

Dale Elder, Manager  
DMAP Operations Section

**Number:** DMAP-IM-12-115

**Authorized Signature**

**Issue Date:** 10/25/2012

**Topic:** Medical Benefits

**Subject:** **DMAP Worker Guides** combined and updated. New and separate Developmental Disabilities Worker Guide

**Applies to:**

- |  |   |
|--|---|
| <input type="checkbox"/> All DHS employees             | <input type="checkbox"/> County Mental Health Directors   |
| <input type="checkbox"/> Area Agencies on Aging        | <input type="checkbox"/> Seniors and People with Disabilities   |
| <input type="checkbox"/> Children, Adults and Families | <input checked="" type="checkbox"/> Other (please specify): DHS and OHA staff and others identified on the SPD, CAF, AMH and DMAP transmittal lists |
| <input type="checkbox"/> County DD Program Managers    |   |

**Message:**

DMAP updated the entire [DMAP Worker Guide](#) as of October 1, 2012, and posted it to the new "Worker Guides" section of the [OHP Staff Tools Web page](#). This section contains:

- The 14 Worker Guides, now combined into [a single document](#).
- A new [guide for Developmental Disabilities staff](#) to use when requesting administrative exams and reports.

With this change, the DMAP Worker Guide page at [http://www.oregon.gov/oha/healthplan/pages/data\\_pubs/wguide/main.aspx](http://www.oregon.gov/oha/healthplan/pages/data_pubs/wguide/main.aspx) is no longer available.

Please refer to the [OHP Staff Tools Web page](#) for future Worker Guide updates.

*If you have any questions about information in the DMAP Worker Guide, see contact information [in the guide](#). For other questions, contact:*

<b>Contact:</b>	DMAP Client and Provider Education
<b>E-mail:</b>	<a href="mailto:dmap.distribution@state.or.us">dmap.distribution@state.or.us</a>

# Division of Medical Assistance Programs Worker Guide

Contains updates through October 1, 2012



Division of Medical Assistance Programs  
Client and Provider Education





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## DMAP/Medicaid Overview

### The Division of Medical Assistance Programs (DMAP)

DMAP is a part of the Oregon Health Authority (OHA). DMAP administers Oregon's medical assistance programs, including the Oregon Health Plan (OHP) and:

- Determines policy and Oregon Administrative Rules (OARs) for medical assistance programs including Medicaid, CHIP and Healthy KidsConnect.
- Is responsible for Title XIX and Title XXI State Plans.
- Informs clients and providers about policy and OAR changes that affect OHP services.
- Pays claims and contracted payments (e.g., payments to managed care organizations) for covered health care services.

### DMAP Resources

The [Provider Contacts List](#) contains current contact information, including client assistance, provider resources, billing, and prior authorization for fee-for-service clients.

The [DMAP Directory](#) contains contact information for DMAP business units.

*If you cannot find the number you need, call DMAP reception 800-527-5772 or 503-945-5772 (Salem).*

### DHS/OHA Branch Offices

#### Self Sufficiency Programs (SSP), Child Welfare (CW), Aging and People with Disabilities (APD), Area Agency on Aging (AAA), Developmental Disabilities (DD), and the Oregon Youth Authority (OYA)

*Note: The name "Children, Adults and Families (CAF)" is obsolete; "Seniors and People with Disabilities (SPD)" is now split into "Aging and People with Disabilities (APD) and Area Agency on Aging (AAA)" and Developmental Disabilities.*

- Branch offices throughout Oregon provide a direct link with clients receiving medical assistance. The various agencies determine eligibility rules for their programs. Branch staff will:
  - Determine a client's eligibility.
  - Provide choice counseling to clients when needed regarding the selection of managed care available in their area.
  - Enter eligibility data into the computer system.
  - Order replacement Medical Care ID cards (now known as Oregon Health IDs) and Coverage Letters or issue temporary Oregon Health IDs when needed.

## Oregon Health ID and Coverage Letter

### Oregon Health ID

The DHS Medical Care ID card is now called the Oregon Health ID. All other information on the card is the same. Cards that say Medical Care ID will not automatically be replaced therefore both versions of the card are currently acceptable.

For households newly eligible for OHP, QMB or CAWEM benefits, their first coverage letter will include a sheet of ID cards (one for each eligible client in the household). If clients lose or misplace their cards, they can ask for a replacement card.

The Oregon Health ID is the size of a business card and lists the client name, prime number and the date it was issued.

Clients should take the Oregon Health ID to all health care appointments to make it easier for providers to check client eligibility.

Client IDs are not *proof* of OHP eligibility.

See OAR 410-120-1140 in DMAP [General Rules](#) for more information. Provider claim denials and billing errors are reduced when providers [verify OHP eligibility](#) and health plan enrollment prior to delivering services. Providers can use the [Provider Web Portal](#), [Automated Voice Response](#) at 866-692-3864, or 270/271 electronic data interchange transaction to information.

### Coverage letter

The coverage letter is for the client's information only so they should not take it to their health care appointments. The coverage letter shows the worker's ID and phone number, and the benefit package copayment requirements and managed care enrollment for everyone in the household. DMAP sends new coverage letters anytime this information changes for anyone in the household. A sample of the coverage letter and Oregon Health IDs are included in this section.

A Quick Benefit Guide (aka [yellow sheet](#)) to OHP benefits and services is included with coverage letters.

### Oregon Health ID and Coverage Letter Replacements

Replacement IDs may be needed if a client moves or if their card has been lost or destroyed. Workers may order replacement IDs through MMIS. Replacement cards and Coverage letters are mailed to the client's mailing address. As cards are replaced, they will say Oregon Health ID.

Workers must enter client addresses using USPS standard abbreviations for (e.g., "St" for street, Ave for avenue). Otherwise, items sent to non-standard addresses may not reach clients and are thrown out by automatic mailing protocols. Workers should check the U.S. Postal Service Web site at [www.usps.com](http://www.usps.com) or use HZIP on the DHS mainframe to verify the accuracy of the address.

For detailed instructions on how to order a replacement or issue a temporary ID or Coverage letter, please see [Self-Sufficiency's Staff Tools](#).

## Sample Coverage Letter – Page 1

5503 XX#### XX P2 EN AT  
 PO BOX ####  
 SALEM, OR 97309  
 DO NOT FORWARD: RETURN IN 3 DAYS

Branch name/Division: OHP/CAF

Worker ID/Telephone: XX/503-555-5555

JOHN DOE  
 123 MAIN ST

HOMETOWN OR 97000

### Keep this letter!

**This letter explains your Oregon Health Plan (OHP) benefits.**

**This letter is just for your information. You do not need to take it to your health care appointments.**

**We will only send you a new letter if you have a change in your coverage, or if you request one.**

Welcome to the Oregon Health Plan (OHP). This is your **new coverage letter**.

This letter lists coverage information for household. This letter does not guarantee you will stay eligible for services. This letter does not override decision notices your worker sends you.

We will send you a new letter and a Medical ID card any time you request one or if any of the information in this letter or on your Medical ID changes. To request a new letter or Medical ID, call your worker.

The enclosed yellow sheet includes a chart that describes the services covered for each benefit package and a list of helpful phone numbers.

We have listed the reason you are being sent this letter below. The date the information in this letter is effective is listed next to your name.

Reasons for letter:

Managed care plan or Primary Care Manager enrollment changed for:

Doe, John – 7/13/2009  
 Doe, Jane – 7/13/2009  
 Doe, Timothy – 7/13/2009  
 Doe, Kathy – 7/13/2009

## Sample Coverage Letter – Page 2

Page 2 lists benefit package and enrollment information for each household member.

The following chart lists coverage information for everyone who is eligible in your household. See the enclosed Benefit Package chart for information about what each benefit package covers. Letters in the Managed Care/TPR enrollments section refer to the plans listed on the Managed Care/TPR Enrollment page.

Name	Date of birth	Client ID #	Copays?	Benefit Package	Managed Care/TPR enrollment
John Doe	01/01/1968	XX1234XX	No	OHP Standard	A, B, C
Jane Doe	02/01/1968	XX1235XX	No	OHP with Limited Drug	A, B, C, G, H, I
Timothy Doe	03/01/2006	XX1236XX	No	OHP Plus	B, C, D, F
Kathy Doe	04/01/2007	XX1237XX	No	OHP Plus	B, C, E, G, H

## Sample Coverage Letter – Page 3

Page 3 lists all managed care and TPR information for the household.

### Managed Care/TPR enrollment

Plan Information	Plan Information	Plan Information
<b>A</b> DMAP Medical Plan Care Oregon 800-555-5555	<b>B</b> DMAP Dental Plan Managed Dental Care of Oregon 866-555-5555	<b>C</b> DMAP Mental Health Plan Clackamas Mental Hlth Org 888-555-55555
<b>D</b> Private Maj Med/Rx/Dent/Vis Blue Cross of Oregon  Pol# 12345678 ABC123456789	<b>E</b> DCM-FFS Disease Management DCM Care Enhance 1-800-711-6687 DCM-PGM	<b>F</b> DMAP Pharmacy Walgreen
<b>G</b> Medicare Part-A Medicare NW - Part A	<b>H</b> Medicare Part-B Medicare-B/BC N Dakota	<b>I</b> Medicare Part-D Has Part D

## Sample Oregon Health ID card

*(DHS Medical Care ID cards are still acceptable as only the card name changed.)*



Front



Back

## OHP Medical Resources

### Benefit packages

OARs: *General Rules 410-120-1160 through 410-120-1230 and OHP 410-141-0480*

Oregon Health Plan (OHP) clients receive coverage for health care services based on their benefit package(s). Coverage is different for each package. Clients are assigned benefit packages based on their program eligibility.

The "Benefit Plan" field on the MMIS Recipient Information panel displays the client's most current benefit package. The packages that indicate OHP medical eligibility are:

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

### Who receives OHP benefits

Clients who receive medical benefits through the OHP are assigned these benefit packages.

*Please note: Children who receive Healthy KidsConnect subsidy payments through the Office of Private Health Partnerships **do not qualify** for OHP benefits. Therefore, they are not in MMIS and do not receive OHP benefits.*

### What's covered

OAR: *OHP 410-141-0480*

The Oregon Health Services Commission (HSC), now known as the [Health Evidence Review Commission](#) (HERC), developed a list of medical conditions and treatments, organized in order of effectiveness called the Prioritized List of Health Services (Prioritized List). Currently, covered services on the Prioritized List are lines 1-498.

This Prioritized List is updated in October and April each year, and in January every two years. The Benefit Plan and the Inquiry panel in the MMIS Reference Subsystem provide Prioritized List coverage information for specific dates of service.

To determine DMAP coverage of a specific health care service, there are two questions to consider:

- **Does the client's benefit package cover the service?** Other pages in this guide provide an overview of the services covered by each benefit package; they do not list all covered services or limitations. Refer to the OARs cited above for more specific information.
- Does the Prioritized List rank the service (treatment) "above the line" (currently line 498) for the client's reported medical condition?

**OHP Plus**

**BMH**

OHP Plus covers most medical, dental, mental health and chemical dependency services.

Preventive services	Maternity and newborn care Well-child exams and immunizations Routine physical exams and immunizations 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																
Family planning services and supplies	Including birth control pills, condoms, contraceptive implants, and Depo-Provera; sterilizations																
Medical and surgical care	Medically appropriate treatments for conditions expected to get better with treatment. Includes, but is not limited to:  <table border="0" style="width: 100%;"> <tr> <td>Appendicitis</td> <td>Diabetes</td> </tr> <tr> <td>Infections</td> <td>Asthma</td> </tr> <tr> <td>Ear Infections</td> <td>Kidney stones</td> </tr> <tr> <td>Broken bones</td> <td>Epilepsy</td> </tr> <tr> <td>Pneumonia</td> <td>Burns</td> </tr> <tr> <td>Eye diseases</td> <td>Rheumatic fever</td> </tr> <tr> <td>Cancer</td> <td>Head injuries</td> </tr> <tr> <td>Stomach ulcers</td> <td>Heart disease</td> </tr> </table>	Appendicitis	Diabetes	Infections	Asthma	Ear Infections	Kidney stones	Broken bones	Epilepsy	Pneumonia	Burns	Eye diseases	Rheumatic fever	Cancer	Head injuries	Stomach ulcers	Heart disease
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Cancer	Head injuries																
Stomach ulcers	Heart disease																
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Speech and language therapy evaluations and treatment																	
Medical equipment and supplies																	
Other services	Dental services, including cleanings, fillings, and extractions 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
--	------------------------

For children under age 21, OHP Plus **also covers** the following benefits:

Services to improve vision	Exams to prescribe glasses or contacts Fittings for glasses or contacts Glasses or contacts	
Other dental services	Crowns Root canals Apexification/recalcification procedures Gingival flap procedures	Apically positioned flap Osseous surgery Surgical revision procedure Alveoplasty Office visit for observation

**OHP with Limited Drug**

**BMD**

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

**QMB + OHP with Limited Drug**

**BMM**

This benefit package covers the same services as OHP with Limited Drug. It also provides the benefits described in the QMB benefit package section.

**OHP Plus - Supplemental**

**BMP**

This benefit package covers certain dental and vision services only for pregnant adults who receive OHP Plus benefits through the BMH, BMD and BMM packages.

Services to improve vision	Exams to prescribe glasses or contacts Fittings for glasses or contacts Glasses or contacts	
Other dental services	Crowns Root canals Apexification/recalcification procedures Gingival flap procedures	Apically positioned flap Osseous surgery Surgical revision procedure Alveoplasty Office visit for observation

**OHP Standard**

**KIT**

This benefit package is similar to OHP Plus with the exception of premiums and benefit limitations.

