Keys to Success—
Partnering with DMAP

Division of Medical Assistance Programs 2008

Welcome!

The Oregon Health Plan (OHP) serves nearly 400,000 Oregonians, and we couldn't do it without providers such as you! We look forward to a successful partnership.

Now that you have agreed to serve Medicaid clients through Oregon's Division of Medical Assistance Programs (DMAP*), you probably have some questions, such as:

- Who is an OHP client?
- What services will DMAP reimburse?
- Are there payers other than DMAP?
- How do I bill DMAP?
- What if I need help?

This material gives an overview to providing and billing for health care services to Oregon Health Plan (OHP) clients. We'll try to answer the big questions and point you to where to find answers to more specific inquiries.

Keys to Success does not take the place of provider Rulebooks or Supplemental Information. Complete rules and billing instructions are online at www.dhs.state.or.us/policy/healthplan/guides/main.html.

We've listed the Oregon Administrative Rules (OARs) on our Web pages by program. In addition, all our providers need the General Rules (OAR 410 Division 120).

You will find more tools to help you in this booklet and on the DMAP Web site at www.oregon.gov/DHS/healthplan/tools_prov/main.shtml.

For more copies of this booklet, contact DMAP at 503-945-5772 or 800-527-5772, or download a copy from our Provider Tools page above.

Department of Human Services
Division of Medical Assistance Programs
500 Summer Street NE, E-35
Salem, OR 97301-1079

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I. Who is an OHP client?

Eligibility verification

When OHP clients seek your health care services, you'll need to first verify their eligibility for Oregon Health Plan (OHP) coverage on the date of service.

DMAP issues a wallet-sized DHS Medical Care ID to eligible clients. Sometimes the local DHS office will issue a temporary ID.

The Medical Care ID only provides the client's recipient number and name, and the card's date of issue. You will need to use one or more of the department's eligibility verification resources to find out the following information:

- The dates the client is eligible
- Whether the client is enrolled in one or more managed care plans
- Any available third-party resources
- If the client must pay you a copayment
- What benefit plan coverage the client receives

For more information about the DHS Medical Care ID and samples of the IDs you may see, refer to the Supplemental Information for General Rules.

The department's eligibility verification resources can answer basic "who, when and where" eligibility questions as well as give you other service limitations for specific clients:

- Automated Voice Response (AVR). You may access AVR, a free system, by touchtone phone.
- Electronic Data Interchange (EDI) 270/271 offers HIPAA-compliant, computerized answers to your eligibility questions either immediately (real-time) for one inquiry or next working day for multiple submissions. If you use a billing service or clearinghouse to bill DHS electronically, that service may be able to exchange the 270/271 transaction for you.
- The Provider Web Portal is the department's new Web-based eligibility verification resource.

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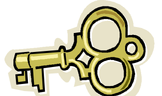

Eligibility verification

- ✓ ***Verify eligibility*** using the EDI 270/271, AVR and Provider Web Portal).
- ✓ ***For copayment information*** – Check the AVR.
- ✓ ***For detailed third-party resource and OHP managed care information*** – Check the Provider Web Portal or AVR.

Resources

Eligibility verification

Rules and Supplemental Info www.dhs.state.or.us/policy/healthplan/guides/main.html or call 800-527-5772 for hard copies.

Eligibility verification resources: www.oregon.gov/DHS/healthplan/tools_prov/electronverify.shtml.

AVR phone number: 866-692-3864.

Web portal: https://www.or-medicaid.gov.

EDI 270/271 transaction: Go to www.oregon.gov/dhs/edi for more information.

Managed care

The Oregon Health Plan uses “managed care” as a tool to help control health care costs.

Managed care plans and Primary Care Managers (PCMs) contract with DMAP to provide health services to OHP clients. These organizations or providers “manage” each enrolled client’s health care on behalf of DMAP.

DMAP contracts with five types of managed care organizations (MCOs):

- Fully Capitated Health Plan (FCHP) —physical health & inpatient care
- Physician Care Organization (PCO) — physical health; no inpatient care
- Dental Care Organization (DCO)
- Mental Health Organization (MHO)
- Chemical Dependency Organization (CDO)

The Provider Web Portal and AVR indicate which MCOs the member is enrolled with. A client may be enrolled in more than one plan for different types of services. If the Web portal and AVR do not report any managed care information, this means that the client receives care on a fee-for-service (FFS or “open card”) basis.

