General Rules Provider Guide

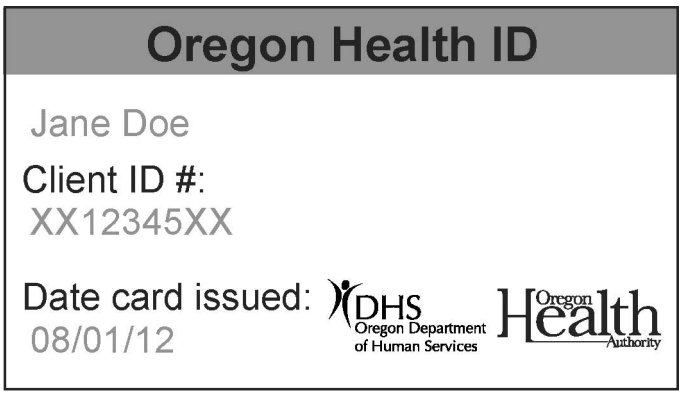
Use this guide as a supplement to General Rules Oregon Administrative Rules (Chapter 410 Division 120). See current General Rules for official policies.

Contents (last updated October 1, 2018)

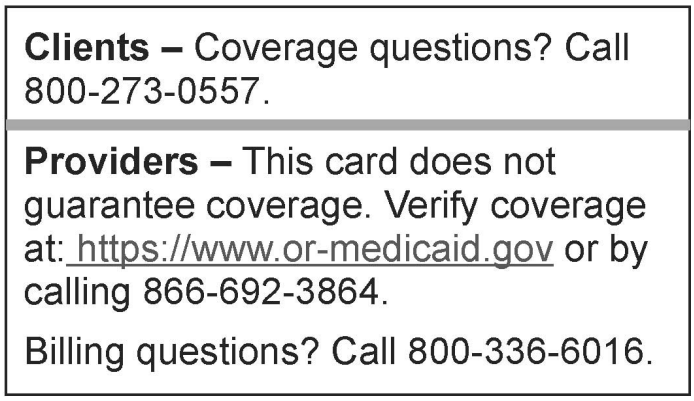
Client eligibility See *OAR 410-120-1140* for more information

The OHP eligibility verification page explains how to verify eligibility and copayment responsibility using the Provider Web Portal, Automated Voice Response, or electronic data interchange (EDI) 270/271 transaction.

Oregon Health ID (formerly Medical Care ID) sample


Oregon Health ID
Jane Doe
Client ID #:
XX12345XX
Date card issued:
08/01/12
DHS
Oregon Department of Human Services
Oregon Health Authority

Front


Clients – Coverage questions? Call 800-273-0557.
Providers – This card does not guarantee coverage. Verify coverage at: https://www.or-medicaid.gov or by calling 866-692-3864.
Billing questions? Call 800-336-6016.

Back

OHP 3263A (Approval Notice for Hospital Presumptive Eligibility) sample

DHS Oregon Department of Human Services

APPROVAL NOTICE FOR TEMPORARY OREGON HEALTH PLAN COVERAGE

Oregon Health Authority

Applicant name: **Patient, Patience A.**	
Applicant SSN: **###-##-####**	Date of birth: **MM/DD/YYYY**
Date of notice: **4/1/2018**	
Issued by: **Hospital Name**	

WHY YOU ARE RECEIVING THIS NOTICE

You qualify for temporary coverage through the Oregon Health Plan (OHP). This form will be your *proof of coverage* until you receive your Oregon Health ID.

- **Start date: 4/1/2018**
- **End date: 5/31/2018,** or the day your full OHP application is approved or denied (whichever comes first)

During this time, the coverage includes all OHP benefits (except for labor and delivery).

WHAT HAPPENS NEXT

We will mail you an Oregon Health ID and letter about your OHP coverage. Please keep this card and coverage letter for the entire time you have coverage.

PLEASE APPLY AS SOON AS POSSIBLE. YOUR OHP COVERAGE IS TEMPORARY, UNLESS YOU TAKE ACTION.

We must receive a completed OHP application by 5/31/2018.

- The hospital will give you an application. They will also tell you how you can get help with your application. You can also apply online. You can learn more about how to apply at **OHP.Oregon.gov**.
- If you do not submit your application, your coverage will end on **5/31/2018**.
- If we get your application before this date, your temporary OHP coverage will end on the day you are approved or denied full OHP coverage.

THIS DECISION IS FINAL

There is no right to request a hearing or appeal this decision.

