fund Procedures

Each DHS branch is able to complete an OMAP 409, which explains the reasons for the services to be paid, and use the SPL1, SPL2 screens to order a check on-line to be prepared and mailed to the client or attendant. Or, the branch may decide to write the check in their branch (especially when there is no time to wait for the check to be issued from Salem) and then complete the information to reimburse the branch for that revolving fund check.

The OMAP 409 form has instructions on the backside of the form. The Computer Guide has the instructions for the SPL screens. When the branch does a revolving fund check, the Financial Accounting Unit must have the revolving fund tissue copy of the check written, in order to reconcile the Revolving Fund account. Reconciled revolving fund checks will appear on the RCIQ check record.

The OMAP 409 with a copy of the AFS 288 Supporting Document Transmittal and the Revolving Fund check tissue copy are sent to:

MicroImaging Unit
P.O. Box 14006
Salem, OR 97309

- If the branch (or you) originated an on-line check to be sent from Salem to the client, the OMAP 409 copy remains in the branch record. The OMAP 409 copy is intended as the branch record of that service.
- If preparation of a CMS 1500 sent to Salem to Financial Accounting to reimburse the branch is necessary, then:
- Route the completed original CMS 1500 to the financial clerk designated in the branch for preparation of the RF check. After the RF check has been typed:
  - ♦ Obtain the client's (or their agent) signature on the third (tissue) copy of the RF check. Retain this copy in the financial clerk files.
  - ♦ Give RF check to client (or their agent) after presentation of identification.
  - ♦ Attach the second (tissue) of the RF check to the completed CMS 1500.
  - ♦ Route all CMS 1500s via completed AFS 288 (Revolving Fund Check & Supporting Document Transmittal) to:

    MicroImaging Unit
    P.O. Box 14006
    Salem, OR 97309

Retain the copy of the CMS 1500 and the yellow copy of the AFS 288 with all supporting documentation in the branch record.

NOTE: Examples of the AFS 288 and CMS 1500 are located at the end of this section.

F. Place of Service Codes

E – Home to Medical Practitioner

F – Home to Hospital

G – Home to Nursing Facility

H – Home to Other (Specify)

J – Nursing Facility to Medical Practitioner
K – Nursing Facility to Hospital
L – Nursing Facility to Home
M – Nursing Facility to Other (Specify)
N – Hospital
P – Hospital to Nursing Facility
Q – Hospital to Other Hospital
R – Hospital to Other (Specify)
S – Medical Practitioner to Hospital
T – Medical Practitioner to Nursing Facility
U – Medical Practitioner to Home
V – Medical Practitioner to Other (Specify)
W – Other (Document in Client Record) to Hospital
X – Other (Document in Client Record) to Other (Document in Client Record)

G. Volunteer Transports (if available in your Service Delivery Area)

1. **Branch Referrals/Responsibility** (If the branch lies within a brokerage area, the brokerage may have the authority for the following services.)

   The branch authority is to determine that the client has no other means of transportation available and public transportation is not an option, then consider the DHS volunteer driver program as a resource for the provision of medical transportation to obtain covered services for eligible clients.

   - Ensure that the medical service the client is being transported to is a covered medical service.
   - Use the lowest cost transport that meets the client's needs.
   - Confirm client eligibility.
   - Submit a completed written ride request on the appropriate form to the volunteer driver program office.

2. **DHS Volunteer Coordinator Responsibility**

   The DHS Volunteer Coordinator will review the ride request form and match it to an appropriate volunteer driver.

   The ride request will be denied if:

   - The service is not an appropriate volunteer activity.
   - The ride request form is not completed.
   - A volunteer driver is not available.
   - The transport is not a Title XIX service.

