Provider matters

Updates about claim processing, policy and resources for Oregon Medicaid providers

November 17, 2017

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Important reminders

Mailing of provider credentialing letters

The Oregon Health Authority (OHA) periodically mails letters to most providers whose records show their license or certification will soon expire.

- Up to three letters are sent to every provider whose license is within 90 days of expiration.
- The letters mean OHA must receive a copy of the provider's current license or certification before the expiration date listed on the letter. Otherwise, their Oregon Medicaid enrollment will end.

Exception

If you practice in Oregon and your license is from one of the following boards, you **do not** need to send a copy of your license or certification.

- Oregon Medical Board
- Oregon State Board of Nursing
- Oregon Board of Pharmacy

These boards send license updates electronically to OHA.

New fee-for-service ride service effective January 1, 2018 in Marion and Polk counties

If you have patients who live in Marion or Polk counties who are not enrolled in CCO, be sure they know the following about help getting to health care visits:

- Starting December 1, they can call Marion-Polk MedLink at 877-236-4026 (TTY 711) for help getting to appointments for on or after January 1, 2018.
- The ride service can help OHP members get to and from health care visits, including the pharmacy. It can help pay for gas mileage. It can also help pay for a bus ride or bus pass.

This change is for fee-for-service members only. OHP members in a local coordinated care organization (CCO) should call the CCO, or their CCO's ride service, for help getting to health care visits.

Do not use the Provider CCO Change Request process to change CCO enrollments

On September 30, 2017, OHA ended the "Provider CCO Change Request" process. This process was a temporary solution to changing CCO enrollments when:

- Members wanted to keep their current primary care provider, and
- Their PCP was part of a different CCO network.

If members still need to change CCOs so they can keep their PCP, they can:

- **Ask online using their self-service ONE account.** To do this, members can login, click "Report a change in circumstances," and mark that they want to change their CCO. Members can learn how to sign up for and use a ONE account at OHP.Oregon.gov.
- **Call OHP Customer Service at 800-699-9075.** Their hours are Monday through Friday, 8 a.m. to 5 p.m.
- **Get help from a local community partner.** To find a community partner near you, go to http://healthcare.oregon.gov/Pages/find-help.aspx.

If members want to have fee-for-service medical so they can keep their PCP:

- **American Indian or Alaska Native members** can fill out the OHP 720 and send it to OHA.
- **Medicare members** should contact their local Aging and People with Disabilities office.
- **All other members** should call OHP Client Services at 800-273-0557.

Training and technical assistance

For Medicare providers: State and federal technical assistance for CMS Quality Payment Program participation and reporting

Reporting for the 2017 Quality Payment Program (QPP) performance period is scheduled to close on March 31, 2018. You can get free technical assistance about QPP participation and reporting from CMS and HealthInsight.

- ***What is the QPP?*** It combines several quality programs for Medicare providers – the Physician Quality Reporting System (PQRS), Medicare EHR Incentive Program for eligible professionals (aka Meaningful Use), and Value-Based Modifier. The QPP has two tracks: the Merit-based Incentive Payment System (MIPS) and Alternative Payment Models (APMs).
- ***How do you find out if you need to report for MIPS for 2017?*** Enter your National Provider Identifier (NPI) in the CMS participation status tool. CMS also has published an interactive tool to check on whether you may be exempt from MIPS reporting based on participation in an Advanced APM.
- ***What happens if you are subject to MIPS and don't report for 2017?*** Your 2019 Medicare payments will be reduced by 4%. You can avoid the negative payment adjustment by submitting test data (such as at least one quality measure or one improvement activity). By reporting for a partial or full year, you also could earn a positive payment adjustment.

How to submit prior authorization attachments using the Provider Web Portal

Later this month, the Provider Web Portal at https://www.or-medicaid.gov will allow providers to upload required documentation when they submit a prior authorization (PA) request.

- You can upload a scan or text file of the documentation. Supported files are .TXT, .PDF and .TIF/.TIFF.
- This means you can submit all information and documents in one request. No more faxing or calling to provide additional information.
- You can also come back at any time to upload more documents to same PA request.

