

# Division of Medical Assistance Programs Worker Guide

Contains updates through November 2015



Division of Medical Assistance Programs  
Client and Provider Education



## Revision Log

For a description of specific Worker Guide changes, please see the DMAP Staff Transmittals at [www.oregon.gov/OHA/healthplan/pages/transmittals.aspx](http://www.oregon.gov/OHA/healthplan/pages/transmittals.aspx) (refer to the date in the table below for the transmittal issue date).

Date	Changes
10/1/12	All separate guides are combined for a single document format; all sections are up-to-date.
12/14/12	<a href="#">Medical Transportation</a> section only
1/1/13	<ul style="list-style-type: none"> <li>■ <i>Table 2: Professional (non-hospital) Services</i> referenced in the Worker Guide Administrative Examinations section.</li> <li>■ Provider Services' telephone number correction in the Medical Transportation section changes effective 12/14/12 (above).</li> </ul>
7/1/13	<ul style="list-style-type: none"> <li>■ <a href="#">OHP Medical Resources</a> – Benefit chart updated</li> <li>■ <a href="#">Medical Transportation</a> update</li> <li>■ <a href="#">Health Care Delivery Systems</a> – Added CCOA plan type</li> <li>■ <a href="#">Admin Exams</a> - CPT/HCPCS Codes – Table 2 change only</li> </ul>
10/1/13	<a href="#">Medical Resources</a> – All pregnant CAWEM (standard) clients Statewide are eligible for CAWEM Plus, effective Oct. 1, 2013
11/1/13	<a href="#">Health Care Delivery Systems</a> – Updates to different delivery service area and death sections
12/1/13	<ul style="list-style-type: none"> <li>■ <a href="#">Administrative Examinations and Reports</a> – Updated CPT/HCPCS Table 2 – Professional (non-hospital) Services</li> <li>■ <a href="#">Health Care Delivery Systems</a> – Overview to add CCOG; Coordinated Care Organizations to add note to CCOD; PCO and Death information updated</li> <li>■ <a href="#">Prior Authorizations</a> – Added Select Lab and Radiological studies to the list of equipment and services requiring prior authorization.</li> <li>■ <a href="#">Processing Claims</a>: <i>Office of Forms and Document Management</i> is now called <i>Information Resource Management Services (IRMS)</i>; data from providers who bill electronically is sent electronically.</li> </ul>
2/27/14	<p>Entire guide: Removed references to OHP Standard benefit package.</p> <ul style="list-style-type: none"> <li>■ <a href="#">OHP Medical Resources</a>: Benefit chart replaced</li> <li>■ <a href="#">Health Care Delivery Systems</a> - Updated the number of days a client has to change to a different managed care plan (90 days); added <a href="#">CCO enrollment resolution guide</a></li> <li>■ <a href="#">DMAP - Medical Savings Chart (MSC)</a> – New MAGI codes added to the chart</li> <li>■ <a href="#">Copayments and Special Requirements</a>: Renamed section and removed obsolete information about premiums. Hospice clients are no longer responsible to pay copayments for any OHP services.</li> </ul>
3/27/14	<p>Removed additional references to OHP Standard benefit package.</p> <ul style="list-style-type: none"> <li>■ <a href="#">Copayments and Special Requirements</a>: Updated which clients are no longer responsible to pay copayments.</li> </ul>

Date	Changes
3/27/14	<ul style="list-style-type: none"> <li>■ <a href="#">DMAP/Medicaid Overview</a> –Clarify branch office text and add information about Branch 5503.</li> <li>■ <a href="#">MC Special Conditions - Exemption Codes Chart</a> updated.</li> <li>■ Client Rights and Responsibilities - <a href="#">Billing clients</a></li> </ul>
4/30/14	<ul style="list-style-type: none"> <li>■ <a href="#">OHP Medical Resources</a> - Clarified OHP Plus visual services coverage; updated benefit package chart</li> <li>■ <a href="#">Other Medical Resources</a> – Removed obsolete programs</li> </ul>
5/30/14	<ul style="list-style-type: none"> <li>■ <a href="#">OHP Medical Resources</a> – Updated Prioritized List of Health Services text; updated OHP medical assistance program codes.</li> <li>■ <a href="#">Health Care Delivery Systems</a> – Updated enrollment exemption info, added section about enrollment reason codes; updated <a href="#">Educating clients about health care</a> and <a href="#">Who to contact for help</a>.</li> <li>■ <a href="#">Medical Transportation</a> - Link to staff transmittals is updated</li> <li>■ <a href="#">Co-payments and Special Requirements</a> - Updated instructions for reporting changes to an assigned pharmacy</li> </ul>
11/30/14	Health Care Delivery Systems – <a href="#">Always use the most current charts available.</a> (new section).
4/30/15	<p>Updated hyperlinks throughout document.</p> <ul style="list-style-type: none"> <li>■ <a href="#">DMAP/Medicaid Overview</a>: Edited branch office section for clarity</li> <li>■ <a href="#">Medical Resources</a>: Updated with January 1, 2014 Prioritized List information</li> <li>■ <a href="#">Health Care Delivery Systems</a>: Reorganized for clarity; updated TPL reporting, general contact information; added service area exceptions. updated FCHP references</li> <li>■ <a href="#">Other Medical Resources</a>: Updated BCCTP link</li> <li>■ <a href="#">Health Insurance Premium Payment Program</a>: Renamed section, removed PHI program information</li> <li>■ <a href="#">Prior Authorization</a>: Updated medical transportation information</li> <li>■ <a href="#">Medical Transportation</a>: Updated to remove NEMT ambulance authorization instructions, update contacts and OAR references, and add when branch authorizations are permitted</li> <li>■ <a href="#">Processing Claims</a>: Updated to include all current claim formats</li> </ul>
10/1/2015	Updated <a href="#">Medical Transportation</a> section to update when branch authorizations are permitted (Marion and Polk counties only).
11/1/2015	Updated <a href="#">Medical Transportation</a> section to remove branch authorization instructions. Starting November 1, 2015, all non-emergent medical transportation requests are handled by the brokerage or CCO (not DHS/OHA).

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## DMAP/Medicaid Overview

### The Division of Medical Assistance Programs (DMAP)

DMAP is a part of the Oregon Health Authority (OHA). DMAP administers Oregon's medical assistance programs, including the Oregon Health Plan (OHP) and:

- Determines policy and Oregon Administrative Rules (OARs) for medical assistance programs including Medicaid and Children's Health Insurance Programs (CHIP).
- Is responsible for Title XIX (Medicaid) and Title XXI (CHIP) State Plans.
- Informs clients and providers about policy and OAR changes that affect OHP services.
- Pays claims and contracted payments (e.g., payments to coordinated care organizations) for covered health care services.

#### *DMAP resources*

The [Provider Contacts List](#) contains current contact information, including client assistance, provider resources, billing, and prior authorization for fee-for-service clients.

The [DMAP Directory](#) contains contact information for DMAP business units.

If you cannot find the number you need, call DMAP reception **800-527-5772** or **503-945-5772** (Salem).

### DHS/OHA Branch Offices

Branch offices throughout Oregon provide a direct link with clients receiving medical assistance. Self Sufficiency Programs (SSP), Child Welfare (CW), Aging and People with Disabilities (APD), Area Agency on Aging (AAA), Developmental Disabilities (DD), and the Oregon Youth Authority (OYA) determine eligibility rules for their programs. Depending on the agency, branch staff will:

- Determine a client's program eligibility.
- Refer clients to OHP Customer Service (branch 5503) for Medicaid/CHIP eligibility.
- Provide choice counseling to clients when needed regarding the selection of managed care available in their area.

OHP Customer Service (Branch 5503) acts as the branch office for all medical-only clients, and does the following for all clients with Medicaid/CHIP eligibility:

- Determine a client's medical eligibility.
- Enter medical eligibility data into the computer system.
- Order replacement Medical Care ID cards (now known as Oregon Health IDs) and Coverage Letters or issue temporary Oregon Health IDs when needed.

## Oregon Health ID and coverage letter

### Oregon Health ID

For households newly eligible for OHP, QMB or CAWEM benefits, their first coverage letter will include a sheet of ID cards (one for each eligible client in the household). If clients lose or misplace their cards, they can ask for a replacement card.

The Oregon Health ID is the size of a business card and lists the client name, prime number and the date it was issued.

Clients should take the Oregon Health ID to all health care appointments to make it easier for providers to check client eligibility.

### ***Client IDs are not proof of OHP eligibility.***

See OAR 410-120-1140 in DMAP [General Rules](#) for more information. Provider claim denials and billing errors are reduced when providers [verify OHP eligibility](#) and health plan enrollment prior to delivering services. Providers can use the [Provider Web Portal](#), [Automated Voice Response](#) at 866-692-3864, or 270/271 electronic data interchange transaction to information.

### ***Sample Oregon Health ID card***

DHS Medical Care ID cards are still acceptable as only the card name changed.



### Coverage letter

The coverage letter is for the client's information only so they should not take it to their health care appointments. The coverage letter shows the worker's ID and phone number, and managed care enrollment for everyone in the household. DMAP sends new coverage letters anytime this information changes for anyone in the household. A sample of the coverage letter follows.

A Quick Benefit Guide (a.k.a. [yellow sheet](#)) to OHP benefits and services is included with coverage letters.

**Sample coverage letter – Page 1**

<p>5503 XX#### XX P2 EN AT          PO BOX #####          SALEM, OR 97309          DO NOT FORWARD: RETURN IN 3 DAYS</p>	<p><b>Keep this letter!</b></p> <p><b>This letter explains your Oregon Health Plan (OHP) benefits.</b></p> <p><b>This letter is just for your information. You do not need to take it to your health care appointments.</b></p> <p><b>We will only send you a new letter if you have a change in your coverage, or if you request one.</b></p>
<p>Branch name/Division: OHP/CAF          Worker ID/Telephone: XX/503-555-5555</p> <p>JOHN DOE          123 MAIN ST          HOMETOWN OR 97000</p>	

Welcome to the Oregon Health Plan (OHP). This is your **new coverage letter**.

This letter lists coverage information for household. This letter does not guarantee you will stay eligible for services. This letter does not override decision notices your worker sends you.

We will send you a new letter and a Medical ID card any time you request one or if any of the information in this letter or on your Medical ID changes. To request a new letter or Medical ID, call your worker.

The enclosed yellow sheet includes a chart that describes the services covered for each benefit package and a list of helpful phone numbers.

