Keys to Success

Partnering with the Oregon Health Plan (OHP)

Welcome!

The Oregon Health Plan (OHP) serves more than 1,000,000 Oregonians, and we couldn't do it without providers like you. We look forward to a successful partnership.

- *Keys to Success* gives an overview of billing for health care services to OHP members and where to find answers to more specific inquiries.
- *Keys to Success* does not take the place of OHP provider guidelines (rules and supplemental information). Find them at **OHP.Oregon.gov/Rules**.

You will find more tools to help you in this booklet and at **OHP.Oregon.gov/Providers**.

Table of contents

Who is an OHP member? 2
Which OHP members can I serve? 4
What services does OHP cover? 5
Prior Authorization 8
Third Party Liability (TPL) 11
Billing OHA electronically 12
Billing on paper 13
Billing OHP members 15
More resources 17

Who is an OHP member?

OHP members receive a wallet-sized Oregon Health ID (formerly the DHS Medical Care ID).

The ID provides the member's ID number and name, and the card's date of issue. You will need to use one or more of OHA's eligibility verification resources to find out:

- The dates the member is eligible
- Whether the member is enrolled in one or more coordinated care organizations (CCOs) or OHP health plans
- Any available third-party liability (TPL, or other health coverage)
- What benefits OHA covers for the member.

Members approved for OHP through Hospital Presumptive Eligibility (HPE) or **HealthCare.gov** may not have an Oregon Health ID to present. You will need to wait until these members are issued an ID before verifying eligibility using OHA's resources.

Key to Success – Verify eligibility

Verify eligibility on the date of service.

- The member's benefit package(s) determine what services OHA will cover.
- The member's CCO/plan enrollment determines whether to bill OHA or not.
- Use the EDI 270/271, AVR and/or Provider Web Portal.
- Accept HPE and HealthCare.gov approval letters as proof of OHP eligibility. Ask patients to let you know when they get their Oregon Health ID so you can find out their ID number. Use the ID number to verify OHP eligibility in EDI, AVR or the Provider Web Portal before billing OHA.

Resources

The General Rules guidelines include sample ID and eligibility verification requirements.

Eligibility verification resources:

- Automated Voice Response (AVR) is a free touchtone system: 866-692-3864. Use the AVR Eligibility Quick Reference.

- The Medicaid Management Information System (MMIS) Provider Portal is a free service that provides real-time response to individual eligibility inquiries: https://www.or-medicaid.gov. View Provider Portal training material.
- The EDI 270/271 transaction offers real-time response to multiple (batch) inquiries. If you use a billing service or clearinghouse, that service may also provide eligibility verification through the 270/271 transaction. Visit the EDI web page for more information.

Which OHP members can I serve?

As an enrolled Oregon Medicaid provider, you can bill OHA for services you deliver to fee-for-service (FFS, or "open card") members.

- Certain drugs (known as 7/11 or "carve-out" drugs) are billed to OHA for all members.
- To bill for any other services to members in a coordinated care organization (CCO), you must contract with the member's CCO, then bill the CCO. For information about becoming a CCO provider, contact the CCO.

CCOs provide medical, dental and behavioral health services to over 90 percent of OHP members.

The Provider Portal, AVR and EDI 270/271 transaction show the member's CCO. If they do not list any CCO for your type of service (*i.e.,* medical or dental), this means that the OHA covers it.

Key to Success – Verify CCO enrollment

Always check the OHP member's enrollment information to see if they are in a CCO.

If the member is in a CCO that manages the services you provide:

- If you are not under contract with the member's CCO, refer members to their CCO.
- If you are under contract with the CCO, refer to the CCO for coverage, prior authorization (PA) and billing information.

If the OHP member is not in a CCO that manages the services you provide, refer to OHA for coverage, PA and billing information.

Resources

Find contact information for CCOs.

7/11 Drug Carve-Out List (drugs always billed FFS to OHA): Visit the OHP Pharmaceutical Services page.

Eligibility verification: www.oregon.gov/OHA/HSD/OHP/Pages/Eligibility-Verification.aspx

What services does OHP cover?

To answer this question, you need to ask three questions:

- Does the member's benefit package cover the service?
- Does the Prioritized List cover the service for the member's reported medical condition?
- Is the member under age 21? If the service is not covered according to the member's benefit package or the Prioritized List, ask OHA or the CCO to review for medical necessity and appropriateness. OHP will cover all medically necessary and medically appropriate services for members under age 21.