Jane Doe — Authorized Signature

4/1/2018 — Date

Hospital Representative Name and Title: **Jane Doe, Registration Specialist**

Hospital Representative Contact Information: **503-555-5555**

PROVIDER: MAKE A COPY OF THIS NOTICE FOR YOUR RECORDS. THIS NOTICE IS A GUARANTEE OF ELIGIBILITY AS DESCRIBED ABOVE.

The client named is eligible to receive temporary OHP Plus benefits (excluding labor and delivery services). OHP will only pay enrolled providers for services according to administrative rules and guidelines. To learn how to enroll, and review OHP rules and guidelines, visit **www.oregon.gov/OHA/HSD/OHP**.

Send original and 1 copy to 5503, 1 copy to applicant, 1 copy to file OHP 3263A (3/18)

Benefit packages See *OAR 410-120-1210* for more information

The main benefit packages are OHP Plus and OHP with Limited Drug. This chart provides an overview of the services covered by each benefit package.

Some clients may have more than one benefit package:

- Clients who are eligible for both OHP with Limited Drug (BMD) and Qualified Medicare Beneficiary (MED) benefits have code BMM.
- OHP Plus adults (BMM, BMD or BMH) who receive additional dental and vision benefits also have OHP Plus Supplemental (BMP).

Client copayment - See *OAR 410-120-1230* for more information

Some clients are responsible for copayments for outpatient services *(only for services provided prior to January 1, 2017).*

- Do not deduct the copayment amount from the amount you bill. OHA deducts copayment amounts from provider payments, as applicable.
- For more information, see our Copayment FAQ page.

Provider enrollment - See *OAR 410-120-1260* for more information

Refer to our Provider Enrollment web page for information about enrolling as an Oregon Health Plan (OHP) provider.

Prior authorization - See *OAR 410-120-1320* for more information

The following services require prior authorization (PA):

- Durable medical equipment, prosthetics, orthotics and supplies (DMEPOS – Division 122)
- Home health services (Division 127)
- Home Enteral/Parenteral and IV services (Division 148)
- Hospital dentistry and certain dental services (Division 123)

- Physical and occupational therapy (Division 131)
- Private duty nursing (Division 132)
- Speech and hearing services (Division 129)
- Certain pharmaceutical, medical-surgical, vision, and hospital services

Refer to the program-specific administrative rules and supplemental information for specific details and required forms. Submit prior authorization (PA) requests to OHA using the Provider Portal or the MSC 3971.

- For CCO members, contact the CCO for PA instructions.
- For complete instructions on how to submit PA requests to OHA, see the Prior Authorization Handbook.

Billing and payment references - See *OAR 410-120-1280* for more information

Billing instructions are available on the OHP provider billing tips page.

- **For information about electronic billing,** go to the Electronic Business Practices Web page.
- For information about the paper remittance advice and other ways to get claim status information via the Provider Web Portal, AVR or EDI 835 (Electronic Remittance Advice), go to the OHP remittance advice page.
- For information about how to adjust a claim, refer to the Claim Adjustment Handbook.

Billing for clients with other insurance- See *OAR 410-120-1280* for more information

Bill all prior resources (third-party liability, or TPL) before billing OHA.

Do not collect TPL coinsurance, copayments or deductibles from the client if you are also billing OHA for what TPL will not pay.

For clients with TPL (including Medicare), OHA pays the Medicaid allowable rate or fee, minus the previous amount paid.

- If TPL denies the claim, OHA will pay the Medicaid allowable amount of the claim for the covered services.
- If TPL pays part of the claim, and their allowable is less than OHA's, then OHA will pay the Medicaid allowable amount, minus the amount TPL paid.
- .If TPL pays part of the claim, and their allowable is equal to or more than OHA's, then OHA will consider the claim paid in full and you will not receive additional payment from OHA.
- If Medicare pays part of the claim, OHA will pay the difference up to the Medicare or Medicaid allowable, whichever is less.

Do not bill clients for services covered but not paid by OHA.

Timely filing requirements - See *OAR 410-120-1300* for more information

Claims must be submitted within 365 days from the date of service. If a claim is still unresolved after 365 days, but has been submitted within 365 days, you have an additional 180 days to resolve the claim. Submit these claims on paper with appropriate documentation to:

Provider Services Unit|
500 Summer St NE, E44
Salem, OR 97301

The Provider Portal does not support claims submitted past the timely filing limits.

You can get this document in other languages, large print, braille or a format you prefer free of charge. Contact OHP Provider Services at dmap.providerservices@odhsoha.oregon.gov or 800-336-6016. We accept all relay calls.

Oregon Health Plan
Provider Services
500 Summer St NE, E44
Salem, OR 97301
800-336-6016
OHP.Oregon.gov/Providers