Oregon Health Plan

Billing information for all providers who serve Oregon Health Plan members
Agenda

• Member eligibility
• Documentation and billing
• Resources
MEMBER ELIGIBILITY
Oregon Health Plan (OHP) eligibility

- Providers are responsible to verify eligibility on each date of service
  - OHP coverage
  - Benefit plan
  - Coordinated care, managed care or fee-for-service
- **Member medical ID does not guarantee coverage**
- Member eligibility and coverage may change

Oregon Administrative Rule (OAR): 410-120-1140
Service delivery

- Covered services for eligible OHP members are delivered through:
  - **Coordinated care:** State contracts with a plan to handle prior authorization and billing; Coordinated Care Organization (CCO)
  - **Managed care:** State contracts with a plan to handle prior authorization and billing; Managed Care Organization (MCO)
  - **Fee-for-service (FFS):** The Oregon Health Authority (OHA) handles prior authorization and billing
Coordinated care

- Physical, mental health and dental (CCOA)
- Physical and mental health (CCOB)
- Mental health only (CCOE)
- Mental and dental health (CCOG)

Managed care

• Dental Care Organization (DCO)
• Mental Health Organization (MHO)
• Medical care
  – Fully Capitated Health Plan (FCHP); includes drug coverage
  – Primary Care Manager (PCM)
  – Physician Care Organization (PCO)

Tools to verify eligibility

- Provider Web Portal (PWP)
  - Real-time eligibility
  - Web-based system
- Automated Voice Response (AVR)
  - Telephone-based system
  - 866-692-3864
- Electronic Data Interchange (EDI)
  - Real-time eligibility
  - Electronic information exchange

http://www.oregon.gov/OHA/HSD/OHP/Pages/Eligibility-Verification.aspx
Steps to verify a service is covered

• Verify member eligibility on the date of service

• Refer to the Prioritized List to confirm funding and/or pairing
  – PWP
  – http://www.oregon.gov/oha/HSD/OHP/Pages/Prioritized-List.aspx
  – Need help? Code Pairing and Prioritized List hotline: 800-393-9855

• Refer to applicable Oregon Administrative Rules (OARs)
  – Use all applicable OARs to determine coverage criteria, limitations, restrictions, and exclusions
  – Need help? Provider Services Unit: 800-336-6016
Documentation

• Maintain documentation for all services provided that supports the charges billed. Ensure the date of service in the documentation matches the date of service on the claim.

• Include:
  – Date of service;
  – The individual who provided the service; and
  – Other documentation required by Oregon Administrative Rules (OARs), provider guidelines, or contract. Examples:
    • Prior authorization
    • Progress reports
    • Chart notes

Before billing OHP

- Make sure the person is eligible for OHP
- Determine if the member is enrolled in an OHP managed or coordinated care plan (if so, authorization and billing is through the plan)
- Verify if the member has other insurance
- Bill all other resources first
  - Third-Party Liability (TPL); private insurance
  - Medicare
Billing for Medicaid-covered services

- Bill appropriate parties
  - Coordinated or managed care plans
  - OHP (fee-for-service)

- Billing charges, copayments, and third-party payments
  - Bill usual and customary charges
  - Report any previously paid amount on the claim to OHP (other insurance and Medicare)

- Payment from OHP is OHP’s allowed amount, minus previous payments and member copayments
  - OHP does not collect copayments for services provided on or after 1/1/2017.
Billing an OHP member

- Providers are prohibited from billing an OHP member for Medicaid-covered services.
- Members may only be billed if all of the following criteria are met:
  - The service is **not** covered by Medicaid;
  - All reasonable covered treatments have been tried OR member is aware of reasonable covered treatments, but selects a treatment that is not covered; and
  - Member and provider have completed an *OHP Client Agreement to Pay for Health Services* (OHP 3165)

[https://aix-xweb1p.state.or.us/es_xweb/DHSforms/Served/he3165.pdf](https://aix-xweb1p.state.or.us/es_xweb/DHSforms/Served/he3165.pdf)
# Tools to submit claims

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<th>Provider Web Portal</th>
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<td>• Web-based billing</td>
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<td>• Available 24 hours a day, 7 days a week</td>
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<td>• Immediate claim status upon submission</td>
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<th>Electronic Data Interchange (EDI)</th>
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<tr>
<td>• Electronic-based billing</td>
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<td>• Batch claim format (ideal for large volumes of claims)</td>
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<th>Paper forms (CMS-1500, UB-04, etc.)</th>
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<td>• Delayed claim status and payment</td>
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<td>• Increased risk of error</td>
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[http://www.oregon.gov/OHA/healthplan/Pages/billing.aspx](http://www.oregon.gov/OHA/healthplan/Pages/billing.aspx)
Resources

• Provider Web Portal
  – https://www.or-medicaid.gov

• Electronic Data Interchange (EDI)
  – 888-690-9888

• Claim Submission and Processing
  – http://www.oregon.gov/OHA/HSD/OHP/Pages/billing.aspx
Resources

- Automated Voice Response
  - 866-692-3864
  - Quick reference guide:
    - https://apps.state.or.us/Forms/Served/he3162.pdf

- Provider Services Unit (PSU)
  - 800-336-6016
  - dmap.providerservices@state.or.us