The Department of Human Services (DHS) requires enrollment in managed care, but gives exceptions to some clients. These clients might have continuity of care issues, such as a woman in the last trimester of pregnancy. Or some clients live in areas of the state where managed care enrollment is not an option. The affected OHP clients receive services on a fee-for-service basis.

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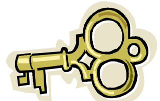
Managed care



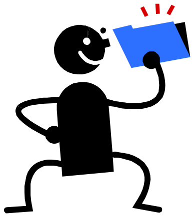
- ✓ Always check the client’s eligibility information on AVR, Web portal and/or the 270/271 to see if they are in managed care.
- ✓ Refer clients to their plan or PCM for services if you are not sub-contracted with the plan; or call the PCM for a referral.
- ✓ Bill the plan if you are authorized to provide services to their members.
- ✓ Check with the plan about their claim filing timelines.
- ✓ For services that require prior authorization, contact the plan.
- ✓ Only bill DMAP for services to clients ***not*** covered by a managed care plan *(i.e.*, fee-for-service clients).

Resources

Managed care

Rules and Supplemental Information
www.dhs.state.or.us/policy/healthplan/guides/main.html
or call 800-527-5772 for hard copies.

Eligibility verification resources
www.oregon.gov/DHS/healthplan/tools_prov/electronverify.shtml



Eligibility flow chart

for fee-for-service OHP clients

1. Is client enrolled in OHP managed care for your type of service?

Yes. Either refer the client to the managed care plan or secure authorization from the plan or PCM to treat the client.

No. Continue to Step 2.

2. Is client eligible for OHP services on this date of service?

No. Inform client they are responsible to pay the bill if you proceed.

Yes. Continue to Step 3.

3. Does client's OHP benefit package cover your service?

No. Does client have other health insurance to cover this service?

- **No.** Inform client they are responsible to pay for not-covered services.
- **Yes.** Proceed with services and bill other insurance.

Yes. Continue to Step 4.

4. Is this service currently funded on the Prioritized List?

No. Inform client they are responsible to pay for not-covered services.

Yes. Continue to Step 5.

5. Does this service require prior authorization?

Yes. Secure PA before providing services.

No. Proceed with services.

II. What services will DMAP reimburse?

Client benefit packages

An OHP client's benefit package will define the medical, dental or mental health services for which they are eligible.

You can determine a client's benefit package by using one of the electronic eligibility verification methods mentioned earlier.

DMAP offers the following benefit packages:

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

A quick-reference chart of the services available through these benefit packages is available on the Eligibility Verification Web page (see Resources section at right).

CAUTION: This table is ***not*** comprehensive, and some services have coverage limitations. Please check the General Rules, OAR 410-120-1200, and your program's Rulebook for specific services that DMAP will and will not pay you to provide.

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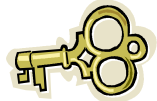
Client benefit packages



- ✓ Determine the client's OHP benefit package type.
- ✓ If the client has a limited benefit package, do not provide the service until you know exactly what the limitations are.
- ✓ Refer to General Rules, OAR 410-120-1210, for benefit package definitions.
- ✓ Refer to your provider type's Rulebook for specific limitations.

Resources

Client benefit packages

Rules and Supplemental Information
www.dhs.state.or.us/policy/healthplan/guides/genrules/main.html
or call 800-527-5772 for hard copies.

Benefit package quick reference
www.oregon.gov/DHS/healthplan/tools_prov/electronverify.shtml.

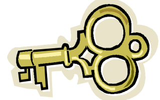
Prioritized List of Health Services

The Oregon Health Services Commission (HSC) created and maintains the Prioritized List of Health Services. They rank pairs of health conditions and treatments by clinical effectiveness (most effective to least) and cost of treatment based on public values.

The list contains 710 lines of paired diagnoses and treatments. The primary diagnosis is the condition, and the treatment is the procedure or service provided for the condition.

Services that help prevent illness rank higher on the list than treatments for conditions in progress. Services lower on the list describe illnesses that get better on their own, are cosmetic in nature or for which no effective treatments are available.