Preventive services	Maternity and newborn care Routine physical exams and immunizations
Diagnostic services	Medical examinations and tests to determine potential health conditions, even if the treatment for the condition is not covered Laboratory, X-ray and other appropriate testing

Family planning services and supplies	Including birth control pills, condoms, contraceptive implants, and Depo-Provera; sterilizations																
Medical and surgical care	<p>Medically appropriate treatments for conditions expected to get better with treatment. Includes, but is not limited to:</p> <table border="0"> <tr> <td>Appendicitis</td> <td>Diabetes</td> </tr> <tr> <td>Infections</td> <td>Asthma</td> </tr> <tr> <td>Ear Infections</td> <td>Kidney stones</td> </tr> <tr> <td>Broken bones</td> <td>Epilepsy</td> </tr> <tr> <td>Pneumonia</td> <td>Burns</td> </tr> <tr> <td>Eye diseases</td> <td>Rheumatic fever</td> </tr> <tr> <td>Cancer</td> <td>Head injuries</td> </tr> <tr> <td>Stomach ulcers</td> <td>Heart disease</td> </tr> </table>	Appendicitis	Diabetes	Infections	Asthma	Ear Infections	Kidney stones	Broken bones	Epilepsy	Pneumonia	Burns	Eye diseases	Rheumatic fever	Cancer	Head injuries	Stomach ulcers	Heart disease
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Hospital care, including emergency care	Emergency ambulance transportation																
Prescription drugs and some over-the-counter drugs																	
Durable medical equipment and supplies	<p>Limited to:</p> <table border="0"> <tr> <td>Respiratory equipment (e.g., CPAP, BiPAP)</td> <td>Suction pumps</td> </tr> <tr> <td>Oxygen equipment (e.g., concentrators and humidifiers)</td> <td>Tracheostomy supplies</td> </tr> <tr> <td>Ventilators</td> <td>Urology and ostomy supplies</td> </tr> <tr> <td></td> <td>Diabetic supplies (including blood glucose monitors)</td> </tr> </table>	Respiratory equipment (e.g., CPAP, BiPAP)	Suction pumps	Oxygen equipment (e.g., concentrators and humidifiers)	Tracheostomy supplies	Ventilators	Urology and ostomy supplies		Diabetic supplies (including blood glucose monitors)								
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Ventilators	Urology and ostomy supplies																
	Diabetic supplies (including blood glucose monitors)																
Other services	<p>Outpatient mental health                      Outpatient chemical dependency services                      Physician services                      Hospice services                      Prescription drugs                      Laboratory and x-ray services                      Dental services- limited to emergency (e.g. acute infection or abscess, severe tooth pain, tooth re-implantation and extraction of symptomatic teeth)</p>																

The following services are **not covered** by OHP Standard:

- Acupuncture, except for treatment of chemical dependency
- Chiropractic and osteopathic manipulation
- Nutritional supplements taken by mouth

- Therapy services (occupational, physical, and speech therapy)
- Private duty nursing and home health care
- Dental routine services (e.g., teeth cleaning, orthodontia, fillings)
- Hearing aids and exams for hearing aids
- Non-ambulance medical transportation
- Vision exams, materials, correction and therapy

## QMB

## MED

The QMB benefit package pays for Medicare Part B premiums and deductibles and covers copayments for services covered by Medicare. If the provider accepts the Oregon Health card for reimbursement, they accept whatever our payment is and the client is not billed. This does not include any cost sharing for Medicare Part D coverage or prescriptions.

Providers are not allowed to bill clients with QMB-only 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.

Clients with **only** the QMB benefit package cannot be enrolled in managed care plans.

## CAWEM - Citizen/Alien-Waived Emergency Medical

## CWM

CAWEM clients are only eligible for treatment of emergency medical conditions including labor and delivery services for pregnancies. Clients on the CAWEM benefit package do not pay premiums or copayments, are eligible for services Statewide and cannot be enrolled in managed care plans.

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 plan.

The following (not all-inclusive) list shows examples of services that are NOT covered for clients on the CAWEM benefit plan:

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

- Transplants or transplant related services
- Therapy services
- Rehabilitation services

## CAWEM Plus

## CWX

For as long as she is pregnant, a CAWEM woman living in Benton, Clackamas, Columbia, Crook, Deschutes, Douglas, Hood River, Jackson, Jefferson, Lane, Morrow, Multnomah, Umatilla, Union or Wasco counties may receive most of the covered services an OHP Plus client receives, and all OHP Plus - Supplemental benefits, through the CAWEM Plus benefit package.

The CAWEM Plus benefit **does not cover** the following OHP Plus benefits:

- Abortions
- Death with dignity
- Hospice care
- Sterilization

DMAP will reimburse for the following services:

- Hospital claims related to the delivery of the child (admission through discharge)
- Pre-natal care, or services needed for the health of the baby
- Post-partum services performed by the medical practitioner who performed the delivery under a bundled rate
- Emergency services

When a woman is no longer pregnant, she is no longer eligible for CAWEM Plus benefits and returns to the CAWEM (CWM) benefit.

## What’s not covered

OAR: OHP 410-141-0500

Services for conditions that HERC ranks of lower priority are generally not covered. The HERC report contains a complete listing of conditions/treatments that are not covered. There may be other limitations depending on the client’s benefit package(s).

### Non-covered conditions

Treatments for the following conditions are **not covered** unless there is another complicating diagnosis:

<p>Conditions that tend to get better on their own</p>	<p>Examples include:</p> <table border="0"> <tr> <td>Measles</td> <td>Viral hepatitis</td> </tr> <tr> <td>Infectious mononucleosis</td> <td>Benign cyst in the eye</td> </tr> <tr> <td>Mumps</td> <td>Minor bump on the head</td> </tr> <tr> <td>Viral sore throat</td> <td>Non-vaginal warts</td> </tr> <tr> <td>Dizziness</td> <td></td> </tr> </table>	Measles	Viral hepatitis	Infectious mononucleosis	Benign cyst in the eye	Mumps	Minor bump on the head	Viral sore throat	Non-vaginal warts	Dizziness	
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Infectious mononucleosis	Benign cyst in the eye										
Mumps	Minor bump on the head										
Viral sore throat	Non-vaginal warts										
Dizziness											
<p>Conditions where a “home” treatment is effective</p>	<p>Home treatments include applying an ointment, resting a painful joint, drinking plenty of fluids, or a soft diet. Such conditions include:</p> <table border="0"> <tr> <td>Canker sores</td> <td>Diaper rash</td> </tr> <tr> <td>Corns/calluses</td> <td>Food poisoning</td> </tr> <tr> <td>Sunburn</td> <td>Sprains</td> </tr> </table>	Canker sores	Diaper rash	Corns/calluses	Food poisoning	Sunburn	Sprains				
Canker sores	Diaper rash										
Corns/calluses	Food poisoning										
Sunburn	Sprains										
<p>Cosmetic conditions</p>	<p>Examples include:</p> <ul style="list-style-type: none"> <li>Benign skin tumors</li> <li>Cosmetic surgery</li> <li>Removal of scars</li> </ul>										
<p>Conditions where treatment is not generally effective</p>	<p>Examples include:</p> <ul style="list-style-type: none"> <li>Some back surgery</li> <li>TMJ surgery</li> <li>Some transplants</li> </ul>										

### Non-covered services

Other non-covered services regardless of condition include, but are not limited to:

- Circumcision (routine)
- Weight loss programs
- Infertility services

## Cost-sharing requirements

OHP: OAR 410-120-1230

*This page does not list all requirements or exceptions.*

### OHP Plus requirements

### BMM, BMH and BMD

Copayments	<p>\$0 for preferred generic prescription drugs, preferred brand-name drugs, and non-preferred generics costing less than \$10</p> <p>\$1 for non-preferred generic prescription drugs costing more than \$10</p> <p>\$3 for all other non-preferred brand-name drugs</p> <p>\$3 for outpatient office visits (such as office visits to see a doctor, dentist or other health care provider).</p> <p>Note: This is for Medicaid provided prescriptions only. Medicare provided drugs have a different copay schedule.</p>
	<p>Copayments are not required for these services:</p> <p>Family planning services and supplies</p> <p>Emergency services, as defined in OAR 410-120-0000</p> <p>Prescription drugs ordered through DMAP's home delivery (mail order) vendor</p> <p>Services covered by the client's managed care plan</p>
	<p>Pregnant women</p> <p>Children under age 19</p> <p>American Indians/Alaska Natives</p> <p>Clients who are eligible for benefits through Indian Health Services</p> <p>Clients who are receiving services under the Home and Community Based waiver and Developmental Disability waiver</p> <p>Clients who are in a hospital as an inpatient, nursing facility, or intermediate care facility for the mentally retarded (ICF/MR)</p>
Premiums	None

### OHP Standard requirements

### KIT

Copayments	None
Premiums	<p>Premiums are charged per member/per month</p> <p>Clients must pay all required premiums before their coverage can be renewed for another enrollment period</p>
	<p>The following clients are not required to pay premiums:</p> <ul style="list-style-type: none"> <li>■ American Indians/Alaska Natives</li> <li>■ Clients with income of 10 percent or less of the Federal Poverty Level</li> <li>■ Clients who are eligible for benefits through Indian Health Services</li> </ul>

OHP medical assistance program codes

\*The BMP benefit only applies to pregnant adults receiving BMH, BMM or BMD benefits.

Code	Program Title	Case Descriptor	Benefit Package							
			BMH	BMM	BMD	BMP	KIT	CWM	CWX	QMB
1, A1	Aid to the Aged	Various; see <a href="#">APD/AAA Staff Tools</a>	X	X	X					
2, 82	Temporary Assistance for Needy Families (TANF)	MAA, MAF	X					X		
V2	Refugee Assistance		X			*				
3, B3	Aid to the Blind	Various; see <a href="#">APD/AAA Staff Tools</a>	X	X	X	*				
4, D4	Aid to the Disabled	Various; see <a href="#">APD/AAA Staff Tools</a>	X	X	X	*				
19, 62	DHS Foster Care		X							
C5	Substitute/Adoptive Care	SAC, SCH, SCP, SFC	X					X		
GA (CSD)	Non-title XIX Foster Care		X							
5	OSIPM-PRS	Various; see <a href="#">APD/AAA Staff Tools</a>	X		X	*		X		
P2	HealthyKidsConnect (CHIP)	KCA (Clients referred to OPHP for contracted HKC insurance carrier coverage.)								
	Qualified Medicare Beneficiary (QMB)	QMB								X
P2, M5, 2, 82	OHP Medical	OPC, OP6, OPP, CEC, CEM	X			*		X		
	OHP Medical	OPU					X	X		
	Breast and Cervical Cancer Program	BCP	X			*		X		
	Children's Health Insurance Program (CHIP)	CHP	X							
	Extended Medical Program	EXT	X			*		X		
CW, CX	CAWEM	CWM						X		
	CAWEM Plus	CWX							X	
QMB	QMB + Any Program	QMM		X						

## Benefit package overview

Clients also receive a copy of this chart with their client coverage letter (see [Oregon Health ID section](#)).

### Oregon Health Plan benefit packages

OHP covers benefits that show a “✓.” Limited services are covered at a reduced level. See the OHP Client Handbook for benefit details. For a copy of the handbook, call 1-800-699-9075.

Covered services	OHP Plus; OHP with Limited Drug*		OHP Standard	CAWEM	CAWEM Plus	QMB
	Children; adults with OHP Plus - Supplemental	Other adults				
Acupuncture	✓	✓	Limited		✓	
Chemical dependency	✓	✓	✓		✓	
Dental	Basic services including cleaning, fillings and extractions	✓	✓		✓	
	Urgent/immediate treatment	✓	✓	Emergency only	✓	
	Other services	✓	Limited		✓	
Hearing aids and hearing aid exams	✓	✓			✓	
Home health; private duty nursing	✓	✓			✓	
Hospice care	✓	✓	✓			
Hospital care	Emergency treatment	✓	✓	✓	✓	
	Inpatient/outpatient care	✓	✓		✓	
Immunizations	✓	✓	✓		✓	
Labor and delivery	✓	✓	✓	✓	✓	
Laboratory and X-ray	✓	✓	✓	Emergency only	✓	
Medical care from a physician, nurse practitioner or physician assistant	✓	✓	✓	Emergency only	✓	
Medical equipment and supplies	✓	✓	Limited		✓	
Medical transportation	✓	✓	Emergency only	Emergency only	✓	
Medicare premiums, copayments (except for drugs) and deductibles						✓
Mental health	✓	✓	✓		✓	
Physical, occupational and speech therapy	✓	✓			✓	
Prescription drugs	✓	✓	✓		✓	
Vision services	For medical and emergency treatment	✓	✓	Emergency only	✓	
	For glasses	✓	Limited		✓	

\* Drug coverage for this benefit package is limited to drugs that are not covered by Medicare Part D.

OHP offers more services and places more limitations than are listed here. This chart is meant to be a guide, not OHP policy.



DMAP 1418 (08/12)

## Health Care Delivery Systems

### Overview

DMAP contracts with private companies, primary care providers and clinics to provide comprehensive coordination and management for Medicaid clients' medical, dental and mental health care. In exchange for the comprehensive services, there are three delivery systems:

- Coordinated care – CCOB and CCOE
- Managed care – FCHP, PCO, DCO and MHO
- Fee-for-service

In the coordinated care and managed care systems, DMAP provides the managed care organizations (MCOs) and coordinated care organizations (CCOs) additional monthly financial support called 'capitation' payments, for each eligible client, regardless of services rendered.

A [comparison chart](#) is included in the OHP application packet that gives information about the health plan options that are available in the area where the client lives. When a client is first enrolled into coordinated or managed care, DMAP, through the Medicaid Management Information Systems (MMIS), sends the client a coverage letter informing them of their status. The plan provides the client with a handbook outlining the services it provides and how to access them. The handbook should arrive in the client's mail within 2 weeks of receiving their coverage letter. Handbooks can also be viewed on CCO and MCO web sites.

Indian Health Services and tribal health clinics either have managed care programs or consider their clinics to be managed care. When discussing managed care enrollment options for American Indians and Alaska natives, specify 'OHP' managed care.

MCOs and CCOs provide a service called **Intensive Care Coordination Services** or **Exceptional Needs Care Coordination** for clients with special needs. They usually are nurses who help members who are having trouble getting the right care to navigate their plan's various processes and get care faster. Always refer a client who is frustrated with their provider to these services. They can access services quickly that some providers cannot access. While plans must provide this service only for seniors and people with exceptional health care needs, in practice they usually help anyone who contacts them. The Member Handbook and the plan provide contact information for these services.

Clients may be exempt from enrollment in coordinated care or managed care either temporarily or permanently for various reasons. See [Enrollment Exemptions](#) in this worker guide for more information. The most common exemptions are for people on Medicare as well as OHP, American Indians and Alaska natives.

**Note:** Medical Case Management (MCM,) Disease Case Management (DCM) and Patient-centered Primary Care Homes (PCPCH) are services provided by plans, **NOT** managed care types.

### Coordinated care types available

#### Coordinated Care Organization (CCOB)

A CCOB provides mental and medical care under one plan. In 2014, dental care will be part of the care CCOBs provide.

- DMAP's goal is to have all OHP members enrolled in CCOBs someday. CCOBs can pay for things that OHP doesn't usually cover because the waiver allows them more flexibility. CCOBs also receive additional funding to cover flexible services. Some CCOBs hire Care Coordinators and Personal Health Navigators to help members. Ask the plan's Customer Service about these helpers.
- Most CCOs provide both medical and mental health care (CCOB).

## **Coordinated Care Organization – Mental health only (CCOE)**

In some areas, CCOs only provide mental health care (CCOE). DMAP covers their medical care on a fee-for-service basis.

## **Patient-Centered Primary Care Homes (PCPCH)**

CCOs are expected to include patient-centered Primary Care Homes (PCPCH or primary care homes) in their provider networks. OHA recognizes health care clinics that provide a patient-centered model of care. At its heart, this type of care fosters strong relationships with providers, patients and their families. Primary care homes improve care by focusing on prevention, catching problems earlier, wellness and management of chronic conditions. Clinics submit applications and the program makes sure they meet the standards of care. Those that achieve this model are recognized as official primary care homes and can achieve three different tiers, or levels, of recognition depending on the criteria they meet.