We have listed the reason you are being sent this letter below. The date the information in this letter is effective is listed next to your name.

Reasons for letter:

Managed care plan or Primary Care Manager enrollment changed for:

Doe, John – 7/13/2009  
 Doe, Jane – 7/13/2009  
 Doe, Timothy – 7/13/2009  
 Doe, Kathy – 7/13/2009

### Sample coverage letter – Page 2

Page 2 lists benefit package and enrollment information for each household member.

The following chart lists coverage information for everyone who is eligible in your household. See the enclosed Benefit Package chart for information about what each benefit package covers. Letters in the Managed Care/TPR enrollments section refer to the plans listed on the Managed Care/TPR Enrollment page.

Name	Date of birth	Client ID #	Copays?	Benefit Package	Managed Care/TPR enrollment
John Doe	01/01/1968	XX1234XX	No	OHP Plus	A, B, C
Jane Doe	02/01/1968	XX1235XX	No	OHP with Limited Drug	A, B, C, G, H, I
Timothy Doe	03/01/2006	XX1236XX	No	OHP Plus	B, C, D, F
Kathy Doe	04/01/2007	XX1237XX	No	OHP Plus	B, C, E, G, H

### Sample coverage letter – Page 3

Page 3 lists all managed care and TPR information for the household.

#### Managed Care/TPR enrollment

Plan Information	Plan Information	Plan Information
<b>A</b> DMAP Medical Plan Care Oregon 800-555-5555	<b>B</b> DMAP Dental Plan Managed Dental Care of Oregon 866-555-5555	<b>C</b> DMAP Mental Health Plan Clackamas Mental Hlth Org 888-555-5555
<b>D</b> Private Maj Med/Rx/Dent/Vis Blue Cross of Oregon  Pol# 12345678 ABC123456789	<b>E</b> DCM-FFS Disease Management DCM Care Enhance 1-800-711-6687 DCM-PGM	<b>F</b> DMAP Pharmacy Walgreen
<b>G</b> Medicare Part-A Medicare NW - Part A	<b>H</b> Medicare Part-B Medicare-B/BC N Dakota	<b>I</b> Medicare Part-D Has Part D

### Oregon Health ID and coverage letter replacements

Replacement IDs may be needed if a client moves or if their card has been lost or destroyed. Workers may order replacement IDs through MMIS. Replacement cards and coverage letters are mailed to the client's mailing address. As cards are replaced, they will say Oregon Health ID.

Workers must enter client addresses using USPS standard abbreviations for (e.g., "St" for street, Ave for avenue). Otherwise, items sent to non-standard addresses may not reach clients and are thrown out by automatic mailing protocols. Workers should check the U.S. Postal Service website at [www.usps.com](http://www.usps.com) or use HZIP on the DHS mainframe to verify the accuracy of the address.

For detailed instructions on how to order a replacement or issue a temporary ID or coverage letter, please see [Self-Sufficiency's Staff Tools](#).

## OHP Medical Resources

### What is and is not covered

**OAR: OHP 410-141-0480 - 410-141-0520**

The Oregon Health Services Commission (HSC), now known as the [Health Evidence Review Commission](#) (HERC), developed a list of medical conditions and treatments called the Prioritized List of Health Services (Prioritized List).

The current Prioritized List contains 669 numbered “lines” of paired conditions and treatments that are ranked or “prioritized” placing greater emphasis on preventative services and chronic disease management as opposed to conditions that get better on their own, are cosmetic in nature, or have no effective treatment available. The primary diagnosis determines the condition, and the treatment is the service provided for the condition.

**Covered lines (1-476)** - OHP covers condition/treatment pairs on lines 1 through 476.

**Not-covered lines (477-669)** - Currently, the OHP does not cover these lines. However:

- DMAP covers medically appropriate diagnostic procedures for conditions regardless of Prioritized List placement.
- DMAP may also authorize payment for a condition-treatment pair when the not-covered treatment serves to improve the outcome of a covered condition.

The Prioritized List is updated in October and April each year, and every other January. The Benefit and HSC List Inquiry panel in the MMIS Reference Subsystem provides Prioritized List coverage information for specific dates of service.

### Non-covered conditions

Treatments for the following conditions are **not covered** unless there is another complicating diagnosis:

Description	Examples
Conditions that tend to get better on their own	<ul style="list-style-type: none"> <li>■ Measles</li> <li>■ Infectious mononucleosis</li> <li>■ Mumps</li> <li>■ Viral sore throat</li> <li>■ Dizziness</li> <li>■ Viral hepatitis</li> <li>■ Benign cyst in the eye</li> <li>■ Minor bump on the head</li> <li>■ Non-vaginal warts</li> </ul>
Conditions where a “home” treatment is effective	<p>Home treatments include applying an ointment, resting a painful joint, drinking plenty of fluids, or a soft diet.</p> <ul style="list-style-type: none"> <li>■ Canker sores</li> <li>■ Corns/calluses</li> <li>■ Sunburn</li> <li>■ Diaper rash</li> <li>■ Food poisoning</li> <li>■ Sprains</li> </ul>

Description	Examples
Cosmetic conditions	Examples include: <ul style="list-style-type: none"> <li>■ Benign skin tumors</li> <li>■ Cosmetic surgery</li> <li>■ Removal of scars</li> </ul>
Conditions where treatment is not generally effective	Examples include: Some back surgery TMJ surgery Some transplants

### ***Non-covered services***

Other non-covered services regardless of condition include, but are not limited to:

- Circumcision (routine)
- Weight loss programs
- Infertility services

### **OHP benefit packages**

***OARs: General Rules 410-120-1160 through 410-120-1230 and OHP 410-141-0480***

Oregon Health Plan (OHP) clients receive coverage for health care services based on their benefit package(s). Coverage is different for each package. Clients are assigned benefit packages based on their program eligibility.

The "Benefit Plan" field on the MMIS Recipient Information panel displays the client's most current benefit package. The packages that indicate OHP medical eligibility are:

- BMH – OHP Plus
- BMD – OHP with Limited Drug
- BMM – QMB + OHP with Limited Drug
  - ✓ BMP – OHP Supplemental (for the 3 packages above)
- MED – Qualified Medicare Beneficiary (QMB)
- CWM – Citizen/Alien-Waived Emergency Medical (CAWEM)
- CWX – CAWEM Prenatal

**OHP Plus****BMH**

OHP Plus covers most medical, dental, mental health and chemical dependency services.

Type of service covered	Description/examples
Preventive services	<ul style="list-style-type: none"> <li>■ Maternity and newborn care</li> <li>■ Well-child exams and immunizations</li> <li>■ Routine physical exams and immunizations</li> <li>■ Maternity case management, including nutritional counseling</li> </ul>
Diagnostic services	<ul style="list-style-type: none"> <li>■ Medical examinations to tell what is wrong, even if the treatment for the condition is not covered</li> <li>■ Laboratory, X-ray and other appropriate testing</li> </ul>
Family planning services and supplies	Including birth control pills, condoms, contraceptive implants, and Depo-Provera; sterilizations
Medical and surgical care	<p>Medically appropriate treatments for conditions expected to get better with treatment. Includes, but is not limited to:</p> <ul style="list-style-type: none"> <li>■ Appendicitis</li> <li>■ Infections</li> <li>■ Ear Infections</li> <li>■ Broken bones</li> <li>■ Pneumonia</li> <li>■ Eye diseases</li> <li>■ Cancer</li> <li>■ Stomach ulcers</li> <li>■ Diabetes</li> <li>■ Asthma</li> <li>■ Kidney stones</li> <li>■ Epilepsy</li> <li>■ Burns</li> <li>■ Rheumatic fever</li> <li>■ Head injuries</li> <li>■ Heart disease</li> </ul>
Medically appropriate ancillary services	<p>When provided as part of treatment for covered medical conditions.</p> <ul style="list-style-type: none"> <li>■ Hospital care, including emergency care</li> <li>■ Home health services</li> <li>■ Private duty nursing</li> <li>■ Physical and occupational therapy evaluations and treatment</li> <li>■ Speech and language therapy evaluations and treatment</li> <li>■ Medical equipment and supplies</li> <li>■ Prescription drugs and some over-the-counter drugs</li> <li>■ Limited vision services</li> <li>■ Hearing services including exams, evaluations, treatment, materials and fitting for hearing aids</li> <li>■ Transportation, including ambulance, to health care for clients who have no other transportation available to them</li> </ul>
Other services	<ul style="list-style-type: none"> <li>■ Dental services, including cleanings, fillings, and extractions</li> <li>■ Outpatient chemical dependency services</li> </ul>

Type of service covered	Description/examples
	<ul style="list-style-type: none"> <li>■ Comfort care – this includes hospice care and other comfort care measures for the terminally ill, and death with dignity services</li> <li>■ Mental health services</li> </ul>

For children under age 21, OHP Plus **also covers** the following benefits:

Type of service covered	Description/examples
Services to improve vision	<ul style="list-style-type: none"> <li>■ Exams to prescribe glasses or contacts</li> <li>■ Fittings for glasses or contacts</li> <li>■ Glasses or contacts</li> <li>■ "Services to improve vision" included under "OHP Plus - Supplemental BMP" are <b>not covered</b> for <b>non-pregnant</b> adults, age 21 and over, unless they have a qualifying medical condition described in OAR chapter 410, division 140.</li> </ul>
Other dental services	<ul style="list-style-type: none"> <li>■ Crowns</li> <li>■ Root canals</li> <li>■ Apexification/recalcification procedures</li> <li>■ Gingival flap procedures</li> <li>■ Apically positioned flap</li> <li>■ Osseous surgery</li> <li>■ Surgical revision procedure</li> <li>■ Alveoplasty</li> <li>■ Office visit for observation</li> </ul>

***OHP with Limited Drug***

***BMD***

OHP with Limited Drug covers the same medical, dental and mental health services as OHP Plus. However, OHP with Limited Drug does not cover drugs already covered by Medicare Part D.

***QMB + OHP with Limited Drug***

***BMM***

This benefit package covers the same services as OHP with Limited Drug. It also provides the benefits described in the QMB benefit package section.

***OHP Plus - Supplemental***

***BMP***

This benefit package covers certain dental and vision services that supplement OHP Plus benefits received through the BMH, BMD and BMM packages.

