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DMAP Policy and Planning Section

Authorized Signature

Number: DMAP- IM-10-098

Issue Date: 08/17/2010

Topic: Medical Benefits

Subject: Provider announcement: Reminders about eligibility, benefits and enrollment

Applies to (check all that apply):

- | | |
|--|---|
| <input type="checkbox"/> All DHS employees | <input type="checkbox"/> County Mental Health Directors |
| <input type="checkbox"/> Area Agencies on Aging | <input type="checkbox"/> Seniors and People with Disabilities |
| <input type="checkbox"/> Children, Adults and Families | <input checked="" type="checkbox"/> Other (please specify): DHS staff and others identified on the SPD, CAF, AMH and DMAP transmittal lists |

Message:

DMAP is posting the following announcement on the [OHP Provider Announcements](#) and [Pharmacy Program Announcements](#) pages. It reminds them of the following:

- To verify client eligibility, managed care enrollment and benefit coverage before providing service, since that information could change at any time;
- To bill DMAP as the last resort, and bill the client's managed care plan unless billing for carve out drugs; and
- The MMIS is updated regularly to make sure claims process according to current client status and policies effective on the date(s) of service.

Later this month, DHS will update the MMIS to deny claims when clients enrolled in managed care have the "HNA" case descriptor on their eligibility record, the services billed are covered by the managed care plan, and the billing provider is not an Indian Health Service or Tribal 638 health care provider.

When these claims deny, providers will receive an Explanation of Benefit message telling them to bill the managed care plan.

Specific information about this change will be in the August issue of *Provider Matters*, to be posted next week on the OHP home page under "MMIS Updates."

To prepare for this change, DHS is reviewing eligibility records to make sure the "HNA" case descriptor is in place only for clients who have provided written identification of Native American and/or Alaska Native descent.

If you have any questions about this information, contact:

Contact(s):	DMAP Pharmacy Program
Phone:	503-947-1195
E-mail:	dmap.rxquestions@state.or.us

For all OHP providers

About client eligibility, benefits and enrollment

Verify client eligibility, benefits and enrollment before providing service

Client eligibility and enrollment information can change at any time, so please verify the client's current Oregon Health Plan (OHP) eligibility and managed care enrollment status before providing service.

You can verify information for OHP clients in three ways. For more information, go to www.oregon.gov/DHS/healthplan/tools_prov/electronverify.shtml.

- Electronic Data Interchange (EDI) - Through DHS or your EDI clearinghouse.
- Automated Voice Response at 1-866-692-3864
- The Provider Web Portal at <https://www.or-medicaid.gov>.

Covered services vary by benefit package

When you verify eligibility through EDI, AVR or Web portal, remember that only the following codes indicate OHP medical eligibility:

- BMD (OHP with Limited Drug)
- BMH (OHP Plus)
- BMM (Qualified Medicare Beneficiary and OHP with Limited Drug)
- BMP (OHP Plus supplemental benefits)
- KIT (OHP Standard)
- CWX (CAWEM Plus - OHP Plus benefits for pregnant CAWEM-eligible women)

The following codes provide limited benefits:

- CWM (Citizen-Alien Waived Emergency Medical)
- MED (Qualified Medicare Beneficiary)

Also make sure the client's benefit package covers the services provided. The chart on page three provides an overview. For specific information, verify client eligibility by specific procedure codes through AVR or Web portal, and refer to the DMAP General Rules (OAR 410, Division 120) for the services covered by each benefit package.

Bill all other payers first

DMAP (Oregon Medicaid) is the payer of last resort. Avoid unnecessary paperwork and denials by billing other payers first. See General Rules OAR 410-120-1280 (Billing) and OAR 410-120-0250 (Managed Care Organizations).

- If the client has Third Party Liability, including Medicare, bill those payers before billing DMAP. If the TPL pays more than DMAP's maximum allowed, DMAP considers this

payment in full. For more information, read the Coordination of Benefit and TPL reminders at www.oregon.gov/DHS/healthplan/notices_providers/2010/cob-letter410.pdf.

- If the client is in an OHP managed care plan, bill the plan, unless you are filling a prescription for certain "carve out" drugs (Therapeutic Classes 7 and 11, Depakote and generic equivalents, and Lamictal and generic equivalents). For a full list of carve out drugs, go to www.oregon.gov/DHS/healthplan/tools_prov/711carveout.pdf.

Keep informed

DHS continues to review and update its claims processing system to ensure that incoming claims process according to the client's current eligibility and enrollment status, as well as the policies effective on the claim's date(s) of service.

- Refer to the most current General Rules, OHP Rules, and program-specific administrative rules and guidelines to make sure you submit claims according to current payment policies. Go to www.dhs.state.or.us/policy/healthplan/guides/main.html for the full list of DMAP programs.
- Read *Provider Matters*, which provides monthly updates about claims processing issues and resolutions. New updates are posted monthly on the OHP home page at www.oregon.gov/DHS/healthplan (look under "MMIS updates").
- Sign up for eSubscribe to receive free e-mail updates whenever these items change. Just go to www.oregon.gov/DHS/healthplan/notices_providers/main.shtml and click on the green eSubscribe envelope. You can choose which alerts you want to receive. It's fast, secure and easy.

Thank you for your continued support of the Oregon Health Plan. We appreciate your patience as we continue to make system improvements.

Questions?

- **About this announcement** – Contact Provider Services Unit at 1-800-336-6016 or e-mail dmap.provider-services@state.or.us. They are available Monday through Friday, 8:30 a.m. to 4:30 p.m.
- **About fee-for-service pharmacy billing and prior authorizations** - Call the Oregon Pharmacy Call Center at 1-888-202-2126.



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Oregon Health Plan benefit plan coverage

DHS will pay for services that show a "✓." Limited services are covered at a reduced level.

Covered services		OHP Plus; OHP with Limited Drug*		OHP Standard	CAWEM	CAWEM Plus	QMB
		Children and pregnant women	Non-pregnant adults				
Acupuncture		✓	✓	Limited		✓	
Chemical dependency		✓	✓	✓		✓	
Dental	Basic services including cleaning, fillings and extractions	✓	✓			✓	
	Urgent/immediate treatment	✓	✓	✓	Emergent only	✓	
	Other services	✓	Limited			✓	
Hearing aids and hearing aid exams		✓	✓			✓	
Home health; private duty nursing		✓	✓			✓	
Hospice care		✓	✓	✓		✓	
Hospital care	Emergency treatment	✓	✓	✓	✓	✓	
	Inpatient/outpatient care	✓	✓	Limited		✓	
Immunizations		✓	✓	✓		✓	
Labor and delivery		✓	✓	✓	✓	✓	
Laboratory and X-ray		✓	✓	✓	Emergent only	✓	
Medical care from a physician, nurse practitioner or physician assistant		✓	✓	✓	Emergent only	✓	
Medical equipment and supplies		✓	✓	Limited		✓	
Medical transportation		✓	✓	Emergent only	Emergent only	✓	
Medicare premiums, copayments (except for drugs) and deductibles							✓
Mental health		✓	✓	✓		✓	
Physical, occupational and speech therapy		✓	✓			✓	
Prescription drugs		✓	✓	✓		✓	
Vision services	For medical and emergent treatment	✓	✓	✓	Emergent only	✓	
	For glasses or contact lenses	✓	Limited			✓	

* Drug coverage for this benefit package is limited to drugs that are not covered by Medicare Part D.

OHP offers more services and places more limitations than are listed here. This chart is meant to be a guide, not OHP policy.