Once recognized as a primary care home, these clinics are eligible to receive per-member, per-month payments from DMAP or their CCO for the enhanced services they provide to certain Medicaid clients with chronic conditions such as diabetes, asthma, or a serious mental health condition. The additional funds allow primary care homes to provide extra services to these clients to improve their health. Medicaid clients are not required to participate and can opt out at any time. If they opt out, they can continue receiving care at the same clinic or can choose a different clinic.

For more information, including a video that explains what a primary care home is, please visit [www.PrimaryCareHome.oregon.gov](http://www.PrimaryCareHome.oregon.gov).

## **Managed care types available**

### **Fully Capitated Health Plan (FCHP)**

In areas where no CCO is available, Fully Capitated Health Plans (FCHPs) provide medical services ranging from physician and hospital inpatient care to physical therapy and many medications.

### **Physician Care Organization (PCO)**

In areas where no CCO or FCHP is available, a PCO may coordinate outpatient medical care. PCOs do not cover inpatient hospital services and post-hospital extended care services; DMAP covers these on a fee-for-service basis.

### **Dental Care Organization (DCO)**

A Dental Care Organization (DCO) is a prepaid plan that provides dental services. DMAP contracts with them to provide comprehensive services and to manage each enrolled client's dental care.

### **Mental Health Organization (MHO)**

In areas where no CCO is available to provide mental health care, Mental Health Organizations (MHO), coordinate mental health services. 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

## Primary Care Manager (PCM)

A PCM is an independent provider that contracts with DMAP to manage a client's health care. PCMs may be physicians, physician assistants, nurse practitioners with a physician back-up, or naturopathic physicians with a physician back-up. PCMs may also be rural health clinics, migrant and community health clinics, federally-qualified health centers, county health departments, Indian Health Service or tribal health clinics. PCM clients must be referred for specialty services by their PCM.

DMAP pays PCMs a nominal monthly case management payment and PCMs bill DMAP on a fee-for-service basis for services provided to the client. With few exceptions, as of November 1, 2012 clients currently enrolled with a PCM will auto-enroll into CCOs. The client can keep their current PCM provider as their physician if the provider is in the CCO's network however the agencies goal is to eventually replace the PCM Program with the PCPCH Program. PCMs are invited to become PCPCHs and if they choose to do so, their status as a PCM will close.

## Plan availability

CCOs and MCOs 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 plans available and whether or not they have enough providers to serve OHP members. An area can be mandatory for dental and at the same time be voluntary for medical.

DMAP determines if a plan is open for new enrollment and whether an area is voluntary or mandatory. The [Comparison Charts by County](#) show which areas have mandatory or voluntary enrollment.

Sometimes a plan must be closed for enrollment to new members. When attempting to enroll a client into a closed plan, check the Managed Care screen or Comparison Chart to see if there is a re-enrollment period. These are usually 30 days, but can be from 0 to 120 days. If the client's break in enrollment was less than the number of re-enrollment days, the client will be able to get back into the plan. Workers should contact DMAP's [Client Enrollment Services](#) (CES) staff 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 enroll.

## Enrollment process

The medical or dental plan enrollment process usually takes 1-1 ½ weeks.

The MMIS managed care screen gives the following information (based on the FIPS/ZIP codes for the client’s residence address):

- The medical and dental plans available
- Whether the plan is open or closed for new enrollment
- If closed, whether previous members may re-enroll
- What the time limits are for re-enrollment (e.g., 30, 60, 90 or 120 days since last enrolled in that plan)

Some clients are not required to be in a plan because they have an approved exemption (e.g, AI/AN heritage, TPL or Medicare coverage). See [Enrollment Exemptions](#) in this worker guide for detailed information.

## For mandatory service areas

Clients who live in a mandatory service area and do not have an approved exemption are required to enroll in the following types of plans:

- A DMAP-contracted medical plan (CCO, FCHP or PCO), and
- A DMAP-contracted dental plan (DCO). Starting in 2014 DCOs will be part of CCOs.

A client’s MHO enrollment is automatically determined by which medical plan the client enrolls in. If there is no medical plan available, separate enrollment in an MHO is required.

Non-exempt clients in mandatory service areas are enrolled in plans the following two ways:

<b>Client choice</b>	Clients should select a CCO if one is available. If no CCO or FCHP is available in their area, they may receive medical care on a fee-for-service basis.
<b>Auto-enrollment</b>	<p>Clients who don’t choose a medical plan, or choose a plan that is not currently available are auto-enrolled into a plan.</p> <p>Auto-enrollment is a systematic weekly process. The worker must send a notice to the client telling them:</p> <ul style="list-style-type: none"> <li>■ The name of the managed care plan they have been enrolled in, and</li> <li>■ They have a right to change to a different managed care plan within 30 days of the enrollment if another plan is available.</li> </ul> <p>Auto-enrolled clients can ask their caseworker (within 30 days from the enrollment) to change to a different plan if another one is available where they live. However, they cannot go back to fee-for-service (open card) unless they have an approved exemption. Auto-enrolled clients that do not request a change within 30 days may change plans later using one of their disenrollment options.</p>

## For voluntary service areas

OHP client enrollment in voluntary service areas is not required, however, it is preferred. Enrollment in coordinated or managed care can increase access to services and also provide valuable resources.

If a client is already enrolled in a plan and moves to a voluntary ZIP code served by their plan, they will stay enrolled in that plan.

Clients not enrolled in a plan receive their medical and/or dental services on a fee-for-service basis. The client will continue to receive services fee-for-service until the area changes to mandatory or if the client moves to a mandatory area.

## Effective date of plan coverage

*OAR: OHP 410-141-0060*

Managed care enrollment is done weekly. When enrollment information is entered into MMIS:

- Before 5:00 p.m. on a Wednesday, coverage begins the following Monday.
- On Thursday or Friday, coverage begins one week from the following Monday.

Newborns are enrolled retroactively back to their date of birth as long as their birth mother was enrolled in a medical plan at childbirth. The payment (retroactive to their date of birth) is made at end-of-month cutoff after the baby is added to the case.

## Disenrollment or changes in health plan enrollment

*OAR: OHP 410-141-0080*

Clients may change their plan at these times as long as another plan is available:

- When they reapply or the worker re-determines benefits;
- If they move and their existing plan does not provide service at their new address;
- Within 30 days of an enrollment error or auto-enrollment;
- Within 90 days of first-time enrollment (for new OHP members); or
- When approved by DMAP. DMAP reviews requests for disenrollment for just cause, such as lack of access to appropriate care or needing services that the plan excludes for religious reasons.
- Contact CES for assistance with managed care enrollment issues. For additional assistance with managed care related issues, contact a DMAP Prepaid Health Plan Coordinator.

## Different delivery service area

When a client moves out of their current plan's service area, change their address and plan enrollments as soon as possible.

- For assistance with enrollment errors that occur due to an address change, contact DMAP [Client Enrollment Services](#) (CES).

## Death

If a client dies, workers must change the "Living Arrangement" field to "DE" for deceased. Just entering the date of birth does not end eligibility and enrollment.

## New health coverage

Clients are also disenrolled from their plan when they are determined to have private or employer-sponsored major medical health insurance (Third-Party Liability, or TPL). Disenrollment occurs the last day of the month that the TPL is identified.

## Enrollment exemptions - MC Special Conditions

OAR: OHP 410-141-0060

There are times when a client may be approved for a temporary or permanent exemption from plan enrollment if they meet certain criteria. Temporary exemptions are sometimes approved to allow a client a small window of time to complete a needed medical service or procedure. When temporary exemptions are approved they should include a specific start and end date.

Some exemption codes are restricted and can only be entered by CES or HIG (Health Insurance Group). Other exemptions can be entered by authorized caseworkers. An example of an exemption that workers cannot add would be one for TPL (Third Party Insurance). An example of an exemption an authorized worker could enter would be one for Continuity of Care. Training on the exemption process is offered through the Learning Center. For questions regarding the exemption process, contact [CES](#). Email [HIG](#) for questions about TPL exemptions. Other contact information for HIG

- Phone: 503-378-6233;
- Fax: 503 378-0358;
- Email: Referrals TPR (in Outlook); for all others: [referrals.tpr@state.or.us](mailto:referrals.tpr@state.or.us)

## MC Special Conditions - Exemption Codes Chart

In MMIS, exemptions are called MC Special Conditions and are located in the MMIS Managed Care subsystem. This table lists exemption types available and guidance about who can enter each code.

MC Special Conditions Reason	Exemption can only be added by DMAP/CES	Exemption can only be added by HIG	Exemption can be added by authorized APD worker
Assessment and evaluation (A&E)	X		
Behavioral Rehabilitation Services	X		
Client is hospitalized	X		
Client is in a temporary exception status waiting	X		
Client is in a medical management program	X		
Continuity of care	X		X
Domestic Violence Protection	X		
End Stage Renal Disease –	X		
Exceeded Contract Limits –	X		
Hearing scheduled	X		
Language barrier	X		
Medical fragile child	X		
Medical Medicare choice	X		X

MC Special Conditions Reason	Exemption can only be added by DMAP/CES	Exemption can only be added by HIG	Exemption can be added by authorized APD worker
Medical necessity	X		
Other	X		
Providence Elder Place (PACE)	X		
Psychiatric Residential Treatment Services (PRTS)	X		
Psychiatric Security Review Board (PSRB)	X		
Rehabilitation/Inpatient/Facility	X		
Religious considerations	X		
Rosemont Treatment (CD/BRS)	X		
SCF-Parent no response	X		
Secure Adolescent Inpatient Program (SAIP)	X		
Secure Children Inpatient Program (SCIP)	X		
Secure Residential Treatment (SRTF)	X		
Special needs child	X		
Stabilization and Treatment Services (STS)	X		
Stop Loss	X		
Surgery scheduled for client	X		
Third Party Liability		X	
Third trimester pregnancy	X		

### Third party liability (TPL)

When a client has private or employer-sponsored health insurance, also called TPL, it must be reported to the HIG as quickly as possible using the [MSC415H](#) (Notification of Other Health Insurance) or the [MSC0156](#) (Rush Request). Workers are also required to code the PHI field on the case. See *Entering the 0-7 TPL Coding and Good Cause* (below) for more information about how to code the PHI field. If HIG verifies TPL is an active major medical health insurance policy (major medical insurance means that the policy provides inpatient and outpatient hospital, lab, x-ray, physician and pharmacy benefits) the client cannot be enrolled into a CCO or MCO. Clients with active TPL that have good cause coding cannot be enrolled in a physical health plan. They receive their medical services on a fee-for-service basis. Clients that have private or employer-sponsored dental insurance are required to enroll in a dental managed care plan.

Only HIG can add or end a TPL exemption. Questions or assistance related to TPL exemptions should be directed to HIG and not to CES.

In many cases, the state can reimburse clients for the premiums that they pay for their private or employer-sponsored health insurance through the HIPP (Health Insurance Premium Payment) program. For more information about HIPP, see *Payment of Private Health Insurance Premiums*.

## Enrollment Codes and Requirements to Enroll

The table below lists the most common private health insurance policy types a client may have. Use this chart to determine the enrollment requirements for the policy types listed. If your clients policy type is not listed or you need additional information please contact HIG.

Enrollment codes for private health insurance		Can client enroll?			
Private Coverage Type	Code	CCO/FCHP/ PCO	PCM	DCO	MHO
Accident	20	Yes	Yes	Yes	Yes
Cancer	04	Yes	Yes	Yes	Yes
Champ VA	05	No	No	Yes	Yes
Dental	06-07	Yes	Yes	Yes	Yes
Hospital only	9	Yes	Yes	Yes	Yes
Long Term Care	10	Yes	Yes	Yes	Yes
Major Medical	13 -16	No	No	Yes	Yes
Medicare Supplement: A, B, C-J	21-23	Client choice	Client choice	Yes	Yes
Prescription only	29-30	Yes	Yes	Yes	Yes
Student Insurance	32	No	No	Yes	Yes
Skilled Nursing	25	Yes	Yes	Yes	Yes
Tricare/Triwest	34	No	No	Yes	Yes
Vision (Optical) only	26-27	Yes	Yes	Yes	Yes

## Entering 0-7 TPL Coding and Good Cause

The TPL field on a client's case tells MMIS if the client has private or employer-sponsored health insurance and if MMIS can coordinate claims with the private insurance company. In most cases, the State must be the payer of last resort. Caseworkers are required to report TPL changes and to update the TPL field on the client's case so claims will be paid or denied correctly.

The table below explains each of the codes. In addition to coding the client's case, workers also need to send a MSC415H, or MSC0156 (for rush requests) to HIG.

**Caution:** The TPL field on a client's case does not stop or start enrollment into managed care. Workers need to be sure the TPL field contains correct information and send the DHS415H to HIG.

Code	Reason	Details - the client has:
0	No TPL	No private health insurance
1	Has TPL	Private health insurance - There are no safety or access concerns. <i>Note: Includes Indian Health services (HIS) benefits</i>
2	TPL through Mom Safety Concerns	Private health insurance provided by their mother - Do not pursue due to safety concerns.
3	TPL through Dad Safety Concerns:	Private health insurance provided by their father - Do not pursue due to safety concerns.
4	TPL through both Mom and Dad Safety Concerns	Private health insurance provided by mother and father - Do not pursue due to safety concerns.

Code	Reason	Details - the client has:
5	TPL through Multiple Safety concerns:	Private health insurance provided by multiple carriers - Do not pursue because of safety concerns.
6	TPL through Other Safety Concern	Private health insurance provided by someone other than their mother or father - Do not pursue because of safety concerns.
7	TPL other reason	Good cause not to use their private health insurance for a reason that is NOT a safety risk such as access to care.* <i>*Note: Access to care means that a client is unable to get care due to their private insurance. For example a child with Kaiser Permanente provided by an absent parent and the child lives in a county not served by Kaiser. This code should not be used to avoid co-pays or to divert claims to DMAP instead of the TPL.</i>

## Medicare clients and medical plan enrollment

OAR: OHP 410-141-0060

Clients eligible for both Medicaid and Medicare can choose to enroll with any medical plan available in their area, or choose to receive services on a fee-for-service basis.

If they are already enrolled in a medical plan, they may choose to enroll in that plan’s Medicare Advantage (MA) Plan, enroll in another plan’s MA Plan, or keep Medicare fee-for-service (original Medicare). Medicare rules require that Medicare clients always have the option of FFS instead of managed care.

<p><b>DMAP medical plan with corresponding Medicare Advantage Plan</b></p>	<p>Clients who are enrolling in their DMAP medical plan’s corresponding Medicare Advantage Plan must complete the <a href="#">OHP 7208M</a> within 30 days of receiving it. Clients that do not complete this form may be disenrolled from their managed health care plan. The following information is needed to complete the <a href="#">OHP 7208M</a>:</p> <ul style="list-style-type: none"> <li>■ Information about the client – name, phone number, address, County, date of birth, gender, Social Security number, and Medicare claim number</li> <li>■ Name of the client’s Primary Care Provider (PCP)</li> <li>■ Name of the client’s DMAP medical plan</li> <li>■ Name of the Medicare Advantage Plan the client chooses</li> <li>■ Effective date of Medicare:                     <ul style="list-style-type: none"> <li>Part A – Hospital insurance coverage</li> <li>Part B – Medical insurance coverage</li> </ul> </li> </ul> <p><i>Important:</i> 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. However, they can stay in the plan if they were already enrolled before being diagnosed with ESRD.</p>
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<b>DMAP medical plan without a corresponding Medicare Advantage Plan</b>	Enroll these clients in their DMAP medical plan like all other clients. These clients will receive their health care as follows: Medicare services – from original Medicare (fee-for-service) Medicaid services – through their DMAP medical plan
<b>Changing Medicare Advantage Plans</b>	Clients can only be in one Medicare Advantage Plan at a time. To disenroll from a Medicare Advantage Plan, the client must complete the <i>Request to Terminate Insurance form</i> ( <a href="#">OHP 7209</a> ) and send it to the Medicare Advantage Plan they are leaving.