Type of service covered	Description/examples
Services to improve vision	<ul style="list-style-type: none"> <li>■ Exams to prescribe glasses or contacts</li> <li>■ Fittings for glasses or contacts</li> <li>■ Glasses or contacts</li> </ul>

Type of service covered	Description/examples
Other dental services	<ul style="list-style-type: none"> <li>■ Crowns</li> <li>■ Root canals</li> <li>■ Apexification/recalcification procedures</li> <li>■ Gingival flap procedures</li> <li>■ Apically positioned flap</li> <li>■ Osseous surgery</li> <li>■ Surgical revision procedure</li> <li>■ Alveoplasty</li> <li>■ Office visit for observation</li> </ul>

**QMB**

**MED**

The QMB benefit package pays for Medicare Part B premiums and deductibles and covers copayments for services covered by Medicare. If the provider accepts the Oregon Health card for reimbursement, they accept whatever our payment is and the client is not billed. This does not include any cost sharing for Medicare Part D coverage or prescriptions.

Providers are not allowed to bill clients with QMB-only coverage for deductible and co-insurance amounts for services covered by Medicare (except for Medicare Part D prescriptions). However, providers may bill these clients for services that are not covered by Medicare, and for Medicare Part D prescriptions.

Clients with **only** the QMB benefit package cannot be enrolled in managed care plans.

**CAWEM - Citizen/Alien-Waived Emergency Medical**

**CWM**

CAWEM clients are only eligible for treatment of emergency medical conditions including labor and delivery services for pregnancies. Clients on the CAWEM benefit package do not pay premiums or copayments and cannot be enrolled in managed care plans.

Services that are ongoing, require prior authorization, payment authorization or that can be scheduled in advance are **not covered** for clients on the CAWEM benefit plan.

Refer to [OAR 410-120-1210](#) for coverage and exclusion details.

**CAWEM Plus**

**CWX**

CAWEM Plus prenatal benefit is Statewide (effective October 1, 2013), and is in effect only during a woman’s pregnancy. For as long as she is pregnant, a CAWEM woman living in Oregon may receive OHP Plus - Supplemental benefits, through the CAWEM Plus benefit package.

The CAWEM Plus benefit **does not cover** the following OHP Plus benefits:

- Abortions
- Death with dignity
- Hospice care
- Postpartum care (except when included as part of a global delivery procedure)

- Sterilization

DMAP will reimburse for the following services:

- Hospital claims related to the delivery of the child (admission through discharge)
- Pre-natal care, or services needed for the health of the baby
- Post-partum services performed by the medical practitioner who performed the delivery under a bundled rate
- Emergency services
- Refer to [OAR 410-120-0030](#) for coverage and exclusion details.

When a woman is no longer pregnant, she is no longer eligible for CAWEM Plus benefits and returns to the CAWEM (CWM) benefit.

**Benefit package overview – Benefit chart updated 3/14**

Clients receive a copy of this chart with their client coverage letter (see [Oregon Health ID section](#)).

**Your Oregon Health Plan benefits**

The chart below shows what benefits are available under your OHP coverage. Check with your provider or CCO to see if a specific service is covered.



Benefits covered under: OHP Plus, OHP with Limited Drug and CAWEM Plus
Chemical dependency
Dental <ul style="list-style-type: none"> <li>▪ Basic services including cleaning, fluoride varnish, fillings and extractions</li> <li>▪ Urgent or immediate treatment</li> <li>▪ Crowns for pregnant women and children under age 21.</li> <li>▪ Sealants, root canals on back teeth for children under age 21.</li> </ul>
Hearing aids and hearing aid exams
Home health; private duty nursing
Hospice care – not covered for CAWEM Plus clients
Hospital care <ul style="list-style-type: none"> <li>▪ Emergency treatment</li> <li>▪ Inpatient and outpatient care</li> </ul>
Immunizations
Labor and delivery
Laboratory and X-rays
Medical care from a physician, nurse practitioner or physician assistant
Medical equipment and supplies
Medical transportation
Mental health
Physical, occupational and speech therapy
Prescription drugs <ul style="list-style-type: none"> <li>▪ OHP with Limited Drug only includes drugs that are not covered by Medicare Part D</li> </ul>
Vision <ul style="list-style-type: none"> <li>▪ Medical services</li> <li>▪ Services to correct vision for pregnant women and children under age 21</li> <li>▪ Glasses are covered for pregnant adults and adults who have a qualifying medical condition such as aphakia or keratoconus, or after cataract surgery.</li> </ul>

**Other benefit packages:**

- CAWEM – Covers emergency medical, emergency dental and emergency transport services.
- Qualified Medicare Beneficiary (QMB) – Only covers Medicare premiums and copayments (except for Medicare Part D) and deductibles.

DMAP 1418 (Rev 03/14)

## OHP medical assistance program codes

The BMP benefit only applies to pregnant adults receiving BMH, BMM or BMD benefits.

Code	Program Title	Case Descriptor	Benefit Package						
			BMH	BMM	BMD	BMP	CWM	CWX	QMB
1, A1	Aid to the Aged	Various; see <a href="#">APD/AAA Staff Tools</a>	X	X	X				
2, 82	Temporary Assistance for Needy Families (TANF)	MAA, MAF	X				X		
V2	Refugee Assistance		X			*			
3, B3	Aid to the Blind	Various; see <a href="#">APD/AAA Staff Tools</a>	X	X	X	*			
4, D4	Aid to the Disabled	Various; see <a href="#">APD/AAA Staff Tools</a>	X	X	X	*			
19, 62	DHS Foster Care		X						
C5	Substitute/Adoptive Care	SAC, SCH, SCP, SFC, CR1, CR2, CR3	X				X		
GA (CSD)	Non-title XIX Foster Care		X						
5	OSIPM-PRS	Various; see <a href="#">APD/AAA Staff Tools</a>	X		X	*	X		
P2	Qualified Medicare Beneficiary (QMB)	QMB							X
P2, M5, 2, 82	OHP Medical	AMO, CMO, PCR, PWO, OPC, OP6, OPP, CEC, CEM	X			*	X		
	Breast and Cervical Cancer Treatment Program	BCCTP	X			*	X		
	Children's Health Insurance Program (CHIP) and MAGI CHIP	CHP, C21	X						
	Extended Medical Program	EXT	X			*	X		
CW, CX	CAWEM	CWM					X		
	CAWEM Plus	CWX						X	
QMB	QMB + Any Program	QMM		X					

## Health Care Delivery Systems

### Overview

DMAP contracts with private companies, primary care providers and clinics to provide comprehensive coordination and management for Medicaid clients' medical, dental and mental health care. To deliver these comprehensive services, there are three delivery systems:

- Coordinated care – Medical, dental, and mental health (CCOA); medical and mental health (CCOB); mental health (CCOE); and, mental and dental health (CCOG).
- Managed care – Medical (PCO), dental (DCO) and mental health (MHO).
- Fee-for-service – Medical, dental and mental health

In the coordinated care organization (CCO) and managed care organization (MCO) systems, DMAP pays a monthly financial allotment called a **capitation payment**, for each enrolled member, regardless of services rendered.

Indian Health Service clinics and tribal wellness centers either have managed care programs or consider their clinics to be managed care. When discussing managed care enrollment options for American Indians and Alaska natives, specify 'OHP' managed care.

*Note:* On the client's [coverage letter](#), Disease Case Management (DCM) will be listed on the Managed Care/TPR page, but it is not a plan type. DCM clients receive medical care FFS.

### *How OHP clients know what delivery system(s) they are in*

A [comparison chart](#) is included in the OHP application packet that gives information about the coordinated or managed care health plan options that are available in the area where the client lives. When applying or renewing their OHP, clients can choose available plan(s) in their area as shown on the chart.

When a client is enrolled into plan(s), DMAP, through the Medicaid Management Information System (MMIS), sends the client a [coverage letter](#) informing them of their status. The plan provides their members with a handbook outlining the services it provides and how to access them. Plan member handbooks can also be viewed on plan websites.

### Coordinated care organization types

CCOA – Mental, medical and dental health coverage

CCOB – Mental and medical health coverage

CCOE – Mental health coverage

CCOG – Mental and dental health

### ***Patient-Centered Primary Care Homes (PCPCH)***

OHA recognizes health care clinics that provide a patient-centered model of care. At its heart, this type of care fosters strong relationships with providers, patients and their families. Primary care homes improve care by focusing on prevention, catching problems earlier, wellness and management of chronic conditions. Clinics submit applications and the program makes sure they meet the standards of care. Those that achieve this model are recognized as official primary care homes and can achieve three different tiers, or levels, of recognition depending on the criteria they meet. CCOs are expected to include Patient-centered Primary Care Homes (PCPCH or primary care homes) in their provider networks.

For more information, including a video that explains what a primary care home is, please visit [www.PrimaryCareHome.oregon.gov](http://www.PrimaryCareHome.oregon.gov).

### ***Intensive Care Coordination***

Plans provide a service called **Intensive Care Coordination Services** or as formerly known, **Exceptional Needs Care Coordination**, for members with special needs. They usually are provided by nurses, called **Intensive Care Managers**, who help members who are having trouble getting the right care to navigate their plan's various processes and get care faster.

- Always refer a member who is verbalizing difficulty with their provider to these services. They can access services more quickly than some providers cannot access.
- While plans must provide this service for seniors and people with exceptional health care needs, in practice they should help anyone who contacts them.
- The [OHP Handbook](#) and the plan's member handbook provide contact information for these services.

## **Managed care types**

### ***Fully Capitated Health Plan (FCHP)***

Fully capitated health plan (FCHP) was the original managed care model implemented by DMAP. Effective May 1, 2015, all FCHPs have been replaced by CCOs (CCOA or CCOB). FCHP enrollment will still display in a client's MMIS enrollment history if applicable.

### ***Physician Care Organization (PCO)***

A PCO provides medical services and may coordinate outpatient medical care. PCOs do not cover inpatient hospital services and post-hospital extended care services; DMAP covers these on a fee-for-service basis. PCOs are being phased out in favor of CCOs. Clients should be enrolled in a CCO (CCOA or CCOB) as CCOs have precedence over the PCO.

### ***Dental Care Organization (DCO)***

A Dental Care Organization (DCO) is a prepaid health plan that provides dental services. DMAP and CCOs contract with them to provide comprehensive services and to manage each enrolled member's dental care. If a CCO with dental services (CCOA or CCOG) is also available the CCO has precedence over the DCO.