The Oregon Legislative Assembly decides how many lines are funded each biennium. Currently, the state funds services on lines 1-503.



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Prioritized List of Health Services

- ✓ If in doubt, providers should check to see if their proposed treatments are currently funded on the Prioritized List.
- ✓ Contact the DMAP Benefit RN Hotline for specific questions about condition/treatment, pair line placement and guidelines:
    - Have the ICD-9-CM code(s) ready
    - Have the CPT/HCPCS code(s) ready

Resources

Prioritized List of Health Services

The Health Services Commission maintains the list online at www.oregon.gov/DAS/OHPPR/HSC/current_prior.shtml.

Contact the DMAP Benefit RN Hotline at 800-393-9855 toll-free, or in Salem the number is 503-945-5939.

Prior Authorization

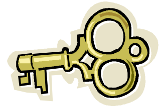
Some treatments or items covered by DMAP require prior authorization (PA):

- Audiology
- Co-morbid conditions
- Dental
- Durable Medical Equipment and supplies
- Home Enteral/Parenteral and IV services
- Hearing Aid services
- Hospital (some inpatient services/outpatient therapies)
- Home Health services
- Pharmaceutical services
- Physical Therapy/Occupational Therapy
- Physician (some medical/surgical procedures)
- Private Duty Nursing
- Out-of-state services
- Speech therapy
- Surgery
- Transplants
- Transportation (non-emergent)
- Vision (lenses, frames, contacts, etc.)

DMAP will authorize payment only for services that are medically appropriate and for which you have supplied the required documentation.

Documentation must support the medical justification for the service.

Key to Success



Prior Authorization

- ✓ Determine if PA is required before rendering services.
- ✓ Verify a service is currently funded on the Prioritized List before requesting PA.
- ✓ Contact the client's plan or appropriate office for PA. A list of current contacts is on the OHP Web site at www.oregon.gov/DHS/healthplan/data_pubs/add_ph_conts.pdf.
- ✓ Use the appropriate forms and submit proper documentation at the time you are making a PA request.
- ✓ Include the specific PA number for each client when billing DMAP.

Resources

Prior Authorization

Check the administrative rules for the type of service you provide for guidance. You will find PA contact phone numbers and addresses plus sample PA request forms in your provider-specific Supplemental Information. Both the Rulebooks and supplements are posted online at www.dhs.state.or.us/policy/healthplan/guides/main.html.

To verify the status of your PA request, contact DMAP Provider Services:

800-336-6016 toll-free
503-378-3697 Salem
dmap.providerservices@state.or.us

III. Are there payers other than DMAP?

Client copayments

DMAP requires fee-for-service clients with OHP Plus or OHP with Limited Drug benefit packages to make a copayment for prescription drugs and outpatient services.

Copayments do not apply to children or pregnant women. People with the OHP Standard benefit package do not have to pay copayments either.

Affected clients pay their copayments directly to the provider.

Providers cannot deny services to a client solely because of an inability to pay a 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.

Copayment amounts:

- $1 for non-preferred Plan Drug List (PDL) drugs or Generics in non-PDL classes costing more than $10
- $0 for preferred PDL Generic or Generics in non-PDL classes costing less than $10
- $0 for preferred PDL brands
- $3 for all other non-PDL brands
- $3 for outpatient services (see OARs)

The AVR will tell you what copayment amount, if any, applies to the client. If you do not hear a message on AVR stating that some clients are required to pay copayments, then don't collect a copayment.

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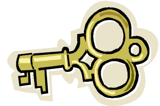


Client copayments

- ✓ Verify which of your services require copayments.
- ✓ Determine which clients are exempt from copayments.
- ✓ Collect copayments only from affected clients.
- ✓ Do not deduct the copayment amount from the usual and customary fee when you submit your claim.
- ✓ Your remittance advice will show the copayment amount that has been automatically deducted from the amount paid.

Resources

Client copayments

For copayment information, see General Rules, OAR 410-120-1230. www.dhs.state.or.us/policy/healthplan/guides/genrules/main.html.

Also, check the specific Rulebook for your provider type at www.dhs.state.or.us/policy/healthplan/guides/main.html.

A quick reference copayment chart is available on the Eligibility Verification Web page at www.oregon.gov/DHS/healthplan/tools_prov/electronverify.shtml.