## Choice counseling

Usually clients will make their own decisions about plans knowing it is important to choose plans that best meet their needs. To help them decide, DMAP includes [Comparison Charts](#) with all new application packets. Comparison charts are a choice counseling tool and are formatted so that all plans in a specific area can be compared to one another.

If the client is unable to choose a plan, one may be chosen for them by a legal health representative, *power of attorney*, guardian, spouse, family member, a team of people, or an agency caseworker.

The following checklist shows major discussion areas to cover when helping a client choose a plan:

### Choice counseling checklist

- Does the client reside in a mandatory or voluntary enrollment area?
- Does the client's doctor (PCP) or dentist (PCD) participate with an available plan?
- Do the client's children have a PCP? Does the PCP participate with an available plan?
- Is the medical or dental office near the client's home or on a bus line? Can they get to their appointments easily?
- What transportation is available to the client to access medical services?
- 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 for general hospital care? Is it near their home?
- Does the family have special medical, mental health, or chemical dependency needs to be considered?

## Educating clients about health care

The case worker or case manager can help educate clients about accessing health care by sharing the following information:

- Emergent care means services that are needed immediately because of a serious injury or illness. Some examples are: broken bones, profuse bleeding, a tooth that has been knocked out, suspected heart attack and loss of consciousness. Refer to the *OHP Client Handbook* ([OHP 9035](#)) for more information.
- There could be a one to three month wait for a routine appointment, especially with a dentist, so keep preventive care appointments; do not wait until an emergency arises.

- If you cannot keep a routine appointment, you must cancel the appointment at least 24 hours in advance.
- Primary care providers (PCPs) manage your health care needs. The PCP works with you to keep you healthy. If you need a specialist, the PCP may need to make a referral.
- Bring both your Oregon Health ID and plan card to all appointments. In some cases identification may be requested.
- Some providers may not be taking new patients.
- Follow the rules of your plan and respect providers and their staff.
- You should receive a *Member Handbook* with a *Provider Directory* about 2 weeks after enrolling in a medical or dental plan for the first time.
- Call the OHA Statewide Processing Center to order a copy of the *OHP Client Handbook* ([OHP 9035](#)). It contains helpful information such as:
  - ✓ How to resolve billing problems
  - ✓ How to resolve provider care problems
  - ✓ How the appeal and grievance process works
  - ✓ Review your Oregon Health ID and coverage letter each time you receive one to make sure it is accurate.
  - ✓ Notify your worker of changes in your household such as new pregnancy, change of address, change to the number of people in your household, etc.

Remember: Many clients have not had access to health care and do not automatically know doctor's office etiquette. See the *OHP Client Handbook, Rights and Responsibilities* for more information.

## Who to contact for help

Issue	Contact	Phone/Fax
Plan enrollment No plan assigned or wrong plan on Oregon Health ID AI/AN exemptions Medical exemptions	DMAP Client Enrollment Services Unit	800-527-5772 Fax: 503-947-5221
<ul style="list-style-type: none"> <li>Plan claim problems</li> <li>Available services or physicians</li> </ul>	Client's managed care plan	Phone number listed on client Oregon Health ID
MMIS or CM case coding problems	OPAR Client Maintenance Unit	503-378-4369
<ul style="list-style-type: none"> <li>Adding or ending TPL</li> <li>TPL exemptions</li> <li>Plan disenrollment when there is TPL</li> </ul>	OPAR Health Insurance Group	503 378-6233 Fax: 503 373-0358
Unresolved client or managed care plan problems	DMAP Client Services Unit	800-273-0557
Continuity of care exemptions Expedited hearing requests	DMAP Medical Unit	503-947-5270 Fax 503-945-6548
Mental Health Organizations problems	Addictions and Mental Health Division	503-947-5522
Problems with any dental or medical plan	DMAP Delivery Systems PHP Coordinator	503-945-5772

## Other Medical Resources

### Family Health Insurance Assistance Program (FHIAP)

This resource is now provided for children under age 18 only – no adults.

FHIAP was created by the 1997 Oregon Legislature to help low-income Oregonians afford private health insurance. The program subsidizes or pays for a significant portion of a member's health insurance premium.

FHIAP is a subsidy program, not an insurance plan. FHIAP will subsidize the medical and prescription drug portion of the premium, as well as vision or dental premiums if the coverage (or benefit) is offered by the same medical insurance company. FHIAP members must pay deductibles, co-pays or any other coinsurance associated with their health insurance plan.

For more information about FHIAP, call 1-888-564-9669, Monday through Friday, 8 a.m. to 5 p.m. or go to [www.fhiap.oregon.gov](http://www.fhiap.oregon.gov).

### Oregon Medical Insurance Pool (OMIP)

OMIP is a high-risk health insurance pool established to cover adults and children who are unable to obtain medical insurance because of their health conditions. This is not an income-based program. Members must have the financial resources to pay the premiums. OMIP does not subsidize premiums or reduce them according to an individual's ability to pay.

OMIP also provides a way to continue insurance coverage for those who exhaust COBRA or are looking for portability benefits and have no other options.

To apply, call the customer service unit between 8 am and 5 pm at 1-800-848-7280 and ask for an OMIP packet or download an application at the Web site [www.omip.state.or.us](http://www.omip.state.or.us).

### Oregon Breast and Cervical Cancer Treatment (BCCPT) Program

BCCP helps low-income, uninsured, and underserved women gain access to lifesaving screening programs for early detection of breast and cervical cancers. The Oregon BCCP provides screening funds to promote early detection of breast and cervical cancer among Oregon's medically underserved individuals. BCCP is funded by the Centers for Disease Control and Prevention, the Susan G. Komen for the Cure Oregon and SW Washington Affiliate, and the American Cancer Society.

For information about free mammograms, call 1-877-255-7070.

For information regarding eligibility, screening and diagnostic services, call 1-877-255-7070, visit your local county health department or see [www.oregon.gov/DHS/ph/bcc](http://www.oregon.gov/DHS/ph/bcc).

## Payment of Private Health Insurance Premiums

### Overview

Oregon Health Plan (OHP) clients may also have individual (private) or employer-sponsored insurance, also known as Third Party Liability (TPL). The State (Medicaid) is the payer of last resort, so the client's TPL normally becomes the primary payer.

The State has two programs that may be able to reimburse OHP clients for the amount they pay for third party insurance. These programs assist the State in providing cost-effective health care.

- HIPP - Health Insurance Premium Payment program – Reimburses eligible policyholder's for the amount they pay for their employer-sponsored health insurance. Payments usually go directly to the policyholder.
- PHI - Private Health Insurance program - Covers insurance premium costs for eligible household members with health care costs estimated (if covered by DMAP) to be higher than the cost of paying the premium. Payments usually go to the insurance carrier instead of the policyholder (although there can be exceptions).

Both HIPP and PHI do **not** pay premiums for:

- Non-SSI institutionalized and waived clients whose income deduction is used for payment of health insurance.
- Vision, dental, long-term care or other stand-alone policies.
- Clients covered by Medicare Part A and/or Part B.

### Health Insurance Group

The Health Insurance Group's (HIG) Premium Reimbursement Coordinators, located within the Office of Payment Accuracy and Recovery (OPAR), determine eligibility for both HIPP and PHI. Determining eligibility includes collecting documents from clients, reviewing for cost effectiveness, data entry in MMIS to issue payments and all other administration related to the program. Contact a Reimbursement Coordinator by calling 503 378-6233 or by e-mail at [ReimbursementsHIPP](mailto:ReimbursementsHIPP) (in Outlook) or [reimbursements.hipp@state.or.us](mailto:reimbursements.hipp@state.or.us) (outside of Outlook). Documents can be faxed to 503 378-0358.

### Managed care plans

Clients that are determined eligible for the HIPP or PHI program cannot enroll into a medical managed care plan. The client's private or employer-sponsored health insurance becomes the primary payer. DMAP pays for any Medicaid services that are not covered by the third party insurance on a fee-for-service basis.

In the event a client is already enrolled in a managed health care plan at the time third party insurance is reported to HIG, the client will be disenrolled from that plan on the last day of the month it is reported.

### HIPP - Health Insurance Premium Payment

#### Program requirements

The HIPP program provides premium reimbursement for eligible Medicaid clients covered by employer-sponsored group health insurance.

**Effective January 1, 2012**, the policyholder does **not** have to be in the **same household**. It is possible to reimburse eligible absent parents, grandparents or others who are paying for the health insurance premiums. However, the State does not reimburse for third party insurance premiums if the policyholder has been court ordered to provide it.

As a condition of Medicaid eligibility, employed individuals with CEM, EXT, GAM, MAA, MAF and OHP (except OHP-CHP and OHP-OPU) **must** enroll in their employer-sponsored group health insurance if it is cost-effective. Self-employed individuals who opt to purchase group health insurance may also apply for HIPP. See Oregon Administrative Rule *461-155-0360*.

To qualify for HIPP, the employer-sponsored health insurance must be:

- A comprehensive major medical policy that includes inpatient and outpatient hospital, physician, lab, x-ray and full pharmacy benefits; and,
- (Note: Insurance policies that cover a specific conditions or diseases such as a cancer-only policy or only have a prescription discount card are not eligible.)
- Determined cost-effective based on the [Medical Savings Chart \(MSC\)](#); and,
- Meet HIPP requirements in OAR 410-120-1960.

*Note: The State does not reimburse the employer's share of the premium cost.*

## HIPP eligibility

The HIG coordinator that receives a [MSC415H](#) (Notification of Other Health Insurance) uses the following steps to determine if the employer-sponsored insurance is cost effective:

- Determine if the Medicaid client has EXT, GAM, MAA, MAF, OSIPM or OHP (excluding OHP-CHP, OHP-OPU and CWM/CWX).
- Verify the insurance is a major medical policy and enter TPL information into MMIS.
- Contact the client for more information if they pay all or part of their premium.
- Confirm with the employer the premium amount and how often it is paid (for example, \$75.00 is taken out of employee's pay every week).
- Compare each eligible client by PERC code to the amount allowed for that PERC code on the [Medical Savings Chart](#). Each person's allowed amount is added to the allowed amount for all others eligible on the case (in some instances HIG may include people on separate cases). For example, a child may be on their own D4 case but living in the same household with other family members who are on a separate case.

If the premium payment exceeds the combined allowed amount on the MSC, HIG will check to see if anyone in the benefit group qualifies for the PHI program.

If *OAR 410-120-1960* and the above requirements are met, HIG authorizes and enters the HIPP reimbursement payment into MMIS.

Reimbursements are paid by check through MMIS. Reimbursements are **no longer** made through the Electronic Benefits Transfer (EBT) process (also known as ReliaCard), or by workers using the 437 Special Cash Pay process.

HIG re-determines eligibility at least annually and more frequently, if needed.

### Examples:

- Mom's employer provides insurance for her, Dad and two children. Only the children are eligible for Medicaid. Mom has \$435.00 deducted from her check each month for her portion of the insurance. The children have PERC codes of H2 and HB. The combined insurance allowance on the [Medical Savings Chart](#) is \$687.00 (\$448.00 for HB and \$239.00 for H2). The cost of their insurance is cost effective because the premium amount is below the allowable amount.
- Dad does not live in the household and is not covered by Medicaid, but he provides insurance through his employer for his disabled son who lives in a group home. The son's PERC is D4. The cost of the insurance is \$537.00 per month. The allowance on the [Medical Savings Chart](#) is \$1141.00. The cost of their insurance is cost-effective because the premium amount is below the allowable amount.
- Client has a private policy that they purchased. The premium is \$430 per month. The client has cancer. The allowable amount on the [Medical Savings Chart](#) for his XE PERC code is \$249.00. Because the client has an illness that is covered on the [Special Conditions Chart](#), we can make an additional allowance of \$231.00 in our calculation ( $\$249.00 + \$231.00 = \$480$ ). The combined amount is greater than the \$430.00 cost of the premium that makes it cost effective for reimbursement under the PHI program.

## PHI - Private Health Insurance

### Program requirements

In special situations, DMAP may pay health insurance (third party) premiums even if the premium is greater than what is allowed on the [Medical Savings Chart](#) (MSC). This may occur when the third-party insurance cost is less than the estimated cost of DMAP paying fee-for-service for their medical care.

Individual **and** employer-sponsored insurance may qualify for the PHI program. Payments for PHI generally go directly to the insurance carrier however payments may be paid directly to the policyholder or their representative. PHI **may or may not cover everyone** in the benefit group and the reimbursement may be a pro-rated portion of the premium.

### PHI eligibility determination

The HIG coordinator follows these steps to determine if PHI is cost effective:

- Determine if the Medicaid client has EXT, GAM, MAA, MAF, OSIPM or OHP (excluding OHP-CHP, OHP-OPU and CWM/CWX).
- Verify the insurance is a major medical policy and enter TPL information into MMIS.
- Determine if anyone in the household covered by the third party insurance has a specific medical condition listed on the [Special Conditions Chart](#) (SCC). The listed conditions are associated with higher utilization costs.
- Confirm with the client or insurance company the amount of insurance premiums and how often they are paid.

If anyone covered by Medicaid and third party insurance has a medical condition covered on the MSC, add the amount for the eligible persons' PERC code on the MSC to the amount allowed on the SCC and determine if the insurance premium is equal to or less than the combined allowed amounts.

If the third party insurance is determined cost-effective and all requirements in OAR-410-120-1960 are met, HIG authorizes and enters the PHI reimbursement payment into MMIS.

PHI eligibility is re-determined at least annually and more frequently, if needed.

## How to refer clients for HIPP or PHI

You will typically use the client’s completed [MSC415H](#) to refer them for HIPP or PHI eligibility review. E-mail the form to [ReimbursementsHIPP](#) (in Outlook) or [reimbursements.hipp@state.or.us](mailto:reimbursements.hipp@state.or.us) (outside of Outlook) or fax to 503-373-0358. For questions, call a HIG Premium Reimbursement Coordinator at 503-378-6233.