### ***Mental Health Organization (MHO)***

In areas where no CCO provides mental health care, a Mental Health Organization (MHO) coordinates mental health services. Services provided by the MHO include:

- Evaluation
- Case management
- Consultation
- Mental health-related medication and medication management
- Individual, family, and group therapy
- Local acute inpatient care
- 24 hour urgent and emergency response
- For adults only:
  - Rehabilitation services
  - Skills training
  - Supported housing
  - Residential care

### **Plan availability**

DMAP determines if a plan is open for new enrollment and if enrollment is voluntary or mandatory. The plans also determine if they are open or closed to new enrollment, as approved by DMAP.

If a plan must be closed for enrollment, the plan still may be open to returning members. When attempting to re-enroll a client into a closed plan, check the Managed Care screen or Comparison Chart to see if there is a re-enrollment period. These are usually 30 days, but can be from 0 to 120 days.

If the member's break in enrollment was less than the number of days in the re-enrollment period, the member will be able to get back into the plan. Workers should contact [Client Enrollment Services](#) (CES) staff to see if the client can be re-enrolled. If a case already has someone enrolled in a plan that is closed, any new or returning family members can also enroll.

### **Always use the most current plan availability charts**

The [Comparison Charts by county](#) show which areas have mandatory or voluntary enrollment. There are many ways to access the comparison charts. You can:

1. Go online to <http://www.oregon.gov/oha/healthplan/pages/plans.aspx> and print out the most current charts.
2. Sign up for text or email notifications through eSubscribe at [https://public.govdelivery.com/accounts/ORDHS/subscriber/new?topic\\_id=ORDHS\\_69](https://public.govdelivery.com/accounts/ORDHS/subscriber/new?topic_id=ORDHS_69) to find out when updated charts are posted.

3. View recent eSubscribe notifications at [https://public.govdelivery.com/topics/ORDHS\\_69/feed.rss](https://public.govdelivery.com/topics/ORDHS_69/feed.rss).
4. Order printed charts for free from the OCE Print Shop using the [OHA 6625](#) (OHP Application Order Form).
5. Branches can subscribe with the OCE Print Shop to automatically receive revised charts whenever that county is revised. The branch sends an email to [ocemailroom@oce.oregon.gov](mailto:ocemailroom@oce.oregon.gov) with the following information in the body of the email:

Request to subscribe for a recurring order:

- a. Branch number, or name of outreach agency
- b. Specify full application packets that include Comp Charts, or just Comp Charts
- c. Quantity and languages to send in the recurring order (English, Spanish, Russian or Vietnamese)
- d. Name of person at the agency to receive the order
- e. Address
- f. Phone number

## Enrollment process

The medical, dental or mental health plan enrollment process usually takes 1-1 ½ weeks.

The MMIS Managed Care screen gives the following information (based on the FIPS/ZIP codes for the client's residence address):

- The medical, dental and mental health plans available
- Whether the plan is open or closed for new enrollment
- If closed:
  - Whether previous members may re-enroll
  - What the time limits are for re-enrollment (how many days since last enrolled in that plan)

Clients may be exempt from enrollment into coordinated care or managed care either temporarily or permanently for various reasons. See [Enrollment Exemptions](#) in this worker guide for more information. The most common exemptions are for people enrolled with Medicare as well as OHP, American Indians and Alaska natives.

## Mandatory enrollment

Across Oregon, CCO enrollment is **mandatory**. MHO enrollment is mandatory only for clients not enrolled in a CCO.

Clients who live in a service area that has a CCO and do not have an approved exemption are required to enroll in a CCO for medical, dental or mental health services when those are available.

Non-exempt clients in mandatory service areas are enrolled in plans the following two ways:

**Client choice**

Field staff should help clients select a CCO if one is available. Doing this may help avoid additional changes later. If no CCO is available, they may receive medical care on a fee-for-service basis.

**Auto-enrollment**

Auto-enrollment is a systematic weekly process. Clients who do not choose a medical plan, or choose a plan that is not currently available are auto-enrolled into a plan. The client's worker must send a notice to the client telling them:

- The name of the managed care plan they have been enrolled in, and
- That they have a right to change to a different managed care plan within 90 days of the enrollment if another plan is available.

Auto-enrolled clients can ask their caseworker (within 90 days from the enrollment) to change to a different plan if another one is available where they live. However, they cannot go back to fee-for-service (open card) unless they have an approved exemption. Auto-enrolled clients that do not request a change within 90 days may change plans later using one of their disenrollment options.

**Voluntary enrollment**

Enrollment in voluntary service areas is not required, however, it is preferred. Enrollment in coordinated or managed care can increase access to services and also provide valuable resources.

If a client is already enrolled in a plan and moves to a voluntary ZIP code served by their plan, they will stay enrolled in that plan.

Clients not enrolled in a plan receive their dental, physical or mental health services on a fee-for-service basis. The client will continue to receive services fee-for-service until the area changes to mandatory or if the client moves to a mandatory area.

**Newborn enrollment**

For newborns born to OHP medical plan members, newborns are enrolled in the mother's plan, effective back to their date of birth. For newborns born to FFS members, the newborn is still enrolled in a CCO, just not back to date of birth.

To ensure timely newborn enrollment, report OHP births to OHP Customer Service using the [Newborn Notification](#) form.

**Effective date of plan coverage****OAR: OHP 410-141-0060**

Managed care enrollment is done weekly. When enrollment information is entered into MMIS:

- Before 5:00 p.m. on a Wednesday, coverage begins the following Monday.
- On Thursday or Friday, coverage begins one week from the following Monday.

OHA pays plans the capitation for newly enrolled members at end-of-month cutoff (after they have been added to a case).

## Changing or ending health plan enrollment

OAR: OHP 410-141-0080

### Client choice

Clients may change their plan at these times as long as another plan is available:

- When they reapply or the worker re-determines benefits;
- If they move and their existing plan does not provide service at their new address;
- Within 90 days of first-time enrollment for new OHP clients, an enrollment error, or auto-enrollment;
- When approved by DMAP. DMAP reviews requests for disenrollment for just cause, such as lack of access to appropriate care or needing services that the plan excludes for religious reasons.
- Contact CES for assistance with managed care enrollment issues. For additional assistance with managed care related issues, contact a DMAP Account Representative.

### Change of residence

When a client moves out of their current plan's service area, staff will change their address as soon as possible and MMIS will auto disenroll the client during the weekend batch. Only change the residential address for **permanent** home address moves.

- Do not manually disenroll the client for month-end; it can cause access to care issues in the new service area.
- If the client needs to be disenrolled sooner than the weekend batch or for assistance with enrollment errors that occur due to an address change, contact [CES](#).

*Reminder:* Temporary placements such as substance use disorder residential treatment are not considered a change of residence. Use the facility address as the client's temporary mailing address; do not change the client's residential address. Contact CES if a client in residential treatment is having access to care issues.

### Moves between two service areas served by the same plan

When a client moves into a different service area that is still served by his or her current CCO/plan, MMIS views the move to a new service area as an enrollment change. This will generate a new [coverage letter](#) that states the reason as a change in plan enrollment, even though from the client's perspective, enrollment did not change.

### Death

If a client dies, workers updating client information in the Client Maintenance (CM) system will not update the Living Arrangement or date of death through the system interface to MMIS panels. In order for the eligibility to process correctly from CM, workers need to end the eligibility using a deceased code ("D") instead of a regular end of eligibility code ("E"), and the appropriate reason code as needed. When the CM user uses the "D" code and date of death, CM will send the transaction to MMIS that will automatically apply the date of death and update the living

arrangement. This in turn will also disenroll the member from any managed care plans as of the date of death. Just entering the date of death does not end eligibility or enrollment.

### ***New health coverage***

Clients are also disenrolled from their plan when they are determined to have private or employer-sponsored major medical health insurance ([Third-Party Liability, or TPL](#)). Disenrollment occurs the last day of the month that the TPL is identified.

### ***Use DMAP reason codes when changing or ending enrollment***

Enrollment staff must use the most appropriate reason code when disenrolling or re-enrolling a client. For a list of most commonly used codes, go to the [834 Maintenance Reason Code Crosswalk](#) and look at the far left column (*DMAP Reason Codes*).

### **Service area exceptions**

As outlined in Oregon Administrative Rule (OAR) [410-141-3160\(10\) and \(14\)](#), CCOs are responsible for coordinating care even when members are in a temporary placement to receive care outside the CCO’s service area.

CES uses the **Service Area Exception (SAE)** process to ensure uninterrupted CCO enrollment for OHP members in such placements.

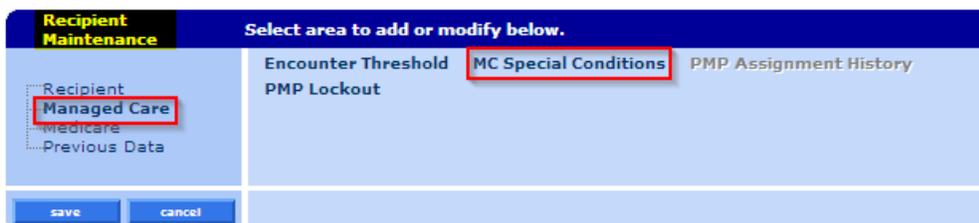
### **How to review for Service Area Exceptions (SAEs)**

If present, SAEs will display in the MC Special Conditions panel of the client’s MMIS Recipient Subsystem record.

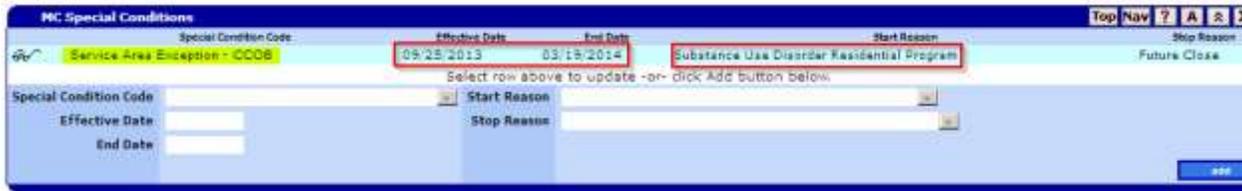
1. In the MMIS Recipient Subsystem, click on **Search** and enter the client’s Prime Number in the “Current ID” field.



2. Once in the Recipient Information Panel, go to **Recipient Maintenance**. Click on **Managed Care**, then click on **MC Special Conditions**.



3. In the **MC Special Conditions** Panel, review for current dates. SAEs will have Special Condition Codes that begin with “Service Area Exception.” The **Start Reason** column will show why the client requires the SAE.



