
Oregon Health Plan

Billing information for all providers who serve
Oregon Health Plan members



Agenda

- Member eligibility
- Documentation and billing
- Resources

MEMBER ELIGIBILITY

Oregon Health Plan (OHP) eligibility

- Providers are responsible to verify eligibility on each date of service
 - OHP coverage
 - Benefit plan
 - Coordinated care, managed care or fee-for-service
- **Member medical ID does not guarantee coverage**
- Member eligibility and coverage may change

Service delivery

Covered services for eligible OHP members are delivered through:

- *Coordinated care*: State contracts with a plan to handle prior authorization and billing; Coordinated Care Organization (CCO)
- *Managed care*: State contracts with a plan to handle prior authorization and billing; Managed Care Organization (MCO)
- *Fee-for-service (FFS)*: DMAP handles prior authorization and billing

Coordinated care

Coordinated Care

- Physical, mental health and dental (CCOA)
- Physical and mental health (CCOB)
- Mental health only (CCOE)
- Mental and dental health (CCOG)

<http://www.oregon.gov/oha/OHPB/pages/health-reform/ccos.aspx>

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Managed care

- Medical care
 - Fully Capitated Health Plan (FCHP); includes drug coverage
 - *Primary Care Manager* (PCM)
 - Physician Care Organization (PCO)
- Dental Care Organization (DCO)
- Mental Health Organization (MHO)

Tools to verify eligibility

- Provider Web Portal (PWP)
 - Real-time eligibility
 - Web-based system
- Automated Voice Response (AVR)
 - Telephone-based system
 - 866-692-3864
- Electronic Data Interchange (EDI)
 - Real-time eligibility
 - Electronic information exchange

<http://www.oregon.gov/oha/healthplan/pages/verify.aspx>

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Steps to verify a service is covered

1. Verify member eligibility on the date of service
2. Refer to the Prioritized List to confirm funding and/or pairing
 - PWP
 - <http://www.oregon.gov/oha/herc/Pages/PrioritizedList.aspx>
 - **Need help?** Benefit RN Hotline: 800-393-9855
3. Refer to applicable Oregon Administrative Rules (OARs)
 - <http://www.oregon.gov/oha/healthplan/pages/policies.aspx>
 - Use all applicable OARs to determine coverage criteria, limitations, restrictions, and exclusions
 - **Need help?** Provider Services Unit: 800-336-6016

DOCUMENTATION AND BILLING

Documentation

- Maintain documentation for all services provided that supports the charges billed. Ensure the date of service in the documentation matches the date of service on the claim.
- Include:
 - Date of service;
 - The individual who provided the service; and
 - Other documentation required by Oregon Administrative Rules (OARs), provider guidelines, or contract. Examples:
 - Prior authorization
 - Progress reports
 - Chart notes

<http://www.oregon.gov/oha/healthplan/pages/policies.aspx>

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Before billing OHP

- Verify member eligibility and enrollment
 - Make sure the person is eligible for OHP
 - Determine if the member is enrolled in an OHP managed or coordinated care plan (if so, authorization and billing is through the plan)
 - Verify if the member has other insurance
- Bill all other resources
 - Bill other insurance, including Medicare prior to billing OHP, and report any previously paid amount on the claim to OHP
 - Payment from OHP is OHP's allowed amount, minus previous payments and member copayments

Medicaid-covered services

- Pursue all other resources before billing Medicaid
 - Third-Party Liability (TPL); private insurance
 - Medicare
- Bill appropriate parties for Medicaid-covered services
 - Coordinated or managed care plans
 - OHP (fee-for-service)
- Billing charges, copayments, and third-party payments
 - Bill usual and customary charges
 - Do not deduct the member copayment from the billed amount
 - Report third-party payments (other insurance and Medicare)

Billing an OHP member

- Providers are prohibited from billing an OHP member for Medicaid-covered services
- Members may only be billed if all of the following criteria are met:
 - The service is not covered by Medicaid;
 - All reasonable covered treatments have been tried OR member is aware of reasonable covered treatments, but selects a treatment that is not covered; and
 - Member and provider have completed an OHP Client Agreement to Pay for Health Services (DMAP 3165)

<https://apps.state.or.us/Forms/Served/oe3165.pdf>

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Tools to submit claims

- Provider Web Portal
 - Web-based billing
 - Available 24 hours a day, 7 days a week
 - Immediate claim status upon submission
- Electronic Data Interchange (EDI)
 - Electronic-based billing
 - Batch claim format (ideal for large volumes of claims)
- Paper forms (CMS-1500, UB-04, etc.)
 - Delayed claim status and payment
 - Increased risk of error

<http://www.oregon.gov/OHA/healthplan/Pages/billing.aspx>

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Resources

Provider Web Portal

<https://www.or-medicaid.gov>

Instruction and step-by-step guides:

<http://www.oregon.gov/oha/healthplan/pages/webportal.aspx>

Electronic Data Interchange (EDI)

888-690-9888

<http://www.oregon.gov/oha/healthplan/Pages/edi.aspx>

Claim Submission and Processing

<http://www.oregon.gov/OHA/healthplan/Pages/billing.aspx>

Resources

Automated Voice Response

866-692-3864

Quick reference guide:

<https://apps.state.or.us/Forms/Served/he3162.pdf>

Provider Services Unit (PSU)

800-336-6016

dmap.providerservices@state.or.us