H. Forms <http://dhsforms.hr.state.or.us/forms/databases/FMPRO?-db=FormTbl.fp5&-lay=Main&-format=Findforms_FMP.htm&-findany >

- Revolving Fund Check & Supporting Document Transmittal (AFS 288)
- Example of CMS-1500
- Medical Transportation Screening/Input Document (OMAP 409)
- Medical Transportation Screening Documentation (OMAP 410)
- Medical Transportation Eligibility Screening and Medical Transportation Order (OMAP 406)
- Medical Transportation Order (OMAP 405T)

State of Oregon
Department of Human Services
Adult and Family Services Division

Revolving Fund Check and Supporting Document Transmittal

Send To: **Microfilm**
P. O. Box 14006
Salem, Oregon 97309

Date: ____________________

From: ____________________ **Branch** **AFS Cost Center:** ____________________

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

For Administrative Payment Unit Use Only

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

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

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

APPROVED OMB-0938-0008

PLEASE DO NOT STAPLE IN THIS AREA

CARRIER

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) CHAMPUS (Sponsor's SSN) CHAMPVA (VA File #) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

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

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other

CITY STATE

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

Employed Full-Time Student Part-Time Student

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. ___ . ___
2. ___ . ___
3. ___ . ___
4. ___ . ___

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE FROM MM DD YY TO MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1										
2										
3										
4										
5										
6										

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN # GRP #

PHYSICIAN OR SUPPLIER INFORMATION

MIF/N90-1B

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

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

Medical Transportation Screening/Input Document

for payments made directly to client/attendant
(see reverse for instructions)
Complete all information applicable

Disposition
❐ Pick-up (enter date) ______________
❐ Mail-by (enter date) ______________

I Client Info

Pgm _______________ Branch ______________ Wkr ID ______________ Case # ____________________________
Client ____ Prime # ____________________________
Last First M I
SSN # ____________________________
Home Address ____ Phone # ____________________________
Street City State Zip
Mail Address ____ DOB ____________________________
Street City State Zip
Payee (if other than client) ____
GRDN on SPL2 GRDN CD

II Reason/ Resource Info

Reason (medical necessity) for travel/trip ____

____

Is public transportation or transportation by a relative, or friend available at no cost to OMAP? (circle one) Yes No

III Appointment Info

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

Appt. Date ___________________ (mo, day, yr) Time _____________ (am, pm) Verified by ________________________

Depart _____________ (mo, day, yr) Time __________ (am, pm) Return _______________ (mo, day, yr) Time ________ (am, pm)

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

IV Trip Information (see reverse side for criteria)

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

* or less if available

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

Procedure Code = 35

TOTAL $ ____________

V Data Entry & Authorization

Terminal Entered by ____ Date ________________________
Revolving Fund Check # ________________________________ (attach tissue copy)
Worker/Requestor ____ Date ________________________
Branch Authorizing Signature ___________________________________ Date ________________________

OMAP 409 (Rev 07/18/02)

Instructions

Disposition

Pick-up - Enter date.
Mail-by - Enter date

Section I – Client Info

PGM – Enter client program number.
Branch – Enter branch number.
Wkr ID – Enter worker ID number.
Case # – Enter case number.
Client – Enter full name of client.
Prime # – Enter client prime number.
SSN # – Enter client Social Security number.
Address – Enter client home address, city, state.
Home mail Address - Enter client mailing address, city state (if different).
Phone # – Enter client phone number.
Client DOB - Enter client date of birth.
Payee – Enter payee name on check, if other than client. (GRDN, Guardian, on SPL2. Then enter "G" as GRDN Code)

Section II – Reason/Resource Info

Enter reason (medical necessity) for travel/trip.
Circle Y **(yes)** or N **(no)** to indicate what resources are available.
If resource available but not used, state reason.

Section III – Appointment Info

Destination – Enter doctor, hospital name, address, city, state, and phone number, if known.
Appt. Date & Time – Enter date and time of appointment.
Verified by – Enter name of branch worker who verified appointment.
Departure Date – Enter date and time (complete only if meals or lodging authorized).
Return Date – Enter return date and time (complete only if meals or lodging authorized).
Ongoing Trips – Enter beginning and ending dates of ongoing rides. Circle appointment days.