Examples of when to refer a client for the HIPP or PHI program are:

- Client indicates they pay for all or part of a third party insurance on Section 5 of the MSC415H or Extra Form E (part of the 7210 application). Workers may submit either the MSC415H or Extra Form E.
- Client reports they have COBRA insurance.
- Paycheck stubs show that health insurance is deducted from a paycheck but the client has not submitted a MSC415H. In this case, workers should “pend” the application in lieu of a completed MSC415H. Upon receipt of the completed form, send referral to HIG.
- Client is employed by a company that offers group health insurance, even if the client has opted out. HIG will contact the client or employer to find out if the insurance is cost effective.
- Client is working and indicates they have a private, individual health insurance plan.  
*Note: Client may purchase health insurance directly from the insurance carrier and it will not show on their paycheck stub.*

For instructions on how to complete the [MSC415H](#), go to [OPAR-AR-11-001](#).

## Reference

### Hearings

Insurance premium reimbursements are not a medical benefit and therefore are not subject to hearings. See OAR 410-120-1960.

### Questions?

Client or worker questions related to HIPP or PHI should be directed to a Premium Reimbursement Coordinator at 503 378-6233 or e-mail at [Reimbursements\\_HIPP](#) (in Outlook) or [reimbursements.hipp@state.or.us](mailto:reimbursements.hipp@state.or.us) (outside of Outlook). Documents can be faxed to 503 378-0358.

Client questions regarding third party insurance and Medicaid eligibility should be referred to their local OHP branch worker.

### Forms

MSC415H: <https://apps.state.or.us/cf1/DHSforms/Forms/Served/de0415h.pdf>

### Other resources

[Medical Savings Chart](#) & [Special Conditions Chart](#)

### Applicable OARs:

DMAP	DHS/OHA
------	---------

410-120-1960	461-120-0330	461-120-0350	461-135-1100	461-170-0035
410-120-0345	461-120-0345	461-135-0990	461-155-0360	461-180-0097

### **DMAP - Medical Savings Chart (MSC)**

The Medical Savings Chart is used to determine eligibility for the Health Insurance Premium Payment (HIPP) and Private Health Insurance (PHI) programs.

*Effective January 1, 2012, Health Insurance Group, Office of Payment Accuracy and Recovery*

<b>Eligibility group</b>	<b>PERC Code</b>	<b>Cost-effective premium amount (employee cost)</b>
CEM	HD, HE, HF, HG	\$147
OHP-OPC	H1, H2, H3, H4, OHP-OPC	\$239
OHP-OP6	HB, HA	\$448
OHP-OPP	L2, L6, L8, HC	\$705
EXT	XE	\$249
MAA/MAF	2, 82	\$386
SAC	C5	\$1785
OSIP-AB	3, B3	\$495
OSIP-AD	4, D4	\$1141
OSIPM-OAA	1, A1	\$180
Foster Children-SCFR	19	\$237
GA	5, GA	\$163

### **DMAP - Special Conditions Chart add-on list**

The Special Conditions Chart (SCC) is used to determine eligibility for the Health Insurance Premium Payment (HIPP) or Private Health Insurance (PHI) programs when premium amounts exceed the Medical Savings Chart and a recipient has one of the conditions listed below.

*Effective January 1, 2012, Health Insurance Group, Office of Payment Accuracy and Recovery*

<b>CCS2 Code</b>	<b>Description</b>	<b>Average paid per-client, per-month</b>
019	Pancreatic disease – excluding diabetes	\$396
002	Cancer	\$231
009	Blood disorder (sickle cell, hemophilia)	\$213
001	TB, HIV/AIDS, Hepatitis A, B or C	\$173
018	Liver Disease	\$157
015	Cardiovascular disorders	\$137
023	Childbirth (if neonatal delivery cost PMPM is \$268)	\$105
012	CNS disorder-Multiple sclerosis, Epilepsy, Cerebral Palsy, Plegia (Quad, Para, Mono), Paralysis, Parkinsons, Huntingtons	\$65
027	Spina bifida	\$65
010	Mental Health disorders (Autism, DD)	\$61
016	Chronic lung disease, COPD	\$65
011	Alcohol & Chemical dependence disorders	\$54
021	Renal disorders (kidney disease)	\$50
005	Diabetes	\$40

## Administrative Examinations and Reports

### Overview

“Administrative Medical Examinations and Reports” are examinations, evaluations, and reports, including copies of medical records, requested on the DMAP 729 form through the local Department of Human Services (DHS) branch office or requested or approved by the Oregon Health Authority to establish client eligibility for a medical assistance program or for casework planning (See OAR 410-120-0000, Definitions). Typically, it is the DHS Case Worker who determines the need for administrative examinations and reports, and requests these services by completing the DMAP 729 form.

### Child Welfare (CW)

For detailed information about Admin Exams for Child Welfare staff, see Oregon Administrative Rules [413-050-0400 thru 0450](#) Special Medical Services Provided by Child Welfare.

### Presumptive Medicaid Disability Determination Team (PMDDT)

PMDDT will only request Admin Exams from “acceptable sources” (See 20CFR§416.913). Once a diagnosis is established by the acceptable source, PMDDT is able to use other evidence to address severity. PMDDT uses the Social Security Act (SSA) definition of disability, so PMDDT is bound by the CFR and the [Programs Operations Manual System](#).

### Developmental Disabilities (DD)

See the [DD Worker Guide](#) – Procedural Codes for Developmental Disabilities and the Training & Power Point presentation.

### Division of Medical Assistance Programs (DMAP)

DMAP processes Admin Exam claims through the MMIS. Workers use the DMAP 729 series of forms when ordering medical procedures.

### Ordering Medical Procedures - DMAP 729 forms

The DMAP 729 forms are a series of seven forms (links appear at the end of this guide) workers use to order medical procedures. Not all DHS/OHA agencies use every form in the 729 series.

- Instructions to complete the DMAP 729 are on the back of each form.
- Send appropriate DMAP 729s and a release of information to the provider.

### Guidelines for the DMAP 729 Series

- Determine the appropriate examination or report to order.
- No prior authorization is needed for administrative medical exams and reports.

### DMAP 729 series form links

- Administrative Medical Examination/Report Authorization [DMAP 729](#)
- Comprehensive Psychiatric or Psychological Evaluation [DMAP 729A](#)

- Report on Eye Examination [DMAP 729C](#)
- Medical Records Checklist [DMAP 729D](#)
- Physical Residual Function Capacity Report [DMAP 729E](#)
- Mental Residual Function Capacity Report [DMAP 729F](#)
- Rating of Impairment Severity Report [DMAP 729G](#)
- The 729 series of forms are also found on the [DHS/OHA forms server](#).

## Revenue, Current Procedural Terminology (CPT) and Health Care Common Procedure Coding System (HCPCS) Codes

See the tables below for the most current information:

- [Revenue Codes – Table 1](#) – Hospitals Revenue Codes
- [CPT/HCPCS Codes – Table 2](#) – Professional (non-hospital) Services

*Note: For codes 80100, 80101, 80102 and H0048: Services are restricted for use by Child Welfare, and rates of reimbursement are included in the contract between contractor (laboratory) and the State Procurement Office (SPO). Questions regarding drug screening and confirmation services should be directed to Child Welfare.*

## DMAP reimbursement for provider reports

To reimburse providers for the Admin Exam or the Administrative Medical Report related to an Admin Exam, the provider must send CMS 1500 or UB-04 billing forms directly to DMAP to the address on the bottom of the DMAP 729.

**DMAP will only reimburse providers that:**

- Are DMAP-enrolled,
- Have Admin Exam provider contract,
- Have met the requesting DHS program criteria for a qualified provider, and
- Have a current contract to complete Admin Exams with the requesting DHS agency.

## Self-Sufficiency Program (SSP)

- Staff began using the Client Maintenance CM (UCMS) system codes in 2009. See detailed information here: [New Client Maintenance System Coding for Admin. Exams](#).

## Prior Authorizations

Some medical services and equipment require prior authorization (PA) by DMAP or the client's managed care plan before they can be delivered to a client. These services and equipment include, but are not limited to:

- 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
- Most transplants
- Out-of-State services
- Some surgeries

### Where to get prior authorization

If a client is enrolled in managed care the provider should contact the plan directly for prior authorization.

Fee-for-service contact information is available on page 5 of DMAP's [Provider Contacts List](#).

## Client Rights and Responsibilities

Clients who receive medical assistance (a.k.a. Medicaid or Oregon Health Plan) have specific rights and responsibilities:

- The Rights and Responsibilities section 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 involves billing. The Division of Medical Assistance Programs (DMAP) 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.

### Billing of clients

*OARs: 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 client for any service covered by Medicaid, except under the circumstances described below:

- The health service or item is not covered by a DMAP 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 DMAP General Rules OAR 410-120-1230.
- The client did not tell the provider that they had medical coverage from DMAP 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 DMAP in accordance with the Timely Submission of Claims rule. The provider must document attempts to obtain information from the client on potential medical assistance coverage.
- The client did not tell the provider that they had medical assistance coverage prior to the delivery of the service, the service required authorization prior to the delivery of the service, and DMAP staff will not retroactively authorize.
- The client did not tell the provider that they had other insurance coverage and the third party insurer will not make payment because of lack of timeliness or lack of prior authorization. DMAP will not make payment on a service that would have been covered by another insurer if the client had informed the provider of the other insurance in a timely manner.
- A Third Party Resource makes payments directly to the client for medical services.  
*NOTE: Indian Health Services or Tribal Health Clinics are not Third Party Resources and are the payer of last resort.*
- The provider is not enrolled with DMAP.

- The client entered into a payment arrangement before or at the time service was provided. The provider must document the payment terms under which treatment is being provided, the client's acceptance of the terms, 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 medical assistance coverage. If the provider is aware of the client's medical assistance coverage through DMAP, but still bills the client, fax copies of the bills to DMAP Client Services Unit at 503-945-6898 or mail the copies to:*

DMAP, Attention CSU Billing  
500 Summer St NE, E-49  
Salem, OR 97301-1079

## Health care complaint processes

OARs: OHP 410-141-0260 & 410-141-0261

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

All clients may seek assistance with health care concerns or complaints through DMAP'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 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.

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

- Talk to the Primary Care Provider. The client should ask the physician or other provider to attempt to resolve the problem.
- Contact the plan's customer service representative. The plan's telephone number is on the client's Oregon Health ID. 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.
- 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.

## Hearings

OARs: General Rules 410-120-1860 and OHP 410-141-0262 & 410-141-0264

### Managed care plan clients

Clients enrolled in a managed care plan that have been denied a service, may appeal the decision through their plan and request an administrative hearing through DMAP. Clients should follow the instructions on the Notice of Action (initial decision notice) to initiate the appeal process through their plan and/or request an administrative hearing through DMAP within 45 days from the date of the decision notice.

If the client chooses to file an appeal the managed care plan will complete the appeal process and 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 with DMAP within 45 days from the date of the decision notice.

**Fee-for-service clients**

OHP clients who are fee-for-service (also known as “open card”), may request an administrative hearing through DMAP at the time they receive the decision notice. Clients have 45 days from the date of the decision notice to request an administrative hearing.

**Submitting the DHS 443 to DMAP Hearings Unit**

<b>Managed care plan clients</b>	Ensure that the client has fully completed the <a href="#">DHS 443</a> . Ask the client for a copy of the Notice of Action or the Notice of Appeal Resolution (decision notices) from the managed care plan to include with the <a href="#">DHS 443</a> . If they do not have a copy, forward the <a href="#">DHS 443</a> to DMAP.
<b>Fee-for-service clients</b>	Ensure that the client has fully completed the <a href="#">DHS 443</a> . Ask the client for a copy of the decision notice to include with the <a href="#">DHS 443</a> . If they do not have a copy, forward the <a href="#">DHS 443</a> to DMAP.

Forward the [DHS 443](#) to DMAP immediately, as the hearing process timelines have been shortened. Forward all DMAP hearing requests, with attachments, to:

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

## Medical Transportation

### Introduction

*OARs: OHP 410-136-0030 through 410-136-0860*

Non-emergent medical transportation (NEMT) assists clients going to and from routine or scheduled Oregon Health Plan (OHP) medical services. It does not include emergency ambulance transportation to a hospital. Clients in an emergency situation should call 911 for immediate assistance or go directly to the nearest hospital emergency room.

NEMT is federally mandated by the Centers for Medicare and Medicaid Services (CMS) rule, 42 CFR 431.53. Medical transportation is available to clients who have no other means to access appropriate medical care.

The Division of Medical Assistance Programs (DMAP) Medical Transportation Services Program in Oregon Administrative Rules, (OAR) chapter 410, division 136, provides for NEMT services for clients with an OHP Plus benefit package (**BMD, BMH, BMM, or CWX**). NEMT resources are **not** available for clients with OHP Standard (KIT), CAWEM (CWM) or Medicare-only (MED), as these clients are not mandatory populations under Medicaid.

This guide outlines the relationship and responsibilities of transportation brokerages, DHS/OHA branch office staff and the OHP in providing NEMT services to OHP eligible clients. Please read carefully as there are details, "A-typical" situations, and exceptions to consider. **Eligible clients in need of NEMT should first be referred to their regional transportation brokerage for service.**

This guide also covers prior authorization (PA) requirements broken down within 6 steps for branch office staff to follow. There are exceptions mentioned throughout this guide and information may be repeated for clarity.

### Transportation brokerages

- A transportation brokerage (brokerage) is a single point of contact for most, but not all, transportation services offered by the OHP for NEMT. **Eligible clients in need of NEMT should first be referred to their regional transportation brokerage for service.**
- Brokerages cover all areas of the State by regions. Find a link for brokerage contact information and map in the 'Resources' section at the end of this guide.

### Verifying Client Eligibility

- Brokerages verify OHP client eligibility, assess the client's needs and resources, and arrange and provide NEMT as appropriate.
- Brokerages authorize transports that are the least expensive, medically-appropriate mode in advance of the service being provided.

### Types of NEMT

- Brokerages can provide bus tickets and passes, taxi service, wheelchair vans, stretcher vans, secured transportation and common carrier.
- Brokerages may provide OHA Volunteer transportation. Brokers work with branch staff and volunteer coordinators (in counties that have volunteer transportation programs) to determine if

a client can be served more cost-effectively using a volunteer. If so, the branch and volunteer coordinator will arrange transportation.

- Brokerages arrange commercial travel (airline, train, etc.) and transportation locally to and from departure location if DMAP has approved out-of-State travel for OHP-covered medical services.
- The branch office staff will need to work with the client to arrange for reimbursement of any prior-authorized meals, lodging, and transportation that occurs in the other state.
- Brokerages may provide ambulance or air ambulance services in DMAP-piloted areas only. On rare occasions when clients require NEMT by ambulance or air ambulance, the transportation brokerage will refer the client to the branch office for authorization, unless located in a pilot area where the brokerage will make the arrangements. See prior authorization, step 4, detailing more information on ambulance services arranged by the branch.

## Client Reimbursement

- Brokerages **may** provide client reimbursement in approved DMAP-piloted areas only:
  - All client requests for reimbursement for NEMT services must be prior authorized.
  - If the brokerage does not provide client reimbursement, they will refer the client back to the branch office for assistance.
  - If the brokerage provides client reimbursement, the brokerage will provide reimbursement for prior-approved meals and lodging. Branch Office staff must not reimburse for these services provided by a brokerage.
  - The brokerage may be more likely to have cost effective alternatives to reimbursement when a client has recurring regularly scheduled appointments, such as dialysis.