OHP benefit packages

OHP offers medical, behavioral health and dental care through the following benefit packages:

- **OHP Plus** – BMH
- **OHP with Limited Drug** – BMD.
- **QMB with OHP with Limited Drug** – BMM
- **OHP Plus Supplemental** – BMP
- **OHP Bridge -** BRG
- **CWM Plus** – CWX

Other (limited) medical assistance packages:

Qualified Medicare Beneficiary (QMB) – MED. OHA only pays for Medicare A and B cost sharing (coinsurance and deductibles).

Citizenship Waived Emergency Medical (CWM) – CWM. OHA only pays for emergency services and female sterilization. As of July 1, 2023, most CWM members now have OHP Plus (BMH) benefits. If you find a member still has CWM benefits, contact Provider Services.

OHP Prioritized List

The Prioritized List of Health Services ranks pairs of health conditions (diagnosis codes) and treatments (procedure codes) by clinical effectiveness and cost. The list contains

654 lines of paired conditions and treatments. The primary diagnosis determines the condition.

Pairs that help prevent illness rank higher on the list than pairs for conditions in progress. Pairs lower on the list treat illnesses that get better on their own, are cosmetic in nature or have no effective treatment available.

- OHP covers pairs that are ranked on lines 1- 469 (“above the funding line”).
- OHP may cover diagnostic procedures for conditions regardless of Prioritized List placement.

OHP may also cover a condition-treatment pair ranked on a line greater than 469 (“below the funding line”) if it is for:

- A comorbid condition whose treatment will improve a condition-treatment pair ranked above the funding line, or
- An unfunded condition/treatment pair that is medically appropriate and medically necessary, or
- The member’s health and development (for members under age 21).

These services require prior authorization.

Services for members under age 21

Beginning January 1, 2023, OHA and CCOs must cover all medically necessary and medically appropriate services for OHP members under age 21, regardless of placement on the Prioritized List of Health Services. Medical necessity and medical appropriateness are determined on a case-by-case basis, taking into account the member's needs. You can find guidance for providers about requesting specific benefit coverage for members under age 21 at **Oregon.gov/EPSDT.**

Key to Success – Verify benefit coverage

Determine the member’s OHP benefit package.

Do not provide the service until you know exactly what benefits the member has. OAR 410-120-1210 in the General Rules explains the benefits covered under each benefit package.

Check to see if the proposed treatments are currently funded on the Prioritized List.

Use the Provider Portal Benefits and HSC Inquiry to check line placement of a specific condition/treatment pair.

The Prioritized List page contains links to current, pending and recent changes to the List, and how to use the Provider Portal HSC inquiry.

For services not funded on the Prioritized List, request prior authorization for comorbid service, unfunded services, or services for members under age 21.

Visit the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) page for guidance about requesting authorization for services to members under age 21.

Contact the OHP Code Pairing and Prioritized List Hotline for specific questions about condition/treatment pair line placement and guidelines. Call 800-336-6016 (option 4). Have the diagnosis and procedure code(s) ready.

Prior Authorization

OHA needs to approve some treatments or items before OHP can cover them. This is called prior authorization (PA).

- **For services covered by the CCO,** contact the CCO to see if the service requires PA.
- **For services covered by OHA (FFS):** Refer to the appropriate rules and guidelines (listed below) to find out which services require approval and how to request approval.

Fee-for-service rules and guidelines

- 1915(i) Home and Community-Based Services (division 173)
- Audiology (division 129)
- Behavioral health services (division 172)
- Dental (division 123)
- Durable Medical Equipment and supplies (division 122)
- EPSDT (division 151)
- Hearing Aid services (division 129)
- Home Enteral/Parenteral and IV services (division 148)
- Home Health services (division 127)
- Hospital (division 125)
- Medical-Surgical services (division 130)
- Out-of-state services (division 120)
- Pharmaceutical services (division 121)
- Physical/Occupational Therapy (division 131)
- Private Duty Nursing (division 132)
- Speech therapy (division 129)
- Transplants (division 124)

- Transportation (division 136)
- Unfunded or comorbid conditions (division 141)
- Vision (division 140)

OHA will only approve requests that include all required documentation and prove that the service is medically appropriate. All providers listed on the request must be enrolled OHP providers.

Key to Success - Request PA when required

Determine if PA is required before rendering service. You can use the Provider Portal Benefits and HSC Inquiry to determine if a specific procedure requires PA.