### Who approves Service Area Exceptions

For the following exception reasons, specific groups are responsible for:

- Reviewing the client’s case; and
- Adding the exception, or submitting the request to CES (if the request is approved).

Reason	Who reviews case?	Who adds the SAE?
<b>Access to care</b>	DMAP CCO Account Representatives	Account Representatives or CES
<b>AMHI (Adult Mental Health Residential Placement)</b>	AMHI Coordinators	CES
<b>Behavior Rehabilitation Services Psychiatric residential treatment (for Child Welfare recipients)</b>	Child Welfare Medical Assistance Resource Coordinators (MARC)s	Child Welfare MARCs
<b>Continuity of care</b>	DMAP Medical Management Unit	Medical Management or CES
<b>Reasons related to domestic violence protection (good cause)</b>	Eligibility workers	CES

### How to submit SAE requests

Send an email to DMAP CES ([ces.dmap@state.or.us](mailto:ces.dmap@state.or.us)) that includes the following information. Also include a period of time the exception shall apply (a true date, less than 2 years). Requestors are responsible to monitor the need for continuing exceptions.

- Client name
- Date of birth
- Prime number
- Placement start date
- State Hospital release date *(if applicable)*
- Temporary address *(e.g., facility address)*
- County of responsibility/jurisdiction *(if applicable)*
- Client’s CCO choice *(if appropriate/available)*

## Enrollment exemptions

**OAR: OHP 410-141-0060**

There are times when a client may be approved for a temporary or permanent exemption from plan enrollment if they meet certain criteria. Temporary exemptions are sometimes approved to allow a client a small window of time to complete a needed medical service or procedure. Training on the exemption process is offered through the Learning Center.

### How to request enrollment exemptions

Exemptions should include a specific start and end date.

- Only HIG can enter or update TPL exemptions..
- Authorized APD workers can only enter Continuity of Care and Medicare Choice exemptions.
- All other exemptions are entered by CES.

### MC Special Conditions - Exemption and Exception Reasons Chart

In MMIS, exemptions and service area exceptions are called **MC Special Conditions** and are located in the MMIS Managed Care subsystem. This table lists reasons available and guidance about who can enter each code.

MC Special Conditions Reason	Reason can only be added by:		
	DMAP/CES	HIG	Authorized APD worker
Assessment and evaluation (A&E)	X		
Behavioral Rehabilitation Services	X		
Client is hospitalized	X		
Client is in a temporary exception status waiting	X		
Client is in a medical management program	X		
Continuity of care	X		X
Domestic Violence Protection	X		
End Stage Renal Disease	X		
Exceeded Contract Limits	X		
Hearing scheduled	X		
Language barrier	X		
Incarcerated	X		
Medical fragile child	X		
Medical Medicare choice	X		X
Medical necessity	X		
Other	X		
Providence Elder Place (PACE)	X		
Psychiatric Residential Treatment Services (PRTS)	X		
Psychiatric Security Review Board (PSRB)	X		
Rehabilitation/Inpatient/Facility	X		
Religious considerations	X		
Rosemont Treatment (CD/BRS)	X		

MC Special Conditions Reason	Reason can only be added by:		
	DMAP/CES	HIG	Authorized APD worker
SCF-Parent no response	X		
Secure Adolescent Inpatient Program (SAIP)	X		
Secure Children Inpatient Program (SCIP)	X		
Secure Residential Treatment (SRTF)	X		
Special needs child	X		
Stabilization and Treatment Services (STS)	X		
Stop Loss	X		
Substance Use Disorder Residential Program	X		
Surgery scheduled for client	X		
Third Party Liability		X	
Third trimester pregnancy	X		

Note: COT (Cover Oregon identified insurance), FCH (FamilyCare holds), PER (permanently exempt recipients), and RAR (recipients under additional review) were used for system transition only and are not manually added codes.

### ***Third party liability (TPL)***

When a client has private or employer-sponsored health insurance, also called **TPL**, it must be reported to the HIG as quickly as possible. TPL can be reported online at [www.reportTPL.org](http://www.reportTPL.org). For cases entered in the CM system or Oregon Access, workers are also required to code the PHI field on the case.

Only **active TPL** (*a current major medical health insurance policy that provides inpatient and outpatient hospital, lab, x-ray, physician and pharmacy benefits*) can potentially exempt a client from OHP health plan enrollment.

- Once HIG verifies active TPL, the client **cannot** be enrolled into a physical health plan (CCOA, CCOB, or PCO). This is true even if HIG cannot pursue TPL due to [good cause coding](#). They will receive their medical services on a fee-for-service basis.
- Clients that have private or employer-sponsored dental insurance are required to enroll in a DCO or CCO with dental coverage (CCOA, CCOB, CCOE).

Only HIG can add or end a TPL exemption. Questions or assistance related to TPL exemptions should be directed to HIG and not to CES.

In many cases, the State can reimburse policyholders for the premiums that they pay for their private or employer-sponsored health insurance through the [HIPP \(Health Insurance Premium Payment\) program](#).

### **Enrollment codes and requirements to enroll**

The table below lists the most common private health insurance policy types a client may have. Use this chart to determine the enrollment requirements for the policy types listed. If your client's policy type is not listed or you need additional information please contact HIG.

Enrollment codes for private health insurance		Can client enroll?		
Private Coverage Type	Code	CCOA/CCOB/ FCHP/PCO	CCOG/ DCO	CCOE/ CCOG/ MHO
Accident	20	Yes	Yes	Yes
Cancer	04	Yes	Yes	Yes
<b>Champ VA</b>	<b>05</b>	<b>No</b>	Yes	Yes
Dental	06-07	Yes	Yes	Yes
Hospital only	9	Yes	Yes	Yes
Long Term Care	10	Yes	Yes	Yes
<b>Major Medical</b>	<b>12 -16</b>	<b>No</b>	Yes	Yes
<b>Medicare Supplement: A, B, C-J</b>	<b>21-23</b>	<b>Client choice</b>	Yes	Yes
Prescription only	29-30	Yes	Yes	Yes
Skilled Nursing	25	Yes	Yes	Yes
<b>Tricare/Triwest</b>	<b>34</b>	<b>No</b>	Yes	Yes
Vision (Optical) only	26-27	Yes	Yes	Yes

### Entering 0-7 TPL Coding and Good Cause

If a client with active TPL has domestic violence or safety concerns with the policyholder, the state may decide to not pursue the TPL. In those instances, workers can request **Good Cause coding**.

- Good Cause coding can also be requested if the client has access to care issues (lives in an area where their TPL is not available). For example, a child with Kaiser-Permanente provided by an absent parent and the child lives in a county not served by Kaiser.
- To request Good Cause coding, contact HIG by email at: Referrals TPR (in Outlook) or [tpr.referrals@state.or.us](mailto:tpr.referrals@state.or.us) (Outside of Outlook). You can also call HIG at 503 378-6322.

The TPL field on a client's case tells MMIS if the client has private or employer-sponsored health insurance and if MMIS can coordinate claims with the private insurance company. In most cases, the State must be the payer of last resort.

**Caution:** The TPL field on a client's case or in MMIS does not stop or start enrollment into managed care. Workers need to be sure the TPL field contains correct information and report the TPL to HIG.

The table below explains each of the codes.

Code	Reason	Details - the client has:
0	No TPL	No private health insurance
1	Has TPL	Private health insurance - There are no safety or access concerns. <i>Note: Includes Indian Health services (IHS) benefits</i>
2	TPL through Mom Safety Concerns	Private health insurance provided by their mother - Do not pursue due to safety concerns.

Code	Reason	Details - the client has:
3	TPL through Dad Safety Concerns:	Private health insurance provided by their father - Do not pursue due to safety concerns.
4	TPL through both Mom and Dad Safety Concerns	Private health insurance provided by mother and father - Do not pursue due to safety concerns.
5	TPL through Multiple Safety concerns:	Private health insurance provided by multiple carriers - Do not pursue because of safety concerns.
6	TPL through Other Safety Concern	Private health insurance provided by someone other than their mother or father - Do not pursue because of safety concerns.
7	TPL other reason	Good cause not to use their private health insurance for a reason that is NOT a safety risk such as access to care. <i>This code should not be used to avoid co-pays or to divert claims to DMAP instead of the TPL.</i>

## Medicare clients and medical plan enrollment **OAR: OHP 410-141-0060**

Clients eligible for both Medicaid and Medicare can choose to enroll with any medical plan available in their area, or choose to receive services on a fee-for-service basis.

If they are already enrolled in a medical plan, they may choose to enroll in that plan's Medicare Advantage (MA) Plan, enroll in another plan's MA Plan, or keep Medicare fee-for-service (original Medicare). Medicare rules require that Medicare clients always have the option of FFS instead of managed care.

### ***OHP medical plan with corresponding Medicare Advantage Plan***

Clients who are enrolling in their OHP medical plan's corresponding Medicare Advantage Plan must complete the [OHP 7208M](#) within 30 days of receiving it. Clients that do not complete this form may be disenrolled from their managed health care plan. The following information is needed to complete the [OHP 7208M](#):

- Information about the client – name, phone number, address, county, date of birth, gender, Social Security number, and Medicare claim number
- Name of the client's Primary Care Provider (PCP)
- Name of the client's OHP medical plan
- Name of the Medicare Advantage Plan the client chooses
- Effective date of Medicare:
  - Part A – Hospital insurance coverage
  - Part B – Medical insurance coverage

***Important:*** Clients who have End Stage Renal Disease (ESRD) or receive routine dialysis treatment, or have received a kidney transplant within the last 36 months cannot enroll in a Medicare Advantage Plan. However, they can stay in the plan if they were already enrolled before being diagnosed with ESRD.

### ***OHP medical plan without a corresponding Medicare Advantage Plan***

Enroll these clients in their OHP medical plan like all other clients. These clients will receive their health care as follows:

- Medicare services – from original Medicare
- Medicaid services – through their OHP medical plan (fee for service)

### ***Changing Medicare Advantage Plans***

Clients can only be in one Medicare Advantage Plan at a time. To disenroll from a Medicare Advantage Plan, the client must complete the *Request to End Medicare Advantage and Medicare Special Needs Plan Enrollment* ([OHP 7209](#)) and send it to the Medicare Advantage Plan they are leaving.

