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 December 30, 2016)

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Client eligibility
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

<table>
<thead>
<tr>
<th>Oregon Health ID</th>
<th>Clients – Coverage questions? Call 800-273-0557.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jane Doe</td>
<td></td>
</tr>
<tr>
<td>Client ID #:</td>
<td>XX12345XX</td>
</tr>
<tr>
<td>Date card issued</td>
<td>08/01/12</td>
</tr>
</tbody>
</table>

|---------------------------------------------------------------|

Front

Back
Show this ID to all providers at the time of service, even if you have an ID card from your OHP health plan.
Not valid outside the United States or U.S. Territories.

1. **This ID is a guarantee of eligibility for 7 days beginning on 08/01/12**
   (see Oregon Administrative Rule 410-120-1140).

2. **Client name** Jane Doe
3. **Date of birth** 08/01/1968
4. **Client ID** XX12345XX
5. **Copay?** Yes  No

6. **Benefit Package(s):**
   - A - BMD (OHP with Limited Drug)
   - B - BMH (OHP Plus)
   - C - BMM (QMB + OHP with Limited Drug)
   - D - BMP (OHP Plus Supplemental)
   - E - CWX (CAWEM)
   - F - CWX (CAWEM Plus)
   - G - KIT (OHP Standard)
   - H - MED (Qualified Medicare Beneficiary - QMB)

All non-emergency care must be approved by applicable Health Plan/TPR shown below. See DMAP General Rules OAR 410-120-1210 for specific benefit package limitations. All DMAP Administrative Rules can be found on the DMAP Web site at www.oregon.gov/OHA/healthplan.

7. **Health Plans/Third Party Resource (TPR - Private Insurance) information**
   - **A**
     - Plan type: D - Coordinated Care
     - Phone number: 503-555-5555
     - Plan name: Coordinated Care of Oregon
     - Policy number
   - **B**
     - Plan type: A - Dental
     - Phone number: 503-555-5555
     - Plan name: Dental Health LLC
     - Policy number
   - **C**
     - Plan type: Select one:
     - Phone number: 503-555-5555
     - Plan name
     - Policy number
   - **D**
     - Plan type: Select one:
     - Phone number: 503-555-5555
     - Plan name
     - Policy number

8. **Branch office name** ANYTOWN BRANCH OFFICE
9. **Branch address** 123 MAIN ST, ANYTOWN OR 97300
10. **Branch phone number** 503-555-5555

Authorized signature: [Signature]
Date: 08/01/12

**PROVIDER:** Make a copy of this ID for your records as proof of eligibility.
APPREOVAL NOTICE FOR HOSPITAL PRESCRIPTIVE (TEMPORARY) ELIGIBILITY FOR MEDICAL COVERAGE

WHY YOU ARE RECEIVING THIS NOTICE
You qualify for temporary health coverage through the Oregon Health Plan (OHP). This form will be your proof of coverage until you receive your Oregon Health ID card.

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

Temporary Medical Assistance will cover all services for which you are eligible under the OHP only while you are eligible.

TO FIND OUT IF YOU CAN STAY ELIGIBLE AFTER YOUR TEMPORARY COVERAGE ENDS, YOU MUST APPLY FOR MEDICAL ASSISTANCE AS SOON AS POSSIBLE

The medical coverage you will receive is temporary, unless you take action.

- The hospital will give you an application and assist you to complete it, or give you a list of approved application assisters.
- If we do not receive your application by 4/30/2014, your eligibility will stop on that day.
- If you are not found eligible for ongoing coverage your Presumptive Medical coverage will end effective the date the determination is made.

PRESUMPTIVE ELIGIBILITY DETERMINATIONS ARE FINAL
There is no right to appeal a presumptive eligibility decision.

Authorized Signature
Jane Doe, Registration Specialist
Date: 3/1/2014

Hospital Representative Name and Title:
Jane Doe, Registration Specialist
Hospital Representative Contact Information:
503-555-5555

Send original and 1 copy to 5503, 1 copy to Patient, 1 copy to file.
Benefit packages
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 and Qualified Medicare Beneficiary 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
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
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 Web Portal (instructions) or the MSC 3971.
- For CCO members, contact the CCO for PA instructions.
- For complete instructions on how to submit PA requests to DMAP, see the Prior Authorization Handbook.

Billing and payment references
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**

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**

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