Submit the correct forms and documentation at the time you are making a PA request. PA requirements are available in the guidelines for the type of service you provide (see www.oregon.gov/OHA/HSD/OHP/Pages/Policies.aspx).

Include the specific PA number for each member when billing OHA on paper.

Resources

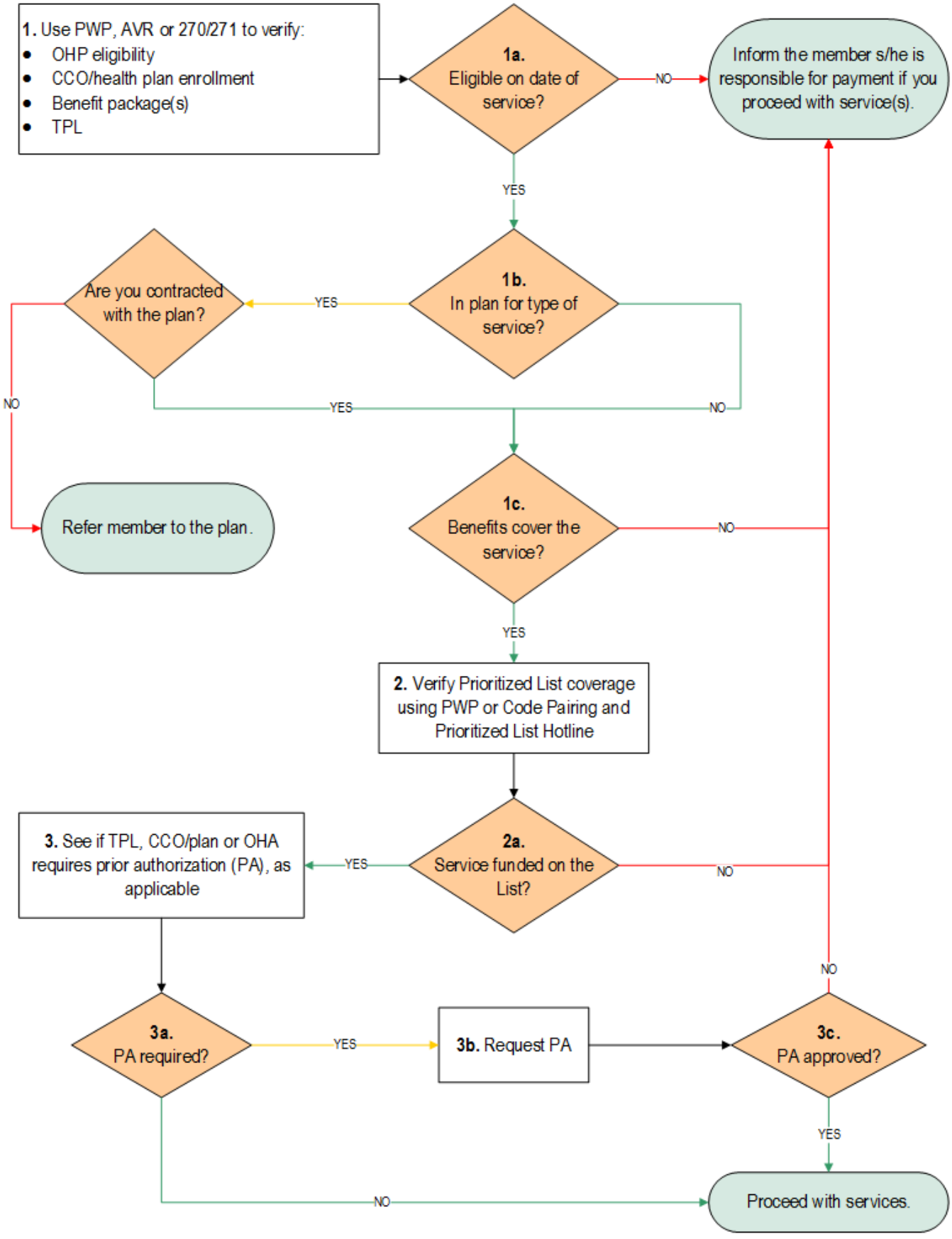
Find fee-for-service (FFS) PA phone numbers and addresses in the Provider Contacts List.

To verify the status of an FFS PA request, check the AVR or Provider Portal.

The Prior Authorization Handbook explains how to submit PA requests to OHA by fax or using the Provider Portal.

View PA training material, forms and other resources on OHA's Prior Authorization page.

Steps to take before providing services to OHP members



Third Party Liability (TPL)

Some OHP members may have other health coverage known as Third Party Liability (TPL).