Section IV – Trip Information

Round Trip Mileage – Enter total # of miles. Enter total mileage reimbursement ($) authorized.
Client Meals & Lodging – Enter total # of meals and nights lodging. Enter reimbursement ($) authorized.
Attendant Meals & Lodging – Enter total # of meals and nights lodging. Enter reimbursement ($) authorized.
Procedure Code – Enter 35.
Other - Circle one, enter reimbursement ($) authorized.
TOTAL – Enter total $ authorized this transaction.

Section V – Data Entry & Authorization

Terminal Entered By – Enter name of entry operator and date entered.
Revolving Fund Check # – Enter number of RF check and attach tissue copy.
Worker/Requestor – Enter name of person making request and date of request.
Branch Authorizing Signature – Obtain signature of branch authority and date of signing.

Meals (Client/Attendant)

Client/attendant meals may be reimbursed when client is required to travel for a minimum of four (4) hours out of their local geographic area AND when the course of travel spans the recognized "normal" meal time. For reimbursement purposes, meals are allowed when:

Breakfast – travel BEGINS before 6:00a.m.

Lunch - travel BEGINS before 11:30 a.m. OR ends after 1:30 p.m.

Dinner – travel ENDS after 6:30 p.m.

Lodging (Client/Attendant)

Client/attendant lodging will be allowed when the travel must BEGIN before 5:00 a.m. in order to reach a scheduled appointment OR when the travel from a scheduled appointment would END after 9:00 p.m. If lodging is available for LESS than the allowed rate, the lesser amount must be authorized.

Attendant

Use the following criteria to determine if an attendant is necessary:

- Client is a minor child.
- Client is mentally/physically unable to get to medical appointment alone.
- Client is unable to drive self home after treatment or service.
- Client's attending physician has signed a statement indicating the need for an attendant because of medical/mental condition of the client.

OMAP 409 (Rev 07/18/02)

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

Next Screening Due Date ________________

MEDICAL TRANSPORTATION SCREENING DOCUMENTATION

Client: ____________________________ Transportation Code: _______________
Prime ID: ___________ DOB: _____________ Prgm: ____ Wrkr: _________
Address: ____
Phone: ____
Contact Person (if applicable): ____
Today's Date: __________________ Completed By: ________________________

Mobility Equipment used:

❒ Wheelchair ❒ Hightop ❒ Extra Wide ❒ Needs transfer assist
❒ Folding Walker ❒ Non-Folding Walker
❒ Other ____

Special Information (eg., needs exceptional assist, behavior problems, extreme obesity, etc.) ____
____

Does client have transportation resources available (eg., car, motorized cart, friend/relative who can provide transportation)?

❒ Yes ❒ No ❒ On Occasion

Why is prior method of transportation no longer usable?

❒ No longer available ❒ Physical/mental condition worsened
❒ Other ____

Transportation Needs (Transportation Code):

___ 0. Not eligible for medical transportation.
___ 1. Can travel (walk, use wheelchair, etc.) up to 1/4 mile (approx. 5 blocks) and board bus/MAX.
___ 2. Can travel (walk, use wheelchair, etc.) to curb unassisted and board LIFT or other vehicle.
___ 3. Needs assistance from home to vehicle to inside clinic/office.
___ 4. Must travel in reclining position (eg., stretcher car).
___ 5. Must have ALS/BLS treatment/intervention/monitoring during transport.
___ 6. Transportation not covered by client's medical insurance.