## Urgent Care After-Hours and Emergencies

- Occasionally, a client may require an urgent, but non-emergency, medical transport after hours when it is not possible to prior authorize. If the client normally uses the transportation brokerage, the client should follow the brokerage's instructions for urgent care on its after-hours telephone message. If the client normally uses reimbursement, the client can drive or be driven to urgent care, and then contact the branch staff for retroactive authorization the following business day.
- The branch should approve retroactive authorization when the client demonstrates medical urgency, such as intense pain, bleeding, fever, allergic reaction, etc., that occurred after branch hours. If the branch determines there was no medical urgency, or the client could have contacted the branch during business hours prior to travel, the request for retroactive authorization should be denied.
- NEMT does not include emergency ambulance transportation to a hospital. Clients in an emergency situation should call 911 for immediate assistance or go directly to the nearest hospital emergency room.
- The branch office may receive retroactive authorization requests from ambulance providers for after-hours service. See the ambulance or air ambulance information in this guide and OAR 410-136-0300, Authorization, for more information.
- If the client had a medical emergency and drove to a hospital emergency room, authorize mileage reimbursement. Emergency is defined in General Rules, OAR 410-120-0000, Acronyms and Definitions.

- Prior authorization is never required for emergency medical transportation. The client may only receive reimbursement for mileage to the nearest hospital emergency room if they did not use an ambulance.
- Do not authorize mileage to a more distant hospital. (See OAR 410-136-0200, Emergency Medical Transportation, *for more information.*)

## Clients without a branch office or case worker

- Many clients do not have an accessible branch office or an assigned case worker. These clients have medical benefits but no other OHA program benefits and are assigned to Branch 5503 (Oregon Health Plan's Statewide Processing Center).
- These clients should contact Branch 5503 at 503-378-2666 or 1-800-699-9075, for NEMT prior authorization and reimbursement.

## Children in subsidized adoptions

- For transportation authorization for children in subsidized adoptions with OHP Plus medical assistance only (County 0060), refer the appropriate person to the DMAP Co-60 Transportation Coordinator at (503) 945-5920. See contact information in the 'Resources' section at the end of this guide.

## Prior Authorization Steps (Branch Office Staff)

This section is intended primarily as a “how to” guide for branch office staff (OHA and AAA) that authorize NEMT for OHP clients. Each branch office designates staff to provide NEMT services for clients and serve as a primary point of contact. Designated staff will perform the following 6 steps for every NEMT authorization:

*(Note: These steps are only necessary for services that are not provided by transportation brokerages. Brokerages follow their operations manuals.)*

1. **Verify client eligibility**
2. **Verify covered medical service**
3. **Verify provider is closest available and enrolled with DMAP**
4. **Determine mode of transportation and attendant needs**
5. **Calculate meal and lodging needs**
6. **Authorize or deny**

### Step 1: Verify client eligibility

- Check MMIS to verify the client is eligible. Only clients with an OHP Plus (BMD, BMH, BMM or CWX) benefit package are eligible for NEMT. The client must be eligible on the date of service, not the date of request.
- Do not authorize NEMT for clients with OHP Standard (KIT), CAWEM-only (CWM) or Medicare-only (MED).
- Do not authorize NEMT for dates after a client's eligibility has ended.

- Check eligibility only for the client receiving medical care, not for the client's "care attendant" or other clients in the same household or on the same case. (See "Guardian or attendant (Care Attendant) below.") (See the section on benefit packages in this guide.)

## Step 2: Verify covered medical service

- NEMT is only available for transportation to and from necessary medical (including physical/dental/mental health) appointments that are covered by OHP.
- If necessary, contact the medical provider, managed care plan, or DMAP for more information to determine if a medical service is covered.
- Note: Covered and non-covered services are defined in General Rules: For covered services, see OAR 410-120-1160, Medical Assistance Benefits and Provider Rules. For non-covered services, see OAR 410-120-1200, Excluded Services and Limitations.
- A visit to a PCP, Urgent Care Clinic, or Hospital Emergency Room for the purpose of diagnosing an unknown condition is always considered a covered medical service for the purposes of NEMT, even if the subsequent diagnosis is for a non-covered condition.
- Medicare does not have an NEMT benefit. Some medical services are covered by Medicare only. For all clients that are Medicare-Medicaid dual eligible, confirm that the service is included as part of OHP covered services.
- Sometimes the medical provider will only bill Medicare for a dual-eligible client because Medicare will pay the entire claim. This is not a determining factor. If the client and service are OHP eligible, non-emergent transportation can be approved.
- NEMT is not available for any non-medical service purpose including, but not limited to visitation, jobs counseling, school or education programs. NEMT is not available for long term care clients viewing or moving into a new facility or to relocate out-of-State.
- Whether or not a service is court-ordered for a client does not affect the need for PA. If the service is a covered service, it is eligible regardless of court order. However, a service is not covered while a client is in the custody or care of a law enforcement agency or a corrections facility.

### Administrative exams

- A client who does not have an eligible OHP Plus benefit package may use NEMT to attend an administrative examination for the purpose of determining eligibility for medical assistance.
- The exam must be requested by the OHA/AAA case manager.
- The case manager must open eligibility using the ADMIN benefit package code for the date of service and complete form DMAP 729.
- If the client uses the transportation brokerage, send a copy of the form to the brokerage.
- NEMT may only be used in this situation to attend the requested examination and may not be used to attend any other medical service.

### Medical Equipment

- NEMT is not available for pick up or delivery of durable medical equipment (DME). All DME providers are required to provide appropriate pickup and delivery as part of their OHP provider terms. Contact the DMAP DME policy analyst. (See *contact information at the end of this guide.*)

## Pharmacy

- NEMT generally is not allowed for visits to a pharmacy unless it is medically-necessary for a new prescription to be filled immediately, the eligible client is already traveling for an OHP-related medical appointment, and the pharmacy is located on the way or is the closest available pharmacy.
- For refills and recurring prescriptions, clients should use postal prescription services. All OHP clients have a postal prescription option available, either from their managed care plan or [Wellpartner](#), or call 1-877-935-5797).
- In some situations, mail order prescription service may not be available or appropriate. This may include prescriptions for certain controlled narcotics that cannot be delivered by mail. Consult with the appropriate mail order prescription service and, if no service is available, you may authorize transportation to the closest appropriate pharmacy.
- Other situations, such as a transient client or a client without regular access to a mailbox, may be evaluated on a case-by-case basis.
- If the client uses postal prescription and receives the wrong prescription or has an unexpected problem from a prescription, there may be an urgent need to go directly to a pharmacy. Approve requests for NEMT under these circumstances.

### Step 3: Verify provider is closest available & enrolled with DMAP

*(Note: American Indian/Alaska Native clients with an "HNA" case descriptor are not restricted to the closest provider, but the closest Indian Health Care Provider (Indian Health Services, 638 Tribal facilities or Urban Indian Health Program Clinic).*

- NEMT is typically only available to transport clients to and from enrolled OHP providers in their local area.
- The client may choose to go to an out-of-area provider, but may not be eligible for NEMT when going out-of-area is purely a client choice and not a medical necessity.
- If the client is in a managed care plan, the appointment should either be with the client's local PCP, or a specialist referred by the PCP and approved by the managed care plan. If the managed care plan assigns a PCP or refers to a specialist out of the local area, verify with the plan that this is the closest available appropriate provider. The managed care plan may authorize a referral to a non-OHP provider. [Managed care plan contact information](#)
- Fee-for-service or open card clients choose any OHP enrolled provider, but are only eligible for NEMT in their local area or the closest available appropriate provider or specialist. Sometimes, clients are unable to access care in the local area because of client-caused situations with providers. **Do not authorize travel out of the local area when the client could access appropriate care locally by complying with reasonable provider requirements.** (See OAR 410-136-0160 for more information.)
- Clients may get prior authorization for NEMT to go to a non-OHP-enrolled provider, such as the Veterans' Administration, Medicare or third party insurance providers, or charity organization appointments (such as Doernbecher's or Shriner's), when the service meets the description of OHP covered service and is provided at no cost to DMAP or the client. You may give prior authorization even when the site of service is out-of-area if it is cost-effective for OHP.

### ***Out-of-State travel***

- Funding of medical services under the Oregon Health Plan is authorized for services provided in-State, or within the 75-mile contiguous zone. Funding of out-of-State services require prior authorization unless the service is provided for an emergent condition and billed accordingly. Non-emergent out-of-State services that are available in Oregon are not covered.
- If the client is in a managed care plan, the plan is responsible for prior authorization for the out-of-State service. If the client is fee-for-service (open card), the out-of-State RN Coordinator in the DMAP Medical Unit will make the final determination for prior authorization of the service. (See contact information at the end of this guide)
- The brokerage will arrange any necessary commercial (airline/train) travel. You will need to work with the brokerage to determine the cost-effectiveness of commercial travel or mileage reimbursement. If out-of-State travel is approved, it may be more cost-effective for the client to travel by commercial carrier than to receive mileage reimbursement.
- The branch office staff will need to work with the client and brokerage to arrange for reimbursement of any prior-authorized meals, lodging and transportation that occurs in another State, unless the brokerage is in a DMAP piloted-area for client reimbursements.
- DMAP cannot authorize NEMT to return a client to Oregon from out-of-State when the client's out-of-State medical care was not prior authorized. *(For more information, see OAR 410-136-0050, Out-of-State Transportation.)*

### **Step 4: Determine mode of transportation and attendant needs**

- If the client is unable to drive or get a ride from a friend or relative and does not require medical monitoring or care during travel, refer the client to the transportation brokerage. The brokerage will perform all eligibility verifications and arrange transportation. The client may still require branch office staff assistance with meal or lodging reimbursement.
- Eligible clients may have other resources available to them for transportation to medical appointments. Other transportation resources may include schools, care facilities or medical providers; public transit; charitable services; relatives or friends; or any other resource. Staff that authorizes NEMT must first verify the client does not have another transportation resource available to access necessary medical care.

### ***Mileage Reimbursement***

- All client reimbursement for NEMT services must be prior authorized. Reimbursement is generally provided **after** travel has occurred and attendance at the appointment has been verified.
- Clients who are able to drive themselves, or who have others willing to drive them to a medical service but who are unable to provide expenses associated with driving, may be eligible for mileage reimbursement if all other criteria is met.
- NEMT is only available for the actual client attending a medical service and if required, one guardian or attendant. In some circumstances when it is necessary to travel with a number of passengers (such as having to find day care for several children) it may be better for the client to ride in a personal vehicle and receive mileage reimbursement as long as other criteria is met (lowest cost mode of transportation). Note: Foster parents are an exception and may be eligible for mileage reimbursement even if a lower cost mode of transportation is available.

- Mileage reimbursement is generally issued to the client, or if the client is a minor, the head of the household on the case. If reimbursement is intended for someone other than the client, obtain written approval from the client before authorizing reimbursement:
  - You may accept a signed statement as simple as "I authorize [Name] to receive my travel reimbursement."
  - Document the consent in the case file and verify that the other person is not receiving any other form of reimbursement for this service.
- If more than one client may carpool to medical appointments, only one client is eligible for mileage reimbursement. Do not reimburse multiple clients for the same trip in the same vehicle.
- If the client requests mileage reimbursement, determine point-to-point miles and driving time for home to service and back using [MapQuest](#) (do not use other programs) for driving directions and mileage:
  - ✓ Do not authorize additional miles. However, in some situations, it may be appropriate for a client to drive an alternate route, such as bad weather or road repair. Branch staff should use their knowledge of the local area and best judgment.
  - ✓ Also, after a medical appointment, a client may need to make a pharmacy stop on the drive home. It is acceptable to retroactively authorize additional miles for the pharmacy stop provided the pharmacy is the closest available pharmacy and the client had an urgent need to fill the prescription (could not use postal delivery). Do not authorize mileage for other stops.
  - ✓ Only authorize mileage for actual client travel. For instance, if a client receives a ride from a relative, do not include miles driven by the relative to pick up the client.
- The reimbursement rate for mileage is \$0.25 per mile and is all-inclusive. Do not authorize additional reimbursement for gasoline, oil, or other expenses related to mileage.

### ***Guardian or Attendant (Care attendant)***

- A client may travel with a medically-necessary care attendant at no additional cost from the transportation provider.
- A care attendant may be a relative, friend, caregiver, or any other person who assists the client during transportation or during a medical procedure. The care attendant is not required to be an adult if the client is an adult.
- For NEMT services, verify eligibility for the client only. If the client is eligible, then the necessary "care attendant" is also eligible. Care attendants may be approved only to travel with the client and are not eligible for compensation. DMAP cannot reimburse a transportation care attendant for providing care or services.

When medically necessary, payment for meals or lodging may be made for one attendant to accompany the client. At least one of the following conditions or circumstances must be met:

- The client is a minor child and unable to travel without an attendant; or
- The client's attending physician has forwarded to the client's branch office a signed statement indicating the reason an attendant must travel with the client; or
- The client is mentally or physically unable to reach his or her medical appointment without assistance; or
- The client is or would be unable to return home without assistance after the treatment or service.

### **Travel with a minor**

- A child under age 12 requires an adult guardian for NEMT from any transportation provider, with exceptions for ambulance and secured transportation.
- A parent or legal guardian of any minor, even if over age 12, may travel with the minor at no additional cost.
- A child may not travel with both a parent and an attendant at no extra cost. Only one additional passenger may travel with the client for free.
- A child over 12 but not yet able to drive may be eligible for mileage reimbursement when driven by a parent or legal guardian. Issue reimbursement to the head of household on the case. *(For more information, refer to OAR 410-136-0245, Child Transports.)*

### **Volunteer Program or other resources**

- In some areas there are OHA volunteer programs not associated with a transportation brokerage that provide transportation for clients. Check with your district volunteer coordinator or the OHA Volunteer Program Manager for additional information. (See Volunteer Program Manager contact information at the end of this guide.)
- If the client has any other transportation resource available that can provide appropriate transportation at no cost to the client or DMAP, then do not authorize NEMT and issue a written denial. Cite OAR 410-136-0300, Authorization.