The Provider Portal and AVR will provide information about any TPL known to OHA.

Providers must bill all TPL first before billing OHA. TPL includes any individual, entity or program that is liable to pay all or part of the cost of any health care services furnished to an OHP member.

Remember that OHA is the payer of last resort. When processing claims, OHA calculates the amount to pay, minus what TPL paid.

Key to Success – Identify and bill TPL first

- Ask the member for all health insurance cards, including Medicare and Medicaid (OHP).
- Do not collect TPL coinsurances, copayments or deductibles from the member.
- If the member has TPL, including Medicare, bill the TPL first.
- If you discover TPL not listed on the Provider Web Portal, EDI or AVR, please report it at www.reportTPL.org.
- When billing OHA, clearly list whether TPL paid or denied. Otherwise, OHA may deny your claim with a message telling you to bill TPL first.

Resources

OAR 410-120-1280(10) in the OHP General Rules explains TPL policy. Table 120-1280 in this rule lists the codes to use when reporting TPL denials on paper claims.

The provider guidelines for your program say when you need to bill OHA for services to Medicare members using the OHP 505 or how to complete your claim to Medicare so that it correctly “crosses over” to OHA for processing.

A list of the 4-digit, third-party resource carrier codes you may see when using the Provider Web Portal or AVR is on the Eligibility Verification page.

Billing OHA electronically

Paper claims are seldom required. You only need to bill on paper when your claim requires attached documentation. We will let you know when you need to bill on paper.

- Electronic billing is the faster, more secure and accurate choice.
- When you transmit an electronic claim, it feeds directly into our provider payment system.
- If there is an error, you will receive a response indicating what to correct. Once corrected, you can resubmit it right away.

You have two options for electronic billing:

- **Electronic data interchange (EDI):** You may be able to use your current billing software to bill OHA; check with your vendor or software team. If you use a billing service or clearinghouse, ask them if they can also bill OHA.
- **Provider Portal:** This free service only requires your NPI and a computer with Internet access. You can also use the portal to electronically adjust any claim you have submitted to OHA within appropriate timeframes. To get started, just follow the instructions on the PIN letter you receive from OHA.

Key to Success – Bill electronically when possible

Determine whether **EDI** or **Provider Portal** is right for you.

- **If you want to bill using EDI,** register as an EDI Trading Partner and test your transmissions with OHA.
- **If you want to bill using the portal, set up an account** using the OHA-issued PIN. We send you a letter containing your PIN when you enroll as an Oregon Medicaid provider.
- **Need a new PIN?** Contact Provider Services Unit at 800-336-6016 or team.provider-access@oha.oregon.gov.

Resources

Learn about using EDI for billing OHA on the EDI web page.

Find Provider Portal billing information on the Provider Portal resources page.

Billing on paper

If you must bill on paper, make sure to complete your claim according to OHA's requirements. Failure to follow OHA's paper billing instructions may delay or prevent your claim from processing:

- Specific fields must be completed and entered in a certain way so that we can scan your paper claim into the system.
- You must use commercially available CMS-1500, ADA and UB-04 claim forms (not scanned versions, computer-generated versions or photocopies).
- When you need to bill OHA directly for services to Medicare members, use the most current OHP 505 form.
- Our system may ask more than 900 potential questions about a claim before it can approve or deny payment. Many claims deny because of missing or incorrect patient or provider data.
- OHA will send you a paper remittance advice (RA) telling you that your claims paid, denied or are in-process. Denied claims may contain errors that require you to correct and resubmit the claim for processing. In-process (suspended) claims will process later. Do not resubmit in-process claims.