Branch: Retain in Branch Record

OMAP410(11/99)

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

Today's Date ________________

MEDICAL TRANSPORTATION ELIGIBILITY SCREENING AND MEDICAL TRANSPORTATION ORDER

Route, Mail or Fax to: Prov Name ________________________ Prov # __________________

Fax # (503) ________________________

Client Name ______________________________ DOB ________ Phone __________________
Last First

Person Submitting Request ____________________________ Phone ______________________

Prime ID # Prg _____ Wkr ID______ ❐ Check box if client has no other transportation available for this appointment

Trip Info: ❐ 1 Way ❐ Round Trip ❐ 3 Way ❐ Ongoing ❐ Change to Ongoing

Mode: ❐ Taxi ❐ WC ❐ SC ❐ Ambulance ❐ SC by Ambulance* ❐ Other

Pick Up Address ____________________________ Apt # ____ City ___________________

Destination ________________________ Address ______________________________________

2nd Destination ____________________ Address ______________________________________

Appt Date ________ Pick-up Time ________ Appt Time _______ Return Time ________

Complete for Ongoings Only

Begin Date _________ End Date __________

Circle days of week
Sun Mon Tues Wed Thurs Fri Sat

Ambulatory

Check all that apply

- ❐ Needs assistance from home to vehicle to inside office/clinic
- ❐ Can walk up to 1/4 mile and board bus/MAX
- ❐ With cane
- ❐ With walker

Wheelchair

Check all that apply

- ❐ Can travel to curb or up to 1/4 mile unassisted and board lift or other vehicle

Wheelchair ❐ Has ❐ Needs the following:
Hi-Top Manual Power Reclining Stretch Chair
(circle)

Wheelchair Transferable. Circle if:
By Self With Minimal Assist

Other

Check all that apply

- ❐ Requires treatment/monitoring enroute
- ❐ Has oxygen
- ❐ Has attendant
- ❐ Other Special Instructions _____________

____
____
____
____
____
____
____

Branch Info

$ Authorized (if special or secured transport) $ ____

Branch ID ___________________________

Wkr/Clk ID __________________________

Wkr/Clk Phone _______________________

Provider: Retain in Documentation File Branch: Retain in Branch Record

*Detailed information must be attached for all secured transports

OMAP 406 (11/99)

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

MEDICAL TRANSPORTATION ORDER

Fax to: ______________________
Transportation Provider

____
Transportation Provider #

____
Fax #

Client Name Last	First	Prime #
Pick-Up Address	Apt #	City
Mode Taxi WC SC Ambulance Other* SC by Ambulance (Circle One)	Trip Info 1-way Rnd Trip 3-Way (Circle One)	
Destination (Dr/Clinic Name)	Destination Address	
2nd Destination	Address	

One-Time

Appt Date:________ Pick-up Time: _____ am pm Appt Time: _______ am pm Return Time: ______ am pm

$ Authorized ________________ (If Special Transport)

Ongoing

Begin Date: __________ End Date: ________________ Sun Mon Tue Wed Thu Fri Sat *(Circle Days Needed)*

Pick-up Time: _________ am pm Appt Time: ___________ am pm Return Time: __________ am pm

Today's Date	Branch #	Wkr/Clk ID Phone #

***Special Instructions**

***(Detailed Information Is Required For All Secured Transports)**

IMPORTANT! Provider: Retain in Documentation File Branch: Retain in Branch Record

OMAP 405T (11/99)

OMAP Worker Guide XIV
Premiums, Copayments and Special Requirements

- Who pays premiums?
- Non-payment of premiums
- Copayments
- Home-delivery pharmacy
- Pharmacy management program

A. Premiums Overview

Some clients must pay premiums for their OHP benefits. This section will tell you who must pay, how they pay, when they pay, what happens if they don't pay, and whom to call if you or the client have questions about premium payments.