### **Ambulance or Air Ambulance**

*(Note: When a client is in a hospital and requires non-emergent ambulance transportation to another hospital, the first hospital will work with the appropriate brokerage or branch to arrange transportation. However, if a client is being transported from hospital to hospital for diagnostic or other short-term services and being returned to the first hospital within 24 hours, the first hospital is responsible for arrangement and payment of the transportation.)*

- The branch office, being responsible to ensure transportation is appropriate and cost-effective, may authorize non-emergent ambulance or air ambulance when appropriate for an eligible client. **Ambulances are only appropriate for medically fragile clients requiring medical care or monitoring during transportation, such as use of a ventilator or constant IV.**
- To authorize ambulance transports, the branch should contact local ambulance providers to determine availability for service and to obtain bid quotes. Under normal circumstances, the ambulance provider must agree to bill according to the DMAP Fee Schedule. However, in unusual circumstances, an ambulance provider may require additional payment authorization due to costs that go above and beyond normal ambulance service. This may occur when a client is bariatric and requires additional staff to assist moving the client, or under other unique circumstances. Discuss all circumstances with the ambulance provider. If no provider is able to accommodate at DMAP Fee Schedule rates, make arrangement with the lowest bidder.
- Branch offices may receive retroactive reimbursement requests from ambulance providers when clients use an ambulance for an after-hours urgent care situation or a hospital discharge. The branch should closely examine these requests to ensure medical appropriateness for ambulance. Do not authorize when ambulance was not the medically appropriate mode of transportation. Clients and hospital discharge staff must follow after-hours procedures for the brokerages and use appropriate and cost-effective, after-hours NEMT providers. *(See also the urgent care after hours and emergency information in this guide.)*

- For air ambulance, contact multiple providers using the contact information at the end of this guide. Hospital or facility social workers may also provide additional provider options. Select the available provider that offers the lowest bid amount. Ensure the bid includes all necessary ground transportation on both ends of the trip – if not, ground ambulance must also be arranged, and the bids should be evaluated accordingly.
- To prior authorize NEMT by ambulance or air ambulance:
  - Complete a form DMAP 405T, Medical Transportation Order, for the provider.
  - The form must include the authorized payment amount.
  - Under the block “\$ Authorized,” if the provider will bill according to the DMAP Fee Schedule, write “Fee Schedule.” Otherwise, write in the total dollar amount authorized for the lowest bidder.
  - Send the original form to the provider and retain a copy in the client case file.
  - Refer any subsequent provider inquiries for payment to the DMAP Provider Services Unit, 800-366-6016.

*(Note: For a medical emergency, no prior authorization is required; the ambulance or air ambulance provider may bill DMAP directly without involving the branch.)*

## Step 5: Calculate meal and lodging needs

### Meals

- Meal reimbursements must be requested by the client and prior authorized before travel. A client is eligible for a meal allowance when traveling out of the local area more than four hours. Count the total duration of the trip, including travel in both directions, and the time spent at the appointment. The travel must also occur during a recognized normal meal time and may be authorized during the following times:
  - Breakfast when travel begins before 6 a.m.
  - Lunch when travel spans the entire period between 11:30 a.m. and 1:30 p.m.
  - Dinner when travel ends after 6:30 p.m.
- When meals are authorized for a full day, reimburse the full amount of \$12 per day. Otherwise, meal reimbursement is calculated using the following fee schedule:

Breakfast:	\$3.00
Lunch:	\$3.50
Dinner:	\$5.50

- Meal reimbursement is considered per diem and does not require the client to submit receipts.
- If the client also receives lodging, you must evaluate the lodging’s capacity for meals. For example, many hotels provide free breakfast, so a breakfast reimbursement would not be provided.
- If the client receives a Supplemental Nutrition Assistance Program (SNAP) benefit this will not reduce any eligible meal reimbursements.

- Meals may be authorized for both the client and one necessary guardian or attendant. Evaluate the client and the guardian or attendant separately. *(See more information under Guardian or Attendant section in this guide.)*
- Do not authorize meals when a meal is provided as part of the medical service or is otherwise available at no cost. For example, if the client receives meals as part of hospital stay but the attendant does not, only reimburse for the attendant's meals.
- Occasionally, a facility may provide clients with an optional meal card or service that is not included as part of the medical service. In these situations, the facility may request direct reimbursement from the branch rather than billing the client. This is allowed with prior authorization:
  - Ensure only the facility is reimbursed.
  - Do not reimburse both the facility and the client.
  - Document in the client's case file.

### Lodging

- Reimbursement for lodging may be provided when the client's prior authorized travel requires overnight stay outside the local area. Usually lodging reimbursement is for a short stay in a hotel or motel. When a client requires multiple continuous nights, lodging reimbursement may be considered and authorized for apartment rentals or other cost effective solutions. The branch office will process reimbursement for lodging. All lodging requests must be made in advance of travel and prior authorized:
  - Lodging may be authorized when the client would have to begin travel before 5 a.m. or return home after 9 p.m.
  - Lodging may be authorized for services that require multiple days out of the area.
  - Lodging is not considered per diem and requires receipts.
  - Lodging is paid the lesser of the actual cost, or \$40 per night. Do not reimburse for client lodging in excess of \$40 per night.
  - Lodging is available for a necessary care attendant only when the client and the care attendant are not able to stay in the same room.
  - Lodging is only available for the number of nights that are necessary.
  - Do not approve lodging for trips that can be completed in one day.
  - Do not approve lodging for multiple appointments on different days when they could be scheduled on the same day.
- Exception to above: In some cases, a client may have a legitimate medical need for multiple out of town appointments on different consecutive days and could make multiple round trips rather than utilize lodging. If it is cost-effective, the client may make one round trip and utilize lodging rather than make multiple round trips.
- Note: State and federal regulations limit the amount of driving time to ten hours per day when commercial drivers carry passengers. On rare occasions, clients in remote areas of Oregon traveling to Portland and back will cause a commercial driver to exceed this limit if making a round trip in a single day. The transportation brokerage should notify the branch if this is an issue. For clients utilizing mileage reimbursement, clients should not be expected to drive in excess of ten total hours in one day. In these cases, it is acceptable to approve an overnight stay even if the client would otherwise be able to complete the trip during the 5 a.m. to 9 p.m. window.
- As with meals, in some situations, a facility may provide lodging that is not considered part of the medical service and may wish to be reimbursed directly by the branch rather than billing the

client. Ronald McDonald House usually prefers this arrangement. This is allowable and can be done with prior authorization.

- Be sure to only reimburse the facility. Do not also reimburse the client.
- Document in the client's case file.
- Do not approve lodging reimbursement when lodging is provided as part of the medical service, such as hospital in-patient.

### **Extended duration stays**

- Clients may sometimes require extended duration stays out of their local area or out of State due to extensive recovery time from surgeries such as transplants. Because the client may be eligible for up to \$40 per night, this can add up to as much as \$1,240 per month. Under these circumstances, there may be various lodging options that are more cost effective and better for clients than staying in a hotel. Consider:
  - Rented apartments, RV parking, or any other solution that may be available.
  - Hospital social workers may be able to provide numerous alternatives to hotels.
- If an alternate lodging solution is used, only reimburse up to the lesser of actual cost and aggregated \$40 per night. For example:
  - If the client stays in a rented apartment for 30 days for \$800, reimburse \$800, not \$1,200.
  - Reimbursement may be made directly to the lodging facility if appropriate. Do not duplicate reimbursement to the client. *(For more information about meals and lodging, see OAR 410-136-0820, Qualifying Criteria for Meals/Lodging/Attendant.)*
- If the client requests meals or lodging but does not qualify, then do not authorize and issue a written denial. Cite OAR 410-136-0820, Qualifying Criteria for Meals/Lodging/Attendant.

## **Step 6: Authorize or deny**

- Authorize or deny NEMT for the client on the DMAP form 0409: Medical Transportation Screening/Input Document.
- If the request is not authorized, issue a written denial and include the notice of hearing rights. Reference all applicable OARs for the reason for denial.
- In some situations, a request may be partially denied. For instance, a client may request mileage and meal reimbursement, but only qualify for mileage. Be sure the denial specifies what is approved and what is denied.
- If authorized, inform the client:
  - The client will be able to complete the reimbursement request after travel.
  - Be sure the client understands that reimbursement is dependent on verification that the client attended the medical service.
  - The client must complete the reimbursement request within 30 days of travel or the request will be denied. Inform the client that requests under \$10 may be held by the branch until subsequent requests accumulate to a total of \$10 or more.

*For more information, see OAR 410-136-0800, Prior Authorization of Client Reimbursed Mileage, Meals and Lodging.*

### **Verify appointment**

- Once the branch has received the completed request for reimbursement DMAP form 0882: Medical Transportation Reimbursement Notice from the client, verify the client attended the medical service. Verification can be by phone call to the provider, by fax or e-mail from the provider, or by provider's signature or stamp on an attendance sheet.
- If the client did not attend the medical service, do not authorize and issue a written denial.
- If the client did not complete the request for reimbursement within 30 days of completion of travel, do not authorize and issue a written denial. Cite OAR 410-136-0800, Prior Authorization of Client Reimbursed Mileage, Meals and Lodging.
- If the request meets all eligibility criteria and the total reimbursement amount is \$10 or more, issue reimbursement. If the request is for less than \$10, the branch may hold the request until subsequent requests accumulate a total reimbursement of \$10 or more. Reimbursement is issued by check from the DHS mainframe using the SPL1, SPL2 screens with code 35. Refer to DHS mainframe manuals for further instructions. Checks are automatically mailed to the client from Salem.
- When there is no time to wait for the check to be issued from Salem, the branch manager may decide to write the check in the branch and then complete the information for DMAP to reimburse the branch for the revolving fund check. The form DMAP 409 has instructions on the backside of the form. Submit copies of the form DMAP 409 and the revolving fund check to:

**Micro-Imaging Unit  
PO Box 14006  
Salem, OR 97309**

The original form DMAP 409 remains in the branch record.

### **Travel advance**

- In exceptional circumstances, a branch may advance a full or partial reimbursement before travel. For example, a client may not have available cash to pay for gasoline and hotel stays prior to receiving reimbursement.
- Only the branch manager may authorize an advance payment to the client considering the risk of overpayment or a "no show:"
  - When the client's travel is complete, be sure to deduct any advance from the final reimbursement.
  - If the client did not attend the medical service, or incurred costs below the advance amount, refer the case to OPAR's Overpayment Recovery Unit at 503-373-7772 (Salem area) or 800-273-0548 (toll free). In the event of multiple overpayments to the same client, aggregate the total in the referral.

*Note: There are minimum recovery amounts for overpayments referred to OPAR. Most advances for NEMT would fall below the minimum threshold, and therefore are unrecoverable. As such, it is imperative that any advance be carefully evaluated in terms of cost and risk. For further information, consult with OPAR.*

## NEMT Policy Exceptions

### Policy Exceptions for cost effectiveness

- NEMT that would ordinarily be unavailable according to program OARs or established exception procedures may be authorized on rare occasions, if it is in the best interest of both the client and OHP. Such policy exceptions are evaluated on a case-by-case basis and are only authorized by DMAP Management.
- In order to evaluate a request for policy exception, DMAP requires cost-benefit analysis. DMAP will only approve a policy exception when there is a demonstrable saving to OHP, a significant benefit for the client, and no burden placed on the client or providers. The OHA/AAA case manager should prepare a written proposal that clearly expresses all costs and benefits for submission to the DMAP Medical Transportation Policy Analyst (Policy Analyst). The DMAP Policy Analyst will review the proposal, ask for additional information if necessary, and submit to DMAP Management for authorization.
- If authorized, the DMAP Policy Analyst will send the case manager confirmation by e-mail and, if appropriate, send a copy to the transportation brokerage. The case manager will make necessary arrangements and retain copies of the authorization and any supporting documents in the client case file. *(Note: See contact information at the end of this guide.)*

## Resources

<p>Kristi Jacobo DMAP Medical Transportation Policy Analyst <a href="mailto:kristi.jacobo@state.or.us">kristi.jacobo@state.or.us</a> (503) 945-6492</p>	<p>Valerie Rux DMAP Medical Transportation Policy Analyst <a href="mailto:valerie.rux@state.or.us">valerie.rux@state.or.us</a> (503) 945-5796</p>	<p>Julie McGuire DMAP Branch 60 Transportation Coordinator <a href="mailto:julie.mcguire@state.or.us">julie.mcguire@state.or.us</a> (503) 945-5920</p>
<p>Carol Camfield, RN DMAP Medical Unit Out-of-State Coordinator <a href="mailto:carol.l.camfield@state.or.us">carol.l.camfield@state.or.us</a> (503) 945-5802</p>	<p>Caroline Price, RN DMAP Medical Unit Transplant Coordinator <a href="mailto:caroline.price@state.or.us">caroline.price@state.or.us</a> (503) 945-6488</p>	<p>Greg Russo OHA Volunteer Program Manager <a href="mailto:gregory.p.russo@state.or.us">gregory.p.russo@state.or.us</a> (503) 945-8994</p>

Transportation brokerages and service area maps

<http://www.dhs.state.or.us/policy/healthplan/guides/medtrans/broker-list-map.pdf>

Oregon Administrative Rules (OARs) for Medical Transportation

<http://www.dhs.state.or.us/policy/healthplan/guides/medtrans/main.html>

Ronald McDonald House

<http://www.rmhcOregon.org/contact>

## Air ambulance companies enrolled with DMAP

This list is not all-inclusive and subject to change. A receiving hospital's transportation planner or social worker may be able to provide additional air ambulance companies or revised contact information.

Company	Telephone	Web site
Access Air Ambulance Boise, ID	208-389-9906	NA
Air Life of Oregon Bend, OR	541-385-6305	<a href="http://www.airlife.org">www.airlife.org</a>
Air St. Lukes Boise RMC Boise, ID	877-785-8537	<a href="http://www.stlukesonline.org">www.stlukesonline.org</a>
Airlift Northwest Seattle, WA	800-426-2430	<a href="http://www.airliftnw.org">www.airliftnw.org</a>
AirLink Critical Care Bend, OR	800-353-0497	<a href="http://www.stcharleshealthcare.org">www.stcharleshealthcare.org</a>
American Medflight Reno, NV	800-799-0400	<a href="http://www.americanmedflight.com">www.americanmedflight.com</a>
Cal-Ore Life Flight (Westlog) Brookings, OR	541-469-7911	<a href="http://www.cal-ore.com">www.cal-ore.com</a>
Bay Cities Air Ambulance Coos Bay, OR	541-266-4300	N/A
Emergency Airlift (Reno Flight Services) Reno, OR	541-756-6802	<a href="http://www.emergencyairlift.com">www.emergencyairlift.com</a>
Life Flight Network	503-678-0206	<a href="http://www.lifeflight.org">www.lifeflight.org</a>
Medic 1 Irwindale, CA	800-347-3262	<a href="http://www.medic1.net">www.medic1.net</a>
Mercy Flights	800-903-9000	<a href="http://www.mercyflights.com">www.mercyflights.com</a>
Northwest Medstar Inland NW Health Services Spokane, WA	800-572-3210	<a href="http://www.nwmedstar.org">www.nwmedstar.org</a>
PHI Air Medical	800-421-6111	<a href="http://www.phiairmedical.com">www.phiairmedical.com</a>
Premier Jets	503-640-2927	<a href="http://www.premierjets.com">www.premierjets.com</a>
REACH Air Medical (Mediplane, Inc.) Santa Rosa, CA	541-257-2600	<a href="http://www.mediplane.com">www.mediplane.com</a>
St. Alphonsus RMC Boise, ID	208-367-2121	<a href="http://www.saintalphonsus.org">www.saintalphonsus.org</a>

## Processing claims

### Overview

DMAP's claims processing system is highly automated. It handles approximately 1 million claims per month. This total number of claims includes capitation payments, point-of-sale, EDI, paper claims and nursing home claims (turn-around document or TAD). If all information is correct, providers who input claims electronically by 2:00 p.m. on Friday could receive a check for payment the following week.

