Oregon Health Plan

Billing information for all providers who serve Oregon Health Plan members

Oregon Health Authority

June 2017

Agenda

- Member eligibility
- Documentation and billing
- Resources

MEMBER ELIGIBILITY

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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)

http://www.oregon.gov/OHA/HSD/OHP/Coordinated-Care.aspx

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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)

http://www.oregon.gov/OHA/HSD/OHP/pages/plans.aspx

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)
  - http://www.oregon.gov/OHA/HSD/OHP/pages/policies.aspx
  - Use all applicable OARs to determine coverage criteria, limitations, restrictions, and exclusions
  - **Need help?** Provider Services Unit: 800-336-6016

DOCUMENTATION AND BILLING

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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

http://www.oregon.gov/OHA/HSD/OHP/pages/policies.aspx

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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

Tools to submit claims

Provider Web Portal

- Web-based billing
- Available 24 hours a day, 7 days a week
- Immediate claim status upon submission

Electronic Data Interchange (EDI)

- Electronic-based billing
- Batch claim format (ideal for large volumes of claims)

Paper forms (CMS-1500, UB-04, etc.)

- Delayed claim status and payment
- Increased risk of error

Resources

- Provider Web Portal
  - https://www.or-medicaid.gov
  - Instruction and step-by-step guides: http://www.oregon.gov/OHA/HSD/OHP/Pages/webportal.aspx
- Electronic Data Interchange (EDI)
  - 888-690-9888
  - http://www.oregon.gov/OHA/HSD/OHP/Pages/edi.aspx
- 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

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