Key to Success – Follow paper billing requirements

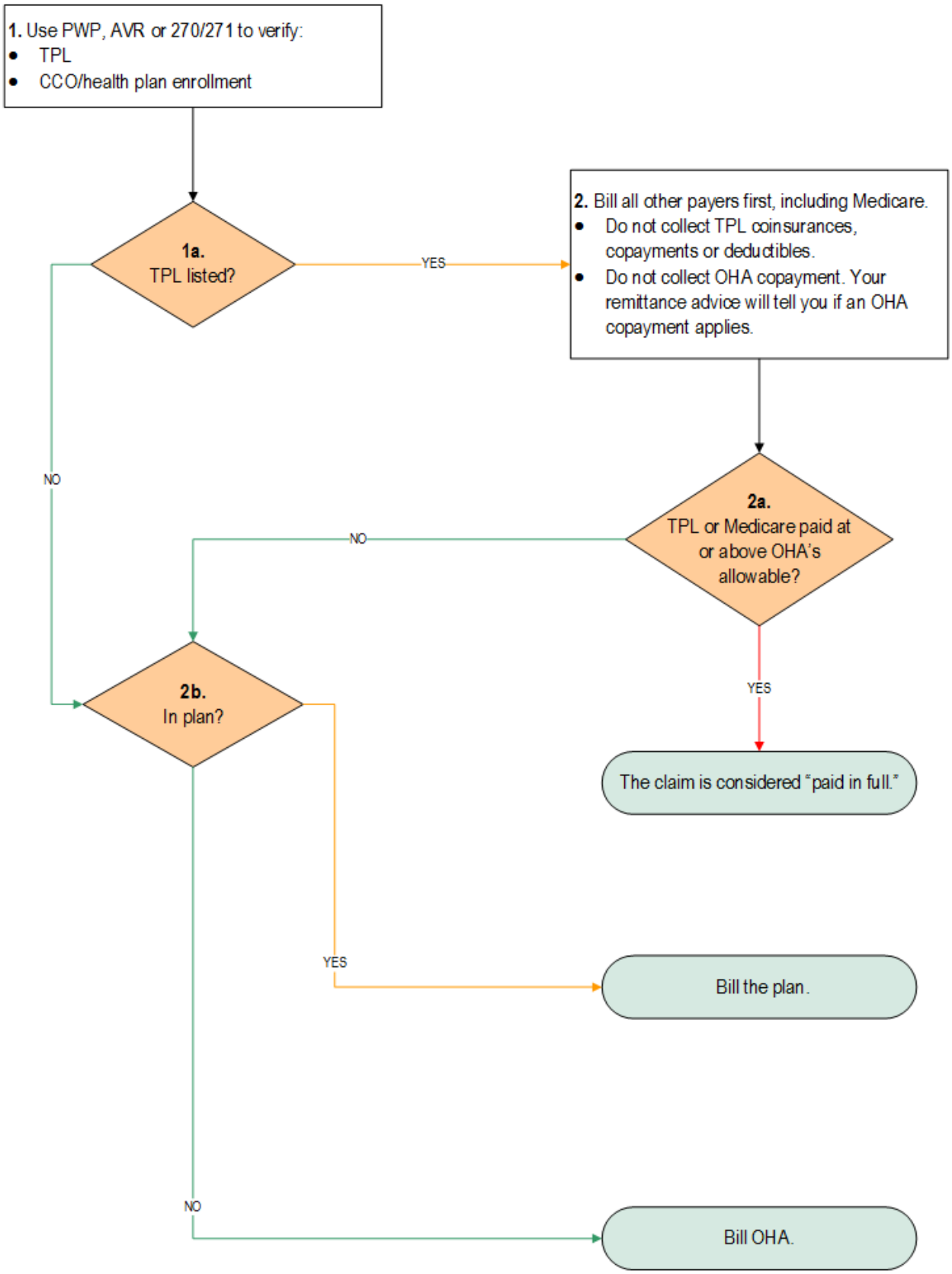
- **Only use commercially available CMS-1500, UB-04 and ADA claim forms** ("red forms"). OHA will return claims submitted on black and white copies of forms.
- Use the current OHP 505 form to bill OHA for services to Medicare members.
- Enter claim information using **blue or black ink**.
- Make sure all required fields are **completed and correctly aligned** on the form.
- Enter your Oregon Medicaid provider number **and** NPI.
- Mail your claim to the appropriate address for your provider type.

Resources

The OHP Billing Tips page includes handbooks that list all required fields, the fields that require specific alignment and other requirements unique to paper claims.

Find current addresses for mailing claims in the Provider Contacts List.

Steps to take before billing OHA



Billing OHP members

As an enrolled Oregon Medicaid provider you **cannot** bill Medicaid (OHP or CWM) members for:

- Covered services, except for certain limited situations outlined in OAR 410-120-1280,
- Missed appointments,
- Covered services that, due to your error, were not paid (*e.g.,* you did not submit required documentation, obtain prior authorization, or bill correctly), or
- Any charges remaining ("balance bill") after you received payment from OHA, the member's CCO/plan, Medicare and/or a third party liability (TPL) insurer, even if the payment is a "zero payment." Such payments are considered "payment in full."

Resolving billing issues

You cannot ask the member to help you to resolve billing issues, other than providing you with their health coverage information (including TPL, OHP and CCO/plan enrollment information).