**Branch staff members are vital to the smooth working of this system.** DMAP depends on field workers to enter timely and accurate eligibility information on clients. Two of the most common errors are that a client changes their name and it is not updated right away or a newborn is not added for medical coverage as soon as possible. If there is an error on a claim, such as a misplaced code or blank field, the claim could suspend or deny. Then the claim will be reviewed by a staff person, causing a delay in payment of several weeks.

### Questions about billings:

- Managed care plan clients should contact their plan if they have questions about billings.
- Fee-for-service (open card) clients or clients with a Primary Care Manager (PCM) should contact DMAP Client Services Unit (CSU) at 1-800-273-0557 if they have questions about billings. It is necessary for CSU to have a copy of the bill in order to answer questions and identify possible solutions. Workers may fax, or have the client fax, a copy of the bill to CSU Billing at 503-945-6898.

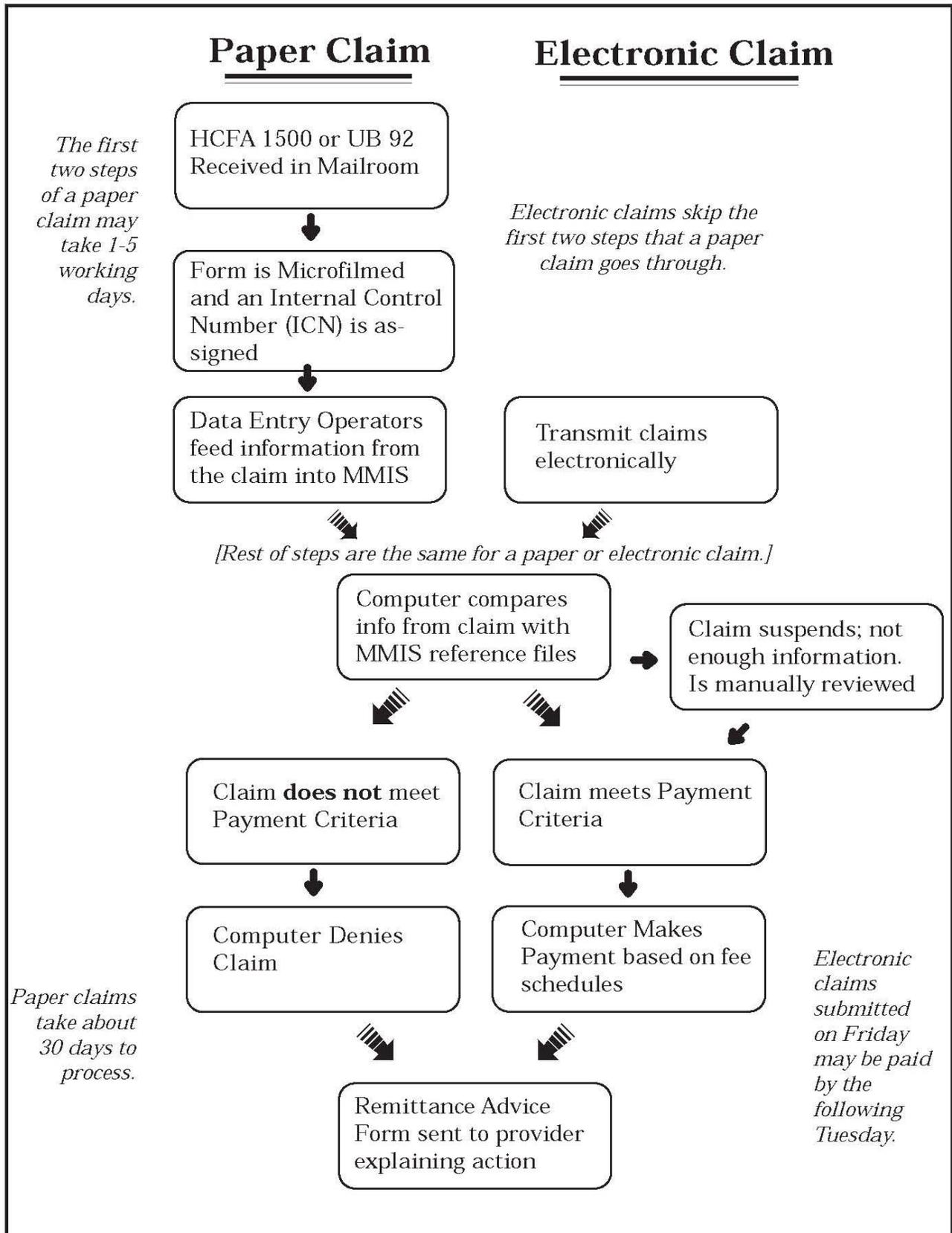
### How a Medicaid claim is processed

When a provider submits a fee-for-service claim to DMAP, it is processed primarily by a computer—the Medicaid Management Information System (MMIS). Unlike most private insurance companies, the DMAP claims processing system is highly automated. Claims are entered into the system prior to verification or visual checks for clerical errors. Because of this automation and the high claim volume, a misplaced code or a blank field can cause the claim to suspend or deny.

### Here's how it works:

- Paper claims submitted by mail go first to the Office of Forms and Document Management (OFDM) Imaging Unit. Here the claim is scanned, given an internal control number (ICN), and batched. Depending on volume, the mail intake and the ICN assignment process may take from one to five working days.
- Claims are then delivered to the Data Entry Unit, where operators manually enter the information appearing on the claims into the MMIS processing system. ONLY required fields of information are keyed into MMIS. Data entry operators can process a single claim in 45 seconds. Because of quality assurance and time requirements, data entry operators cannot alter the information on the claim forms, or take the time to read and annotate notes or written explanations attached to claims.
- Providers who bill electronically bypass these first two steps and their data is entered directly into the system. It is not uncommon for providers to bill using electronic data interchange (EDI) by 2:00 p.m. on Friday and have a check the next week.

- From this point on, the claim is not seen by any DMAP staff member unless it suspends for specific medical or administrative review. The only way staff can immediately access submitted claim information is to check certain MMIS screens.
- When a claim suspends, in essence, MMIS is saying that it cannot make a decision — a claims analyst will have to review the data. It is also possible that internal files need to be updated before the claim can be paid; for example, patient eligibility is the most common reason for internal file discrepancy. Since eligibility is determined and updated at the local DHS/OHA branch level, DMAP depends on caseworkers to supply accurate and timely eligibility information to MMIS. If the claim has suspended for this reason, two weeks are allowed to pass. Then, if DMAP files still show “no eligibility for patient,” the system will automatically deny the claim. Providers receive a denial notice on their remittance advice with an explanation of benefits (EOB) message, such as “Patient ineligible on date of service.”
- There are more than 900 potential questions MMIS may ask about a claim before it can make a payment decision. The computer will try to match data from the claim entered into the system with information about this recipient entered previously.
- Most paper claims are processed within 30 days. Providers receive a remittance advice (RA) explaining payments and denials. The fewer questions the computer asks, the more quickly the claim can be processed.
- Most claims are denied because of incomplete or incorrect patient or provider data. Please be sure your case information is complete and accurate. Only those procedures that require “cost documentation” or “by report” will suspend for medical review. The Medical Unit analyzes those claims.
- The chart on the next page shows how a claim is processed.



## Premiums, Copayments and Special Requirements

### OHP Standard premiums overview

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

### Who pays premiums?

OHP Standard clients, that 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 OHP Standard clients) are exempt from paying premiums:

- A member of a federally recognized Indian tribe, band, or group or an Eskimo, Aleut, or other Alaska native enrolled by the Secretary of the Interior pursuant to the Alaska Native Claims Settlement Act. Once verified, staff must be careful to add the HNA case descriptor to the client on CMUP.
- Clients with CAWEM benefits
- Clients with income at or below 10 percent of the federal poverty level (FPL)

### Premium 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 OAR 461-155-0235.

### Premium billings

The Oregon Health Plan Premium Billing Office sends the billings and collects the OHP premiums. The current contractor is Chaves Consulting, Inc, but workers should always refer to it as the "OHP Premium Billing Office."

DMAP sends premium billing data to the billing office monthly. Daily adjustments made by a worker to a client's premium history are sent to the billing office daily and updated in the client's account record as soon as received, usually the next day.

Premium billings are sent to OHP-OPU clients during the first week of each month.

### Premium payments

Payments are due by the 20th of the current month. Anyone may pay premiums on behalf of a client (OAR 410-120-1390). Clients have several options for paying premiums.

Tell clients who come to a branch office wanting to pay their premiums to mail their payment to the OHP Premium Billing Office, pay online, or call to make payment by phone. Their premium bill includes a return envelope. Tell clients to include the payment portion of the billing along with the payment.

<b>Payment by mail</b>	<p>Clients should not send cash payments by mail. They should only mail checks, money orders or cashier's checks that include the client's name and Oregon Health ID number.</p> <p>Clients who pay their premiums by mail should use the return envelope that comes with their bill. If they do not have the return envelope they can send the payment to:</p>	<p>Chaves Consulting, OHP Premium Billing Office P.O. Box 1120 Baker City, OR 97814-1120</p>
<b>Payment online</b>	<p>Clients may make their payment online using a debit or credit card, or by e-check. Go to <a href="http://www.OHBilling.com">www.OHBilling.com</a>.</p>	
<b>Payment by phone</b>	<p>Clients may make their premium payment by phone using a debit or credit card (<b>not by e-check</b>). Call 1-888-647-2729.</p>	
<b>Payment in person</b>	<p>Billing office staff will accept cash only if presented in person. Clients may pay in person at:</p>	<p>OHP Premium Billing Office Chaves Consulting Baker City, Oregon</p>

## Nonpayment of premiums

Clients do not lose OHP coverage during their twelve-month enrollment period for non-payment of required premiums. However, clients must pay all billed premiums before they can qualify for the subsequent twelve months of OHP coverage. If a client has a premium arrearage that they need to pay in order to continue coverage, you may want to suggest payment by phone in order to expedite the recertification process.

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 and may be at risk of losing coverage altogether when the OHP Standard program is closed to new enrollees. Only OHP-OPU clients are affected by not paying their premium debt.

Clients with the HNA case descriptor and CAWEM clients are exempt from paying premiums. Clients who earn 10 percent or less of the FPL are also exempt. Refer to the Family Services Manual for specifics (OAR 461-135-1100, 461-135-1120, and 461-135-1130).

If the department is notified that a member of the filing group has filed for bankruptcy and the arrearage is a debt that has been stayed in a bankruptcy proceeding, OHP can adjust the arrearage. 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 Self Sufficiency Program (SSP), Child Welfare (CW), OCCS 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.

## OHP Plus and OHP with Limited Drug copayments

*OAR 410-120-1230*

OHP charges some OHP clients a copayment for prescription drugs and/or outpatient services, depending on their eligibility level and benefit package. Copayment information is shown on page two of the client's OHP Coverage Letter. Medicare may also charge copays on the drugs it supplies through Medicare Part D.

Providers cannot deny services to a client 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.

## Exemptions

The following clients also do not have to pay a copayment:

- Pregnant women
- Children under age 19
- Clients with OHP Supplemental
- Clients with the HNA case descriptor
- 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)

## Copayment amounts

Some clients must pay \$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 requiring a copayment

The following are services for which providers can charge 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

Clients do not have 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])

## Prescription copayments

OHP Plus clients do not have to pay a copayment for the following prescriptions:

- Drugs for family planning services, such as birth control pills
- Drugs obtained through the Home-Delivery Pharmacy Program (mail order)
- Most generic medicines
- Any drugs listed on the physical health Preferred Drug List, including most generics

For drugs that require a copayment, clients will pay zero, \$1 or \$3. Amounts are listed in [OAR 410-120-1230](#). Clients may request generics to get a reduced copayment, but they are not required to use generics. Similarly, clients can still get non-preferred brand-name drugs their doctors prescribe, but clients will pay the maximum copayment.

Physical health drugs not on the PDL also require PA. The prescriber requests the PA from the Oregon Pharmacy Call Center.

## Home-Delivery Pharmacy Program (mail order)

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 walk-in pharmacy through the Pharmacy Management Program (i.e., they can use both). 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 [DMAP Web site](#). 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 fax number should only be used by the doctor or health care provider.)

## Pharmacy Management Program (Lock-in)

### Overview

The purpose of the Pharmacy Management Program is to maximize patient safety and minimize risk of medication misuse. Some clients will be restricted to one walk-in pharmacy of their choice to receive prescription drugs.

Although clients will be enrolled in a single walk-in pharmacy or chain, they can use the Home-Delivery (Mail Order) Pharmacy Program and a specialty pharmacy, in addition to the walk-in store.

## Pharmacy Assignment

Clients using three or more pharmacies, using multiple prescribers to obtain the same or comparable prescriptions, having patterns of prescription misuse, or having altered a prescription are candidates for the Pharmacy Management Program. Those clients will be mailed a notice explaining the program and designating the name and address of one pharmacy (based upon the pharmacy the client used most often and most recently), and a notice of hearing rights. The client has 45 days to appeal, or to change their pharmacy. Clients remain in the program beginning the first day of the month, following their notice date, for a period of 18 months.

## Exemptions from the Pharmacy Management Program

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

- Enrolled in a Prepaid Health Plan;
- Has a major medical insurance policy;
- Enrolled in Medicare drug coverage plan and no other third party pharmacy benefits;
- Is a child in DHS care and custody; or
- Is an inpatient in a hospital, long-term residential care facility, or another medical institution.

## Changing an Assigned Pharmacy

Initially, the client has 45 days to change their pharmacy assignment. Thereafter, the client may change their pharmacy up to once every three months. Circumstances such as moving, reapplying for OHP benefits, pharmacy denies service to client, or goes out of business are reasons to change their pharmacy.

Branch workers may e-mail or mail the client's pharmacy choice to Client Enrollment Services (CES). Alternatively, branch workers may contact the Client Services Unit (CSU) at 1-800-273-0557 or e-mail [ces.dmap@state.or.us](mailto:ces.dmap@state.or.us). Please write *Pharmacy Lock-in* in the Subject line. CES mailing address is:

**DMAP Client Enrollment Services**  
**500 Summer St. NE, E44**  
**Salem, OR 97301-1079**

Pharmacists may contact the Oregon Pharmacy Call Center if a recipient needs to change to another pharmacy temporarily or permanently. Reasons for a one-time exception include:

- Selected pharmacy is closed at the time medication is needed
- Selected pharmacy does not have the prescribed medication in stock
- Client is 50 miles or more away from selected pharmacy at the time the prescription needs to be filled.
- Workers who have access to MMIS will find the name of the client's lock-in pharmacy in the MMIS Recipient Maintenance panel (choose Lock-in Details). The Lock-in Details panel will show the selected pharmacy's name, effective dates, and their National Provider Identifier (NPI).

CSU is responsible for giving the information to CES to update the client's Third Party Liability (TPL)

information. A new OHP Coverage Letter is mailed each time a change is made to the client's TPL information.

Branch workers may fax, telephone or mail the client's pharmacy choice to CES. Fax to 503-945-6873 or mail to DMAP Client Enrollment Services (see address above).