If you prefer, you can still fax in additional information using the EDMS Coversheet (MSC 3970).

To learn more about this feature, please read this fact sheet (also posted on the Provider Web Portal page.

Ways to verify a patient's OHP application or renewal status

OHP Provider Services has received many calls and emails from providers asking for the OHP application or renewal status of their patients. While we appreciate the

reasons for these requests, Provider Services cannot respond to these requests for two reasons:

- **OHP Provider Services** (800-336-6016) is not equipped to research or answer application or renewal questions.
- Only **OHP Customer Service** (800-699-9075) can look up this information for the applicant or their authorized representative.

Providers can use the following resources to verify eligibility:

- The Provider Web Portal at https://www.or-medicaid.gov
- Automated Voice Response at 866-692-3864
- For CCO members, use the CCO's eligibility verification service

Members can also use their online account at ONE.Oregon.gov to view application status, report changes, and more. To learn more, visit OHP.Oregon.gov.

Claims

Please exhaust all appeal processes before submitting claim denials for administrative review

As outlined in Oregon Administrative Rules 410-120-1560 through 410-120-1580 in the General Rules provider guidelines, providers can ask for an administrative review when they do not agree with an OHA or CCO payment decision. To do this, providers can complete the *Claim or Payment Authorization Review Request* (OHP 3085) form.

- However, CCO providers must complete all appeal processes of the member's CCO **before** asking OHA for an administrative review.
- As the last resort, OHA's administrative review process must come after the provider completes all other possible ways to resolve the disagreement with the CCO.

If you request an administrative review and OHA finds you have not completed all appeal processes, OHA will refer to you back to the CCO for resolution.

Rules and program changes

Recent rule revisions

410-200-0015 and 410-200-0240 – Requirements set forth by the passage of SB 558 Cover All Kids

410-130-0015 – Allow doula providers to bill directly for services rendered

Sign up to get rule updates via text or email

You can also sign up to get text or email updates about:

- Notices of proposed rulemaking
- Temporary rulemaking notices
- Permanent rulemaking notices, rulebooks, and supplemental information

To learn more, read about how to sign up for rulemaking notices.

Non-covered services now located in the January 1, 2018 Prioritized List of Health Services

Starting January 1, 2018, the Prioritized List of Health Services will have two new lines:

- Line 500 – Conditions for which certain interventions result in marginal clinical benefit or low cost-effectiveness
- Line 660 – Conditions for which certain interventions are unproven, have no clinically important benefit or have harms that outweigh benefits

Lines 500 and 660 will look different from other lines on the list.

- No codes will appear on lines 500 or 660. Instead, they will refer to code tables in Guideline Note 172 or 173. The tables will only list procedure codes.
- No diagnosis codes will be associated with these lines. These services are generally non-covered for all indications.

This does not change OHA's definition of non-covered services.

- Prior to this change, Oregon Administrative Rule (OAR) 410-130-0220 in Medical-Surgical provider guidelines listed most of these codes as not covered.
- An administrative rule change is underway to remove the code list from the OAR, since these codes will be below the funding line on the January 2018 Prioritized List. The rule change is anticipated to be effective February 1, 2018.

Need help?

Find more phone numbers, email addresses and other resources in our Provider Contacts List.

- **Claim-specific questions and issues** – Contact Provider Services (800-336-6016).
- **EDI and the 835 ERA** – Contact EDI Support Services or visit the EDI page.
- **Provider enrollment updates** – Contact Provider Enrollment at 800-422-5047.

- **Pharmacy and prescriber questions (for technical help and fee-for-service prescription PAs)** – Contact the Oregon Pharmacy Call Center at 888-202-2126. You can also fax PA requests to 888-346-0178.
- **Prior authorization status** – Call the PA line at 800-642-8635 or 503-945-6821 (outside Oregon).
- **Web portal help and resets** – Contact Provider Services at 800-336-6016.