### **Choice counseling**

Usually clients will make their own decisions about plans, knowing it is important to choose plans that best meet their needs. To help them decide, DMAP includes [Comparison Charts](#) with all new application packets. Comparison charts are a choice counseling tool and are formatted so that all plans in a specific area can be compared to one another.

If the client is unable to choose a plan, one may be chosen for them by a legal health representative (*power of attorney, guardian, spouse, family member, a team of people, or an agency caseworker*).

The following checklist shows major discussion areas to cover when helping a client choose a plan:

#### ***Choice counseling checklist***

- Does the client reside in a mandatory or voluntary enrollment area?
- Does the client's doctor (PCP) or dentist (PCD) participate with an available plan?
- Do the client's children have a PCP? Does the PCP participate with an available plan?
- Is the medical or dental office near the client's home or on a bus line? Can they get to their appointments easily?
- What transportation is available to the client to access medical services?
- Are the PCP's office hours convenient for the client?
- Where will they go for medicine? Is there a pharmacy near their home?
- Which hospital does the plan require the client to use for general hospital care? Is it near their home?
- Does the family have special medical, mental health, or chemical dependency needs to be considered?

## Educating clients about health care

The case worker or case manager can help educate clients about accessing health care by sharing the following information:

- Emergent care means services that are needed immediately because of a serious injury or illness. Some examples are: broken bones, profuse bleeding, a tooth that has been knocked out, suspected heart attack and loss of consciousness. Refer to the *OHP Handbook* ([OHP 9035](#)) for more information.
- There could be a one to three month wait for a routine appointment, especially with a dentist, so keep preventive care appointments; do not wait until an emergency arises.
- If you cannot keep a routine appointment, you must cancel the appointment at least 24 hours in advance.
- Primary care providers (PCPs) manage your health care needs. The PCP works with you to keep you healthy. If you need a specialist, the PCP may need to make a referral.
- Bring both your Oregon Health ID and plan card to all appointments. In some cases identification may be requested.
- Some providers may not be taking new patients.
- Follow the rules of your plan and respect providers and their staff.
- You should receive a *Member Handbook* with a *Provider Directory* about 2 weeks after enrolling in a medical or dental plan for the first time.
- Call the OHP Client Services to order a copy of the *OHP Handbook* ([OHP 9035](#)). It contains helpful information such as:
  - ✓ How to resolve billing problems
  - ✓ How to resolve provider care problems
  - ✓ How the appeal and grievance process works
  - ✓ Review your Oregon Health ID and coverage letter each time you receive one to make sure it is accurate.
  - ✓ Notify your worker of changes in your household such as new pregnancy, change of address, change to the number of people in your household, etc.

*Remember:* Many clients have not had access to health care and may not automatically know doctor's office etiquette. See the *OHP Handbook, Rights and Responsibilities* for more information.

## Who to contact for help

See the [CCO enrollment guide](#) for whom to contact for specific CCO enrollment issues; also see [this resource list](#) to learn where to direct OHP members and applicants for help.

Issue	Contact	Phone/Fax/Email
<ul style="list-style-type: none"> <li>■ Plan enrollment</li> <li>■ No plan assigned or wrong plan on Oregon Health ID</li> <li>■ AI/AN exemptions</li> <li>■ Medical exemptions</li> </ul>	DMAP Client Enrollment Services	800-527-5772 Fax: 503-947-5221 Email: CES DMAP or <a href="mailto:dmap.ces@state.or.us">dmap.ces@state.or.us</a>
<ul style="list-style-type: none"> <li>■ Plan (CCO, PCO, DCO, MHO) claim problems</li> <li>■ Available services or providers</li> </ul>	Client's CCO or managed care plan	Phone number listed on client's CCO/plan-issued member ID card
MMIS or CM case coding problems	OPAR - CMU Client Maintenance Unit	503-378-4369
<ul style="list-style-type: none"> <li>■ Adding or ending TPL</li> <li>■ TPL exemptions</li> <li>■ TPL changes</li> <li>■ Plan disenrollment when there is TPL</li> </ul>	OPAR - HIG Health Insurance Group To report changes: <a href="http://www.reportTPL.org">www.reportTPL.org</a>	503 378-6233 Email: Referrals TPR or <a href="mailto:tpr.referrals@state.or.us">tpr.referrals@state.or.us</a>
Unresolved client FFS/open card problems	DMAP Provider Payment Specialist	503-945-5772
Continuity of care exemptions Expedited hearing requests	DMAP Medical Management	503-947-5270 Fax 503-945-6548
Problems with any mental, dental or medical health plan	Contact the CCO/plan first  If no resolution, contact Client Services Unit	800-273-0557

## CCO enrollment issue resolution guide

### *The following issues require manual enrollment by DMAP CES or the CCO:*

- OHP eligibility start date is future-effective.
- Enrollment exemption is ending the same day you are trying to enroll the client, even if the enrollment start date is after the exemption end date.

When either of these issues occur, refer to the following chart to determine who to contact.

Potential issue	Solution
Client requests to be enrolled in a different dental plan	If the client is in a CCOA or CCOG, please contact the CCO to make the change. If the client is in a DCO, contact DMAP CES.
Client requests to be enrolled in a specific Health Share of Oregon RAE	Contact Health Share Customer Service at 1-888-519-3845.
Client requests to be enrolled in a different medical plan	Contact DMAP CES.

### *For other issues, review the following chart.*

If the issues and solutions listed below do not work or do not apply to your client's situation, please e-mail [DMAP Client Enrollment Services](#).

Potential issue	Solution
Child Welfare recipient is placed out of the CCO's service area for Behavioral Rehabilitation Services or to return to his/her community.	Please include CCO in care coordination prior to move, and notify the CCO when placement occurs.
Client has Private Health Insurance (Third Party Liability – TPL)	CES cannot process these requests: Send TPL notifications to HIG at <a href="http://www.reportTPL.org">www.reportTPL.org</a> .
Client is disenrolled due to temporary address changes (e.g., placement in an A&D facility).	<b>Only update client address when it is a permanent home address move.</b> Do not change the client's case address due to a placement in a facility or a temporary change in place of residence.
Client is experiencing challenges with out-of-area services	Contact the client's plan to ensure the CCO is aware that the client is obtaining temporary services out of the client's home area.
Newborns	<b>Do not manually enroll newborns if the mother was enrolled in a plan on the newborn's DOB.</b> Please allow the system to auto-enroll the newborn into the mother's plan, unless there are urgent access-to-care issues that require immediate enrollment.

## Other Medical Resources

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### Oregon Breast and Cervical Cancer Treatment (BCCTP) Program

BCCTP helps low-income, uninsured, and underserved women gain access to lifesaving screening programs for early detection of breast and cervical cancers. The Oregon BCCTP provides screening funds to promote early detection of breast and cervical cancer among Oregon's medically underserved individuals. BCCTP is funded by the Centers for Disease Control and Prevention, the Susan G. Komen for the Cure Oregon and SW Washington Affiliate, and the American Cancer Society.

- For information about free mammograms, call 1-877-255-7070.
- For information regarding eligibility, screening and diagnostic services, call 1-877-255-7070, visit your local county health department or see <https://public.health.oregon.gov/PHD/Directory/Pages/program.aspx?pid=86>.

## Health Insurance Premium Payment Program

### Overview

Oregon Health Plan (OHP) clients may also have individual (private) or employer-sponsored insurance, also known as Third Party Liability (TPL). The State (Medicaid) is the payer of last resort, so the client's TPL normally becomes the primary payer.

The **Health Insurance Premium Payment Program (HIPP)** may be able to reimburse OHP clients<sup>1</sup> for the amount they pay for third party insurance. Doing so assists the State in providing cost-effective health care.

HIPP reimburses eligible policyholders for the amount they pay for their employer-sponsored health insurance. Payments usually go directly to the policyholder. HIPP does **not** reimburse premiums for:

- Non-SSI institutionalized and waived clients whose income deduction is used for payment of health insurance.
- Vision, dental, long-term care or other stand-alone policies.
- Clients covered by Medicare Part A, Part B, Part C or Part D.
- Insurance purchased through the Health Exchange when tax credits are being received.
- Insurance that has been court ordered

### Health Insurance Group

HIPP determinations are done by the Health Insurance Group's (HIG) Premium Reimbursement Coordinators. They are located within the Office of Payment Accuracy and Recovery (OPAR). Determining eligibility includes collecting documents from clients, reviewing for cost effectiveness, data entry in MMIS to issue payments and all other administration related to the program. Contact a Reimbursement Coordinator by calling 503 378-6233 or by e-mail at [Reimbursements HIPP](mailto:Reimbursements.HIPP@state.or.us) (in Outlook) or [reimbursements.hipp@state.or.us](mailto:reimbursements.hipp@state.or.us) (outside of Outlook).

### Program requirements

The HIPP program provides premium reimbursement to policyholders that pay for major medical health insurance for eligible Medicaid clients. This might be employer-sponsored group health insurance or privately purchased health insurance.

**To qualify for HIPP, the policyholder does not have to live in the same household as the Medicaid recipient.** It is possible to reimburse eligible absent parents, grandparents or others who are paying for the health insurance premiums. However, the State does not reimburse for third party insurance premiums if the policyholder has been court ordered to provide it.

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<sup>1</sup> Note: The State does not reimburse the employer's share of the premium cost.

To qualify for HIPP, the insurance must be:

- A comprehensive major medical policy<sup>2</sup> that includes inpatient and outpatient hospital, physician, lab, x-ray and full pharmacy benefits; and,
- Determined cost-effective based on the [Medical Savings Chart \(MSC\)](#); and,
- Meet HIPP requirements in [OAR 410-120-1960](#).

## HIPP eligibility

Individuals apply for HIPP at [www.reportTPL.org](http://www.reportTPL.org). After the HIG Premium Reimbursement Coordinator receives the initial request they do an initial screening to see if additional information is needed. If it is, they will send a request to the policyholder for more information. If the required documentation is received and the requirements in [OAR 410-120-1960](#) are met, HIG authorizes and enters the HIPP reimbursement payment into MMIS. Notice of the determination is sent to the policyholder.

Reimbursements are paid by check through MMIS. In most cases, payments begin the month after the determination is made.

HIG re-determines eligibility at least annually and more frequently, if needed.