Do not send a bill to collections without first working with OHA, the member's CCO/plan or TPL to resolve any billing issues.

Billing OHP members for covered and non-covered services

You may bill members for **covered services** under limited circumstances as indicated in OAR 410-120-1280 (Billing), and 410-141-3540 (Member Protections).

You may bill members for **non-covered services** if they first sign a completed Agreement to Pay (OHP 3165) form, or other form that contains the elements of the OHP 3165. This form explains that OHP does not cover the service. The member must sign this form to show they understand the service is not covered and that they agree to be responsible for payment.

Key to Success – Know who and when to bill

Verify the member is eligible and if they are enrolled in a CCO.

- Members may be retroactively eligible. This is especially true of members who present HPE and HealthCare.gov approvals as proof of Medicaid eligibility.
- Before billing a member or sending a bill to collections, re-check eligibility to see if the member is now eligible on the dates of service.

Verify whether the service is covered or not covered.

Whenever you find out a patient has OHP, bill OHA or the CCO, as applicable. Work with OHA or the CCO to resolve issues. Stop all collection actions against the member.

If you are having problems resolving a billing issue with a CCO, call OHA at 503-945-5772 or 800-527-5772. Ask to speak with your CCO's account representative.

Before providing non-covered services, have the member sign an Agreement to Pay form as described in Oregon Administrative Rule (OAR) 410-120-1280. Without this form, you cannot bill the member for the non-covered service(s).

Resources

OAR 410-120-1280 (Billing) in OHP's General Rules provides the criteria and requirements for billing members.

OAR 410-141-3540 (Member Protections) in OHP's MCO and CCO rules lists requirements for billing CCO members.

Agreement to Pay forms: Find other languages on the OHP Forms page or General Rules page.

- OHP 3165, OHP Client Agreement to Pay for Health Services.
- OHP 3166, OHP Client Agreement to Pay for Pharmacy Services
- OHP 4109, OHP Client Agreement to Pay for Planned Community Birth Services

Provider fact sheets about member billing:

- Billing for services to Qualified Medicare Beneficiaries (QMBs)
- Billing Medicaid (OHP and CWM) members: Do's and don'ts

More resources

If you need our help, whether you submit paper or electronic claims, we have trained staff to help you.

Claim resolution

Contact Provider Services at 800-336-6016 (option 5) or email dmap.providerservices@odhsoha.oregon.gov to:

Get help with claim-specific billing questions or complex issues

Direct deposit

Complete a form (MSC 189) and return with original signature and a voided check to ODHS|OHA Financial Services.

Electronic Data Interchange

Email EDI Support Services at dhs.edisupport@odhsoha.oregon.gov to:

- Get technical help with EDI transactions
- Sign up to become an EDI trading partner
- Update your trading partner or submitter information

Policies, rules and guidelines

Bookmark the Oregon Administrative Rules (OARs) that govern your health care specialty. A link to pages for all programs is at **bit.ly/ohp-rules.**

Provider announcements

Bookmark the OHP Provider Announcements at www.oregon.gov/OHA/HSD/OHP/Pages/announcements.aspx.

Provider information updates

Contact Provider Enrollment at 800-336-6016 (option 6) or email provider.enrollment@dhsoha.oregon.gov to:

- Update your provider contact information
- Make other changes to your information on file with OHA

Tools for Providers

www.oregon.gov/OHA/HSD/OHP/Pages/providers.aspx

- Use our searchable provider tools list
- Find quick links to forms and resources by topic
- View recent provider announcements
- Search the provider Q and A bank
- Find common phone numbers and contact information

OHP Provider Self Service Tools

View self-study resources for using the MMIS Provider Portal to verify eligibility, bill OHA, and more.

OHP Provider Training and Support

Enrollment Training and Support – To register for Enrollment Training and Support, find registration link on the Provider Enrollment page

OHA also offers support with MMIS Provider Portal functions and FFS claims process. To register for training or request assistance, please email the Provider Training team at providertraining-medicaid@oha.oregon.gov.

This team offers regular webinars covering:

- MMIS Provider Portal functionality
- OHP member eligibility verification
- FFS claims submission

Who to call for help

For current contacts for providers and members, view the Provider Contacts List

Key to Success – Keep informed!

Sign up to receive text or email updates about new provider announcements, updated rules or other information. Find sign-up links at the OHP Announcements page

Resources for Providers

Visit our Resources for Providers page for additional resouces.

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

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