Third party resources

Some OHP clients may also have other health insurance, otherwise known as a Third Party Resource (TPR). The Provider Web Portal and AVR will provide information about any other coverage.

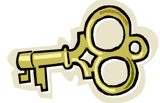
DMAP requires providers to pursue all other payers before billing us. Such resources include any individual, entity or program that is liable to pay all or part of the medical cost of any health care services furnished to an OHP client.

Just remember that DMAP is the payer of last resort.

Occasionally, a client neglects to tell us they have other insurance for themselves or one of their children. If you discover another payer that is not mentioned on the Provider Web Portal or AVR, please tell us. The location of the notification form (DHS 8708) is listed in the next column under Resources.

Key to Success

Third Party Resources



- ✓ If the client has another insurance source, including Medicare, bill them first.
- ✓ Indicate on your claim form how much the other payer paid.
- ✓ If other insurance denied the claim, enter a two-digit TPR explanation code on the paper claim form or a three-character adjustment reason code on electronic claims.

Resources

Third Party Resources

See General Rule OAR 410-120-1280 (4) and Table 1280 for two-digit TPR codes: www.dhs.state.or.us/policy/healthplan/guides/genrules/main.html or call 800-527-5772 for hard copies.

For information on Medicare to Medicaid crossover claims, read your Supplemental Information.

Notify the state via the Insurance Notification Form (DHS 8708) if you discover another TPR for any client. The form is online at http://dhsforms.hr.state.or.us/Forms/Served/DE8708.pdf.

A list of the 4-digit third-party resource carrier codes you may come across when using the Provider Web Portal or AVR can be found on the Eligibility Verification Web page at www.oregon.gov/DHS/healthplan/tools_prov/electronverify.shtml.

IV. Billing DMAP

Billing DMAP electronically

When you are ready to submit your claim for payment processing, you have the choice of billing DMAP electronically or on paper.

Electronic data interchange (EDI) offers the faster, more secure and accurate choice.

When you transmit an electronic claim, it feeds directly into our provider payment system. You will need to buy software, or use a billing service or clearinghouse in order to do this.

DHS will return rapid feedback about the acceptability of your claim format. If there is an error, you will receive a response indicating what data was missing or what was not formatted correctly. Once corrected, you can resubmit it right away. Payment for EDI claims follows faster than by paper billing.

When you submit claims by EDI for clients who are eligible for both Medicare and Medicaid, your claim will "cross over" automatically. You don't have to submit separate claims, as with paper billing.

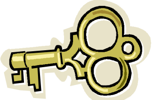
DMAP offers providers a choice of receiving paper remittance advices (RAs) or electronic RAs in the CMS standard format.

Also, DMAP offers providers the choice of a direct deposit payment (*i.e.*, electronic funds transfer—EFT) or paper checks. (See "Exploring more resources" section.)

If you want to sign up for electronic data exchange with DHS, complete a trading partner agreement and return it to us with original signature. (See Resources below.)

Then be sure to eSubscribe for "system alerts." (See "Exploring more resources.")

Key to Success



Billing electronically

- ✓ Secure the software, billing service or clearinghouse that will handle your transmissions.
- ✓ Register as an EDI trading partner with DHS.
- ✓ Test your transmissions.
- ✓ Begin billing electronically.

Resources

Billing electronically

For help with electronic claims submission, see the Introduction to Electronic Business Practices at www.oregon.gov/DHS/edi/getting-started.shtml.

Trading partner agreements are available online at www.oregon.gov/DHS/edi/reg_testing.shtml. Click on the EDI Registration Packet.

For specific questions or for help to register as an EDI trading partner, contact EDI Support Services at 888-690-9888 or dhs.edisupport@state.or.us.

Billing flow chart

for fee-for-service OHP clients

1. Is client enrolled in OHP managed care for your type of service?

Yes. Bill the managed care plan.

No. Continue to Step 2.

2. Does client have a copayment requirement?

Yes. Collect copay and continue to Step 3.

No. Continue to Step 3.

3. Does client have other health insurance?

Yes. Bill all other payers before continuing to Step 4.

No. Continue to Step 5.

4. Does client have Medicare coverage for your services?

Yes. Bill Medicare and wait for payment, denial or automatic crossover before continuing to Step 5.

No. Continue to Step 5.