Examples:

- Mom/Policyholder applies April 1, 2015. Mom's employer provides insurance for her, dad and two children. Only the children are eligible for Medicaid. Mom has \$435.00 deducted from her check each month for her portion of the insurance. The children have PERC codes of H2 and HB. The combined insurance allowance on the [Medical Savings Chart](#) is \$896.00 (\$448.00 for HB and \$448.00 for H2). The cost of their insurance is cost effective because the premium amount is below the allowable amount. They meet all other program requirements and are approved April 15, 2015. Their first payment is issued in May 2015.
- Dad/Policyholder applies April 25, 2015 does not live in the household and is not covered by Medicaid, but he provides insurance through his employer for his disabled son who lives in a group home. The son's PERC is D4. The cost of the insurance is \$537.00 per month. The allowance on the [Medical Savings Chart](#) is \$1141.00. The cost of their insurance is cost-effective because the premium amount is below the allowable amount. They meet all other program requirements and are approved May 10, 2015. Their first payment is issued in June 2015.
- Adult receiving Medicare applies for reimbursement of Medicare supplement. They are denied because Medicare recipients are not eligible for HIPP and because the insurance is a supplement.

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<sup>2</sup> Note: Insurance policies that cover specific conditions or diseases, such as a cancer-only policy or only have a prescription discount card, are not eligible.)

## How to apply for HIPP

To apply for HIPP go to [www.reportTPL.org](http://www.reportTPL.org). Policyholder’s can apply directly or other individuals can help them apply. If internet is not available they can email HIG at [Reimbursements HIPP](mailto:Reimbursements.HIPP) (in Outlook) or [reimbursements.hipp@state.or.us](mailto:reimbursements.hipp@state.or.us) (outside of Outlook) Examples of when to refer a client for the HIPP are:

- Client indicates they have employer-sponsored insurance on their application for medical benefits.
- Client reports they have COBRA insurance.
- Paycheck stubs show that health insurance is deducted from a paycheck. Client is working and indicates they have a private, individual health insurance plan. *Note: Client may purchase health insurance directly from the insurance carrier and it will not show on their paycheck stub.*

For instructions on how to complete the online web form, go to: [OPAR-IM-15-001](#).

## Reference

### Hearings

Insurance premium reimbursements are not a medical benefit and therefore are not subject to hearings. See OAR [410-120-1960](#).

### Questions

Client or worker questions related to HIPP should be directed to a Premium Reimbursement Coordinator at 503 378-6233 or e-mail at [Reimbursements HIPP](mailto:Reimbursements.HIPP) (in Outlook) or [reimbursements.hipp@state.or.us](mailto:reimbursements.hipp@state.or.us) (outside of Outlook).

Client questions regarding TPL and Medicaid eligibility should be referred to their local branch worker or OHP Customer Service at 1-800-699-9075.

### Where to report TPL and apply for HIPP

[www.reportTPL.org](http://www.reportTPL.org)

### Applicable OARs:

DMAP		DHS/OHA		
410-120-1960	461-120-0330	461-120-0350	461-135-1100	461-170-0035
410-120-0345	461-120-0345	461-135-0990	461-155-0360	461-180-0097

**DMAP - Medical Savings Chart (MSC)**

The Medical Savings Chart is used to determine HIPP eligibility.

*Effective January 1, 2014, Health Insurance Group, Office of Payment Accuracy and Recovery*

Eligibility group	PERC Code	Cost-effective premium amount (employee cost)
CEM, OPC	HF, HG, H3, H4, MF, H2	\$239
CEM-OP6	HE, HB, ME ,	\$448
CEM, OHP,OHP	HD, HA, H1, MG, MD	\$448
OHP-OPP	L2, L6, L8, HC, LA, LB, LC, LD	\$705
MAA, MAF, EXT	2, 82, KA, XE	\$386
SAC, Foster Children - SCF	C5, 19, MC	\$1785
MAGI Adults/Couples	M3, M6	\$592
MAGI Families	M1, M5	\$353
OSIP-AB	3, B3	\$495
OSIP-AD	4, D4	\$1141
OSIPM-OAA	1, A1	\$180
GA	5, GA	\$163

**DMAP - Special Conditions Chart add-on list**

The Special Conditions Chart (SCC) is used to determine eligibility for HIPP when premium amounts exceed the Medical Savings Chart and a recipient has one of the conditions listed below.

*Effective January 1, 2012, Health Insurance Group, Office of Payment Accuracy and Recovery*

CCS2 Code	Description	Average paid per-client, per-month
019	Pancreatic disease – excluding diabetes	\$396
002	Cancer	\$231
009	Blood disorder (sickle cell, hemophilia	\$213
001	TB, HIV/AIDS, Hepatitis A, B or C	\$173
018	Liver Disease	\$157
015	Cardiovascular disorders	\$137
023	Childbirth (if neonatal delivery cost PMPM is \$268)	\$105
012	CNS disorder-Multiple sclerosis, Epilepsy, Cerebral Palsey, Plegia (Quad, Para, Mono), Paralysis, Parkinson's, Huntington's	\$65
027	Spina bifida	\$65
010	Mental Health disorders (Autism, DD)	\$61
016	Chronic lung disease, COPD	\$55
011	Alcohol & Chemical dependence disorders	\$54
021	Renal disorders (kidney disease)	\$50
005	Diabetes	\$40

## Administrative Examinations and Reports

### Overview

Administrative Medical Examinations and Reports” are examinations, evaluations, and reports, including copies of medical records, requested on the DMAP 729 form through the local Department of Human Services (DHS) branch office or requested or approved by the Oregon Health Authority to establish client eligibility for a medical assistance program or for casework planning (See OAR [410-120-0000](#), Definitions).

Typically, it is the DHS Case Worker who determines the need for administrative examinations and reports, and requests these services by completing the DMAP 729 form.

### Child Welfare (CW)

For detailed information about Admin Exams for Child Welfare staff, see Oregon Administrative Rules [413-050-0400 thru 0450](#) Special Medical Services Provided by Child Welfare.

### Presumptive Medicaid Disability Determination Team (PMDDT)

PMDDT will only request Admin Exams from “acceptable sources” (See 20 CFR §416.913). Once a diagnosis is established by the acceptable source, PMDDT is able to use other evidence to address severity. PMDDT uses the Social Security Act (SSA) definition of disability, so PMDDT is bound by the CFR and the [Programs Operations Manual System](#).

### Developmental Disabilities (DD)

See the [DD Worker Guide](#) – Procedural Codes for Developmental Disabilities and the Training & Power Point presentation.

### Division of Medical Assistance Programs (DMAP)

DMAP processes Admin Exam claims through the MMIS. Workers use the DMAP 729 series of forms when ordering medical procedures.

#### *Ordering Medical Procedures - DMAP 729 forms*

The DMAP 729 forms are a series of seven forms (links appear at the end of this guide) workers use to order medical procedures. Not all DHS/OHA agencies use every form in the 729 series.

- Instructions to complete the DMAP 729 are on the back of each form.
- Send appropriate DMAP 729s and a release of information to the provider.

#### *Guidelines for the DMAP 729 Series*

- Determine the appropriate examination or report to order.
- No prior authorization is needed for administrative medical exams and reports.

***DMAP 729 series form links***

- Administrative Medical Examination/Report Authorization [DMAP 729](#)
- Comprehensive Psychiatric or Psychological Evaluation [DMAP 729A](#)
- Report on Eye Examination [DMAP 729C](#)
- Medical Records Checklist [DMAP 729D](#)
- Physical Residual Function Capacity Report [DMAP 729E](#)
- Mental Residual Function Capacity Report [DMAP 729F](#)
- Rating of Impairment Severity Report [DMAP 729G](#)
- The 729 series of forms are also found on the [DHS/OHA forms server](#).

***Revenue, Current Procedural Terminology (CPT) and Health Care Common Procedure Coding System (HCPCS) Codes***

See the tables below for the most current information:

- [Revenue Codes – Table 1](#) – Hospital Revenue Codes
- [CPT/HCPCS Codes – Table 2](#) – Professional (non-hospital) services

***DMAP reimbursement for provider reports***

To reimburse providers for the Admin Exam or the Administrative Medical Report related to an Admin Exam, the provider must send CMS 1500 or UB-04 billing forms directly to DMAP to the address on the bottom of the DMAP 729.

DMAP will only reimburse providers that:

- Are DMAP-enrolled,
- Have Admin Exam provider contract,
- Have met the requesting DHS program criteria for a qualified provider, and
- Have a current contract to complete Admin Exams with the requesting DHS agency.

## Prior Authorizations

Some services and equipment require prior authorization (PA) by DMAP or the client's managed care plan before they can be delivered to a client. These services and equipment include, but are not limited to:

- Some durable medical equipment and medical supplies
- Most physical therapy and occupational therapy
- Private duty nursing
- Most home health
- Most speech and hearing
- Some visual services
- Some home enteral/parenteral IV
- Some dental services
- Most transplants
- Out-of-state services
- Some surgeries
- Some behavioral health services
- Select lab and radiological studies

### Where to get prior authorization

If a client is enrolled in managed care the provider should contact the plan directly for prior authorization.

Fee-for-service contact information is available on page 5 of the [Provider Contacts List](#).

To learn about authorization of non-emergent medical transportation, see the [Medical Transportation](#) section of this guide.

## Client Rights and Responsibilities

Clients who Oregon Health Plan (Medicaid/CHIP) benefits have specific rights and responsibilities found in the [OHP Handbook](#).

### **Billing clients** *OARs: General Rules 410-120-1280 and 410-141-0420*

See the OHP Handbook at <https://apps.state.or.us/Forms/Served/he9035.pdf>.

### **Client health care complaints, appeals, and Administrative Hearings processes**

*OARs: OHP 410-141-0260 & 410-141-0261; General Rules 410-120-1860 and OHP MCOs-410-141-02620- 410-141-0266 & OHP CCOs-410-141-3260-410-141-3264*

There will be times when clients are not satisfied with a health care decision made by DMAP, their providers or their CCO/plan. All clients with complaints or concerns have options.

Clients may seek assistance with health care concerns or complaints through their CCO/plan (if they are enrolled) or Client Services Unit for fee-for-service (FFS) clients.

### ***Fee-for-service (FFS) clients***

OHP FFS clients (also known as “open card” clients), must work with DMAP for complaints or a Notice of Action (NOA) that came from DMAP. When DMAP denies a requested service, we use an NOA that includes necessary information such as reason(s) for denial, important dates to attend to and instructions for initiating an administrative hearing if the client is not satisfied with a decision. To request an administrative hearing, the client must follow the instructions on the NOA and submit the request to the state within 45 days from the date of the NOA.

