

## Requesting medical review of CCO disenrollment requests

Coordinated care organization (CCO) members can now ask for temporary fee-for-service (FFS) coverage for continuity of care reasons using the *Member Request for Temporary Fee-for-Service Health Care* (OHP 0416) form. The process begins with members giving the completed form to their primary care provider (PCP).

When a PCP receives a completed form, they must use the Oregon Health Authority (OHA) prior authorization process to request medical review of the patient’s request for FFS coverage.

This document explains how to request these reviews and what notices OHA will send.

### Completing a Provider Web Portal request

If using the Prior Authorization panel to submit your request, complete these fields and submit to OHA. For details about sending Web PA requests, read the [Prior Authorization Handbook](#).

Base information:	Line item:	Notes:
<ul style="list-style-type: none"> <li>■ Client ID</li> <li>■ PA Assignment: “57 – Fee-for-Service OHP”</li> <li>■ Special considerations: No</li> <li>■ Referring Provider ID</li> <li>■ Attachments: Yes</li> <li>■ Diagnosis Code</li> </ul>	<ul style="list-style-type: none"> <li>■ Service Type Code: Procedure Code</li> <li>■ Procedure: G9399</li> </ul>	<ul style="list-style-type: none"> <li>■ Enter “FFS OHP, G9399”</li> </ul> <p>After clicking “Save” to submit the PA:</p> <ul style="list-style-type: none"> <li>■ Click “coversheet”</li> <li>■ Open and print the completed coversheet</li> </ul>

### Gather supporting documents

You must submit the following documents with your PA request:

- The completed OHP 0416 form from your patient (see page 3 for a sample of this form)
- A signed letter of medical necessity that explains why your patient cannot stay enrolled with their current CCO
- Medical records or other documents that support the medical necessity of FFS coverage

### Complete the EDMS coversheet ([MSC 3970](#))

For Web portal requests:	For other requests:
<p>The Web portal coversheet includes your PA number and the text from the “Notes” section of your request.</p> <p>Add your Documentation Identification Numbers:</p> <ul style="list-style-type: none"> <li>■ Provider ID: Your NPI</li> <li>■ Client ID: Patient’s Oregon Medicaid ID</li> </ul>	<p>Mark the “Prior Authorization” and “Routine Processing” boxes.</p> <p>In the “Justification” section, write “FFS OHP, G9399”</p> <p>Under “Documentation Identification Numbers,” list your NPI and the patient’s Oregon Medicaid ID</p>

## Fax completed form(s) and supporting documents to OHA

Fax all documents under a completed EDMS Coversheet ([MSC 3970](#)) to 503-378-5814 (Salem).

## What happens after OHA receives your PA request

Within a month, OHA will send standard PA approval or denial notices to the requesting provider and member. For sample provider notices, please see the [Prior Authorization Handbook](#).

## Approval notices

These fields will show that OHA has approved the request for CCO disenrollment.

- **PA Assignment:** Fee-for-service OHP
- **Codes:** G9399
- **Description:** Doc disc tx choices
- **Requested and Approved Amounts/Units:** 0.00, 1
- **Dates Valid:** [The date range the member is approved for FFS coverage]

## Denial notices

These fields will show that OHA has denied the request for CCO disenrollment.

- **PA Assignment:** Fee-for-service OHP
- **Codes:** G9399
- **Description:** Doc disc tx choices
- **Requested and Approved Amounts/Units:** 0.00, 1
- **Reason for Denial:** The records submitted for review do not show a medical need for fee-for-service OHP. This is required by Oregon Administrative Rule: OAR 410-141-0060(7), 410-141-0080(2)(b)(F)(iii), 410-141-3060(7), 410-141-3080(2)(b)(D)(iii)
- **Additional Notes:** [If needed, OHA will further explain why the request was denied.]

## Questions?

- **If you have questions about submitting requests for medical review**, contact the PA Line at 800-336-6016 (Option 3).
- **Please refer patient questions about requesting temporary FFS OHP coverage** to OHP Client Services, at 800-273-0557.

## Member Request for Temporary Fee-for-Service (FFS) Health Care

### When to use this form

Use this form only if you have a medical reason to leave your coordinated care organization (CCO). Talk to your CCO about your medical needs first. Please do **not** use this form if you are:

- American Indian or Alaska Native: Please use the [OHP 720](#).
- A Medicare member: Please contact your local Aging and People with Disabilities office.

You can read the laws and rules about being in a CCO in Oregon Revised Statute 414.631 and Oregon Administrative Rules 410-141-3060(4), 410-141-3080, 410-141-0060(4), and 410-141-0080.

### Instructions

- **Member:** Fill out and sign this form. Take it to your doctor or primary care provider (PCP).
- **PCP:** Send this form to OHA with medical records. Please follow FFS medical review instructions on the OHP website at [www.oregon.gov/OHA/healthplan/pages/ohp-policy.aspx](http://www.oregon.gov/OHA/healthplan/pages/ohp-policy.aspx).

In a month or less, OHA will send you a letter to tell you whether OHA approved your request. If your request is approved, the letter will also tell you how long you will have FFS coverage.

### Reason for change

1. Please tell us why you need FFS OHP coverage. *If needed, write more on the back of this form:*

2. Did you talk to your CCO about this? *Find CCO phone numbers at [OHP.Oregon.gov](http://OHP.Oregon.gov).*  Yes  No

3. Your CCO has *care coordinators* who can help you get the services you need.  Yes  No  
Did you talk to your CCO's care coordinator about your needs?

### Member information

4. Name: \_\_\_\_\_  
Last First Middle initial

5. Date of birth: \_\_\_\_\_ 6. Oregon Medicaid ID: \_\_\_\_\_

7. Mark the services you no longer want through your CCO:

Medical  Dental  Mental health

8. Your CCO's name: Choose one: \_\_\_\_\_

9. Your doctor or PCP's name: \_\_\_\_\_

### Member's signature

Signature of member or member representative - *Representative must have proof of legal authority to sign for this member*

\_\_\_\_\_ Date

Relationship of representative to member: \_\_\_\_\_ Phone: \_\_\_\_\_

OHP 0416 (1/17)