B. Who Pays Premiums?

Clients who are eligible under the OHP-OPU program are required to pay premiums unless they are exempt. The following OHP-OPU clients (also referred to as HPN persons or clients) are exempt from paying premiums:

- American Indians/Alaska Natives
- Clients eligible for benefits through Indian Health Services
- CAWEM clients
- Clients with income at or below 10 percent of the Federal Poverty Level (FPL)

1. Rate schedule

Premium rates are based on the number of people in the household who must apply together for OHP, the number of people who are required to pay premiums and their total countable income. **For the actual premium amounts, refer to CAF Rule 461-155-0235.**

2. Premium Billings and Payment

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

OMAP sends data to the billing office monthly. Premium billings are sent to clients during the first week of each month. **Payments are due by the 20th of the current month.**

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

C. Nonpayment of Premiums

As of June 1, 2006, clients will no longer lose OHP coverage during their six-month enrollment period for non-payment of required premiums. However, clients must pay all billed premiums before they can qualify for the subsequent six months of OHP coverage. If a client's income has dropped to 10 percent or less FPL at recertification, you may waive their past-due premium obligation. If clients with income higher than 10 percent FPL fail to pay their billed premiums at the deadline imposed at

recertification, they will not be eligible for OHP-OPU. Currently, the OHP-OPU program is closed to new enrollees, so these clients risk losing coverage altogether by failing to pay their premium debts. Only OHP-OPU clients are affected by not paying their premium debt.

American Indians or Alaska Natives who have proof of tribal membership or are eligible for benefits through an Indian Health Program and CAWEM clients are exempt from paying premiums. Clients who earn 10 percent or less of the Federal Poverty Level are also exempt. Refer to the CAF Family Services Manual for specifics. (OAR 461-135-1100, 461-135-1120, and 461-135-1130)

Past arrearage can be adjusted if the Department is notified a member of the filing group filed for bankruptcy and the arrearage is a debt that has been stayed in a bankruptcy proceeding. The decision whether or not arrearage is adjusted or waived, or only part of the arrearage, depends upon the bankruptcy chapter as well as the period of time the bankruptcy covers. Contact a CAF Medical Program Analyst for further information.

- The Department will not attempt collection on any arrearage that is more than three years old. The OHP Billing Office automatically makes this system adjustment.

D. Premium Questions?

- For questions about the billing (whether a payment was received, etc.), call the OHP Premium Billing Office at the number listed on the billing notice, 1-800-922-7592. Workers only may call 503-535-1400.
- A client who has questions about whether he or she must pay premiums (i.e., eligibility), should call his or her worker. The worker's name and branch telephone number appears on each client's OMAP Medical Care ID.

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

Some OHP clients will be charged copayment for prescription drugs and/or outpatient services, depending on their eligibility level and benefit package. Copayment information is shown on the client's Medical ID in fields 7a and 7b.

1. Exemptions

OHP Plus clients who are enrolled in a managed health care plan, including dental and mental health plans, will not be charged copayments for services covered by their plan. Drugs for mental illness are not covered by managed care plans, and require a copayment.

The following clients also will not be charged a copayment:

- Pregnant women
- Children under age 19
- American Indians/Alaska Natives
- Clients eligible for benefits through Indian Health Services
- Any client receiving services under the Home and Community based waiver and Developmental Disability waiver, or is an inpatient in a hospital, Nursing Facility (NF), or Intermediate Care Facility for the Mentally Retarded (ICF/MR)

- CAWEM clients

2. OHP Plus – Copayment Information

Some OHP Plus clients will be charged the following copayments:

- $2 for generic prescription drugs
- $3 for brand name prescription drugs
- $3 for outpatient services (such as office visits to see a doctor, dentist or other health care provider). The copayment is only for the visit to the provider. There is no additional copayment for services rendered by the provider, such as immunizations, lab tests, or x-rays.

Services to a client cannot be denied solely because of an inability to pay an applicable copayment. This does not relieve the client of the responsibility to pay, nor does it prevent the provider from attempting to collect any applicable copayments from the client.