5. Bill DMAP following electronic or paper billing instructions for your provider type.

Billing DMAP via paper claims

If you're not prepared to do electronic billing, DMAP still accepts paper claims. You will find samples of the forms you need and instructions for completing them in the Supplemental Information for your specific provider type.

Mail your paper claim forms to a specific address based on the claim type. See the list of addresses on the next page.

It is crucial that you complete your claim form accurately and legibly. Data entry staff cannot alter the information on your claim form or take the time to read and answer notes attached to your claims. Address any questions to DMAP Provider Services.

Our computerized payment system may ask more than 900 potential questions about a claim before it can determine a payment approval or denial. Many claims are denied because of incomplete or incorrect patient or provider data.

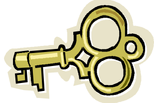
DMAP will send you a paper remittance advice (RA) telling you that your claims were either paid or denied. Denied claims contain errors that need to be corrected and resubmitted.

DMAP offers providers the choice of a direct deposit payment (*i.e.*, electronic funds transfer—EFT) or paper checks.

If you're interested in receiving direct deposit payments, see "Exploring more resources" section.

Key to Success

Billing via paper claims



- ✓ Make sure all required fields are completed on your claim form.
- ✓ Remember to enter your provider number.
- ✓ Make sure your claim form is legible and accurate.
- ✓ Mail your claim to the appropriate address for your provider type.

Resources

Billing via paper claims

Your Supplemental Information includes sample forms and instructions for completing them. Go to your specific program type at www.dhs.state.or.us/policy/healthplan/guides/main.html or call 800-527-5772 to request a hard copy.

The DMAP Web pages also offer more tips at www.oregon.gov/DHS/healthplan/tools_prov/tips/main.shtml.

Current addresses for mailing claims can be found at www.oregon.gov/DHS/healthplan/data_pubs/add_ph_conts.pdf.

Provider Services can answer your questions at 800-336-6016 or DMAP.providerservices@state.or.us.

V. Exploring more resources

Provider Services staff

Sometimes you may need our assistance to bill DMAP accurately. Whether you submit paper or electronic claims, we have trained staff to assist you.

- **For help with electronic data interchange (EDI) claims:** Go to www.oregon.gov/DHS/edi.

For technical assistance, call EDI Support Services at 503-947-5347 (Salem), 888-690-9888 or e-mail dhs.edisupport@state.or.us.

- **For help with paper claims:** When you contact DMAP Provider Services at 800-336-6016, a representative will walk you through the billing process or help you with any specific question you may have. DMAP offers two levels of representatives to assist you:

  Level 1: Billing information, claim status, answers to simple questions.
  Level 2: Extensive research, resolution to more complex issues.

- **To sign up for direct deposit:** Complete a form (DMAP 3077), and return with original signature and a voided check. The form is on the DHS Web site at http://dhsforms.hr.state.or.us/Forms/Served/OE3077.pdf.

Tools on the Web site

DMAP provides a Web site with many helpful pages at www.oregon.gov/DHS/healthplan/index.shtml. From there you can navigate to wherever you need to go.

Tools for Providers will be important for you (look on the left column and click on that title).

Bookmark the **Oregon Administrative Rules (OARs)** that govern your medical specialty. A link to pages for all programs is at www.dhs.state.or.us/policy/healthplan/guides/main.html.

Bookmark the **OHP Provider Announcements** at www.oregon.gov/DHS/healthplan/notices_providers/main.shtml.

Sign up for the free e-mail notification service known as "eSubscribe." By registering with us, you will receive an e-mail every time a new announcement is posted or a rule or supplement changes on the Web pages you select.

You can e-mail DMAP.info@state.or.us if you have questions about where to find something on the DMAP Web pages.

Register your National Provider Identifier with DHS at www.oregon.gov/DHS/edi/npi.shtml.

If you don't have Internet access, call DMAP at 800-527-5772 for hard copies of your Administrative Rules and Supplemental Information.

Find current contact information for providers for eligibility verification, EDI, billing questions, prior authorization, paper claims, and more can be found at www.oregon.gov/DHS/healthplan/data_pubs/add_ph_conts.pdf.

Department of Human Services
Division of Medical Assistance Programs
500 Summer Street NE, E-35
Salem, Oregon 97301