Services Requiring a Copayment

The following are services for which an OHP Plus client would be charged a copayment:

- Office visits, per visit for:
  - Physician/specialist, nurse practitioner, physician assistant or alternative care providers (i.e., chiropractors, naturopaths, acupuncturists)
- Dental services (except for dental diagnostic and preventive routine checkups)
- Mental health and/or chemical dependency (outpatient service)
- Preventive care, per visit for physician/specialist
- Hospital, per visit for outpatient treatments (including surgery) and non-Emergency Room visits (waived if admitted to inpatient care)
- Physical, occupational, or speech therapy services
- Home health services
- Private duty nursing visit and shift
- Enteral/Parenteral IV

Services Exempt from Copayment

OHP Plus clients will **not** be required to pay a copayment for the following services:

- Administrative exams and reports
- Dental diagnostic and preventive routine checkups
- DME supplies
- Emergency services
- Family planning services
- Hospice services
- Routine immunizations
- Total blood cholesterol screenings (men age 35-65, women age 45-64)
- X-ray and lab services (i.e. mammograms, pap smears, fecal occult blood tests, diagnostic sigmoidoscopy [over age 50])

OHP Plus clients will **not** be charged a copayment for the following drugs:

- Prescription drugs for family planning services, such as birth control pills
- Prescriptions obtained through the Home-Delivery (Mail Order) Pharmacy Program

3. OHP Standard – Copayment Information

Copayments for clients on the OHP Standard Benefit Package were eliminated June 19, 2004. (OAR 410-120-1230)

F. Home-Delivery (Mail Order) Pharmacy Program

Clients who have ongoing prescription needs and a stable medication regimen may receive their prescriptions through the OHP Home-Delivery Pharmacy Program. Clients do not have to make copayments on drugs ordered through this program. Clients can use this program even if they are restricted to one pharmacy through the Pharmacy Management Program. Mental health clients may use the home-delivery services only for drugs their mental health plan does not cover.

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

<http://egov.oregon.gov/DHS/healthplan/clients/mailrx.shtml>

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

G. Pharmacy Management Program

1. Overview

The purpose of the Pharmacy Management Program is to minimize drug-seeking behavior by identifying and monitoring high drug utilization and to provide better coordination and management of prescription drugs for beneficiaries. Some clients will be restricted to the pharmacy of their choice to receive prescription drugs.

NOTE: Although clients will be enrolled in a single retail pharmacy, they can still use the Home-Delivery (Mail Order) Pharmacy Program.

2. Selection

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

The designated pharmacy will show on ELGX effective the following Monday, after the Thursday transmission from First Health. If a client selects a pharmacy that is located in multiple locations throughout the State (chain) they will be allowed access to

any pharmacy belonging to that chain regardless of geographical location within Oregon and contiguous service areas.

3. Who Will be Enrolled

All clients who are fee-for-service receiving Medicaid benefits, who are not exempt, will be enrolled into the Pharmacy Management Program.

4. Exemptions from Pharmacy Management Program

Enrollment into the Pharmacy Management Program will be mandatory unless the client:

- Is enrolled in a Fully Capitated Health Plan (FCHP)
- Has private major medical insurance policy
- Has proof they are American Indian or Alaska Native
- Has proof of eligibility for benefits through Indian Health Services
- Is a child in DHS care and custody
- Is an inpatient in a hospital, long-term residential care facility, or other medical institution

5. Changes to a Client's Pharmacy Management Program

Clients may change their pharmacy selection at any time for one of the following reasons:

- They move
- They are reapplying for OHP benefits, or
- They are denied access to pharmacy services by their selected pharmacy

For changes, the worker can either contact OMAP's Health Management Unit (HMU) with the client's pharmacy choice or the client can call the Client Advisory Services Unit (CASU) directly at 1-800-273-0557. CASU will be responsible for giving the information to HMU to update the client's TPR file. New Medical ID cards will be system generated each time a change is made to the client's TPR file.

Branch workers may fax, telephone or mail the client's pharmacy choice to HMU. Branch Workers can call HMU directly at (503) 945-6523. Mail or fax to:

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

[ADA section removed]