### **Notice of Action for changes affecting all clients**

DMAP may also use the NOA to inform all clients at once when we discontinue or change the scope of services or products. This is typically an informational notice that requesting a hearing will not affect, however, DMAP still gives all clients the right to do so if they choose.

Clients may also ask for a hearing by completing the Administrative Hearings Request Form (MSC 443). They can get an MSC 443 and help filling it out from any DHS office or by calling OHP Customer Service at 1-800-699-9075 (TTY 711).

Clients should mail the [MSC 443](#) to DMAP immediately, as the hearing process timelines have been shortened. Forward all DMAP hearing requests, with attachments, to:

Division of Medical Assistance Programs  
Hearings Unit  
500 Summer St. NE, E-49  
Salem, OR 97301-107

## Medical Transportation

### Emergency transportation

Clients who are in an emergency situation should call 911 for immediate assistance or go directly to the nearest hospital emergency room.

- **Prior authorization is never required for emergency medical transportation.** The client may only receive reimbursement for mileage to the nearest hospital emergency room if they did not use an ambulance.
- If the client had a medical emergency and drove to a hospital emergency room, authorize mileage reimbursement. Emergency is defined in General Rules, OAR 410-120-0000, Acronyms and Definitions.

### Non-emergency medical transportation

**OARs: OHP 410-136-3000 through 410-136-3360**

Non-emergent medical transportation (NEMT) is federally mandated by the Centers for Medicare and Medicaid Services (CMS) rule, 42 CFR 431.53 to assist clients going to and from routine or scheduled Oregon Health Plan (OHP) medical services when they have no other means to access appropriate medical care.

The Division of Medical Assistance Programs (DMAP) Medical Transportation Services Program in Oregon Administrative Rules (OAR) chapter 410, division 136, provides for NEMT services for clients with an OHP Plus benefit package (**BMD, BMH, BMM, or CWX**).

NEMT resources are **not** available for clients with CAWEM (CWM) or Medicare-only (MED), as these clients are not mandatory populations under Medicaid.

NEMT is only available for the actual client attending a medical service and if required, one guardian or attendant.

This guide outlines the relationship and responsibilities of transportation brokerages and DHS/OHA branch office staff in providing NEMT services to eligible clients. Please read carefully as there are details, atypical situations, and exceptions to consider.

### Transportation brokerages

A transportation brokerage (*brokerage*) is the single point of contact for NEMT services offered by the OHP. Please refer eligible clients in need of NEMT to [their regional transportation brokerage](#) for service.

### Services provided by transportation brokerages

Brokerages perform the following services to support the NEMT needs of eligible clients:

- Verify OHP client eligibility, assess the client's needs and resources, and arrange and provide NEMT as appropriate.

- Authorize transports that are the least expensive, medically-appropriate mode in advance of the service being provided.
- Provide bus tickets and passes, taxi service, wheelchair vans, stretcher vans, secured transportation and common carrier.
- Work with branch staff and volunteer coordinators (in counties that have volunteer transportation programs) to determine if a client can be served more cost-effectively using a volunteer. If so, the brokerage and volunteer coordinator will arrange transportation.
- Arrange commercial travel (airline, train, etc.) and transportation locally to and from departure location if DMAP has approved out-of-state travel for OHP-covered medical services.
- Arrange for reimbursement of any prior-authorized meals, lodging, and transportation that occurs in the other state.
- Authorize ambulance or air ambulance services.

## Client reimbursement

All client requests for reimbursement for NEMT services must be prior authorized by the brokerage or CCO.

- Branch office staff must not reimburse for these services.

Meal reimbursement is calculated using the following fee schedule:

- Breakfast: \$3.00
- Lunch: \$3.50
- Dinner: \$5.50

Lodging is paid the lesser of the actual cost, or \$40 per night.

The reimbursement rate for mileage is \$0.25 per mile and is all-inclusive. It does not include reimbursement for gasoline, oil, or other expenses related to mileage.

## Urgent care after-hours

Occasionally, a client may require an urgent, but non-emergency, medical transport after hours when it is not possible to prior authorize.

- The client should follow the brokerage's instructions for urgent care on its after-hours telephone message.
- If the client normally uses reimbursement, the client can drive or be driven to urgent care, and then contact the brokerage for retroactive authorization the following business day.

**NEMT does not include emergency ambulance transportation to a hospital.** Clients in an emergency situation should call 911 for immediate assistance.

## Administrative exams

A client who does not have an eligible OHP Plus benefit package may use NEMT to attend an [administrative examination](#) for the purpose of determining eligibility for medical assistance.

- The exam must be requested by the client's case manager.
- The case manager must open eligibility using the ADMIN benefit package code for the date of service and complete form DMAP 729.
- If the client uses the transportation brokerage, send a copy of the form to the brokerage.
- NEMT may only be used in this situation to attend the requested examination and may not be used to attend any other medical service.

## Children in subsidized adoptions

In Marion and Polk counties, DMAP authorizes NEMT for children in subsidized adoptions with OHP Plus benefits only (County 0060 or 6050). Refer the appropriate person to the DMAP Co-60 Transportation Coordinator at (503) 945-5920. See contact information in the [Resources](#) section at the end of this guide.

## NEMT policy exceptions for cost effectiveness

NEMT that would ordinarily be unavailable according to program OARs or established exception procedures may be authorized on rare occasions, if it is in the best interest of both the client and OHP. Such policy exceptions are evaluated on a case-by-case basis and are only authorized by DMAP Management.

- In order to evaluate a request for policy exception, DMAP requires cost-benefit analysis. DMAP will only approve a policy exception when there is a demonstrable saving to OHP, a significant benefit for the client, and no burden placed on the client or providers.
- The DHS/AAA case manager should prepare a written proposal that clearly expresses all costs and benefits for submission to the DMAP Medical Transportation Policy Analyst (Policy Analyst).
- The DMAP Policy Analyst will review the proposal, ask for additional information if necessary, and submit to DMAP Management for authorization.
- If authorized, the DMAP Policy Analyst will send the case manager confirmation by e-mail and, if appropriate, send a copy to the transportation brokerage. The case manager will make necessary arrangements and retain copies of the authorization and any supporting documents in the client case file. *(Note: See contact information at the end of this guide.)*

## Contacts

Topic	Contact
NEMT authorization for subsidized adoptions (Marion, Polk counties)	Julie McGuire DMAP Branch 60 Transportation Coordinator <a href="mailto:julie.mcguire@state.or.us">julie.mcguire@state.or.us</a> (503) 945-5920

Topic	Contact
NEMT policy Requests for policy exceptions	Sarah Wetherson DMAP NEMT Program Manager <a href="mailto:sarah.e.wetherson@state.or.us">sarah.e.wetherson@state.or.us</a> (503) 569-6342

## Other resources

### *Transportation brokerages and service area maps*

<http://www.oregon.gov/oha/healthplan/tools/Transportation%20Brokerage%20Map.pdf>

### *Oregon Administrative Rules (OARs) for Medical Transportation*

<http://www.oregon.gov/oha/healthplan/Pages/medical-transportation.aspx>

### *NEMT information for DHS/OHA staff*

<https://inside.dhsoha.state.or.us/oha/medical-assistance-programs/non-emergent-medical-transportation.html>

## Processing claims

### Overview

The DMAP claims processing system is highly automated. It handles approximately 1 million claims per month. This total number of claims includes capitation payments, electronic claims (point of sale, Provider Web Portal and Electronic Data Interchange 837 transactions), and paper claims. If all information is correct, providers who submit claims electronically by 2:00 p.m. on Thursday could receive payment the following week.

DMAP depends on workers to enter timely and accurate eligibility information on clients. Two of the most common errors are that a client changes their name and it is not updated right away or a newborn is not added for medical coverage as soon as possible.

### How a claim is processed

When a provider submits a claim to DMAP, it is processed by the Medicaid Management Information System (MMIS). The MMIS is a completely automated claim processing system with payment logic built around all of the data elements provided within a claim as it pertains to required, prior authorized and optional services.

Claims enter the MMIS in four ways:

1. Paper claims are mailed to DHS/OHA Information Resource Management Services (IRMS) and submitted to a key/verify process.
2. Providers submit individual claims using the Provider Web Portal at <https://www.or-medicaid.gov>.
3. Providers or their submitter (e.g., billing service or clearinghouse) submit large batches of electronic claims through Electronic Data Interchange (EDI).
4. Pharmacies submit prescription claims through the Oregon Medicaid Point of Sale system.

Once claims enter the MMIS, they are checked against a series of validation rules to check for possible errors and missing or invalid data. A misplaced code or a blank field can cause the claim to suspend for further review or deny outright. If suspended, the claim will be reviewed by a staff person, potentially causing a delay in payment of several weeks.

### *Paper claim processing*

The IRMS Imaging Unit scans incoming paper claims using Optical Character Recognition (OCR) and assigns each one an internal control number (ICN).

- The scanned documents are then manually keyed for OCR accuracy and verified. Depending on volume, this initial process may take one to five working days.
- The data is then sent to MMIS for processing. Images of the documents are stored in an Electronic Document Management System (EDMS) and indexed by identifiers such as client name, prime identification number, the date of service, and provider number.

Because of quality assurance and time requirements, data entry operators cannot alter the information on the claim forms, or take the time to read and annotate notes or written explanations attached to claims. If forms are not properly aligned, this could lead to claims not processing correctly.

### ***Electronic claim processing***

Claims billed electronically using the Provider Web Portal, EDI or POS directly enter MMIS.

- Web claims directly enter the MMIS if all information is entered correctly.
- EDI claims are reviewed for HIPAA compliance and translated to MMIS for processing.
- POS claims are reviewed for NCPDP compliance and translated to MMIS for processing.

### **MMIS claim adjudication**

The MMIS makes determinations on both Web and POS claims in real-time. All claims that enter MMIS by 2 p.m. Thursday are processed during the weekend claim cycle.

There are more than 900 potential questions MMIS may ask about a claim before it can make a payment decision. The fewer questions the computer asks, the more quickly the claim can be processed. Once in MMIS, the claim is not seen by any DMAP staff unless it suspends for specific medical or administrative review.

For all claims reviewed by MMIS, providers receive a remittance advice (RA) explaining payments, suspended claims, and denied claims. Providers can also review the status of all claims they have submitted to DMAP using the Provider Web Portal.

### ***Suspended claims***

When a claim **suspends**, MMIS is saying that it cannot make a decision — a claims analyst will have to review the data.

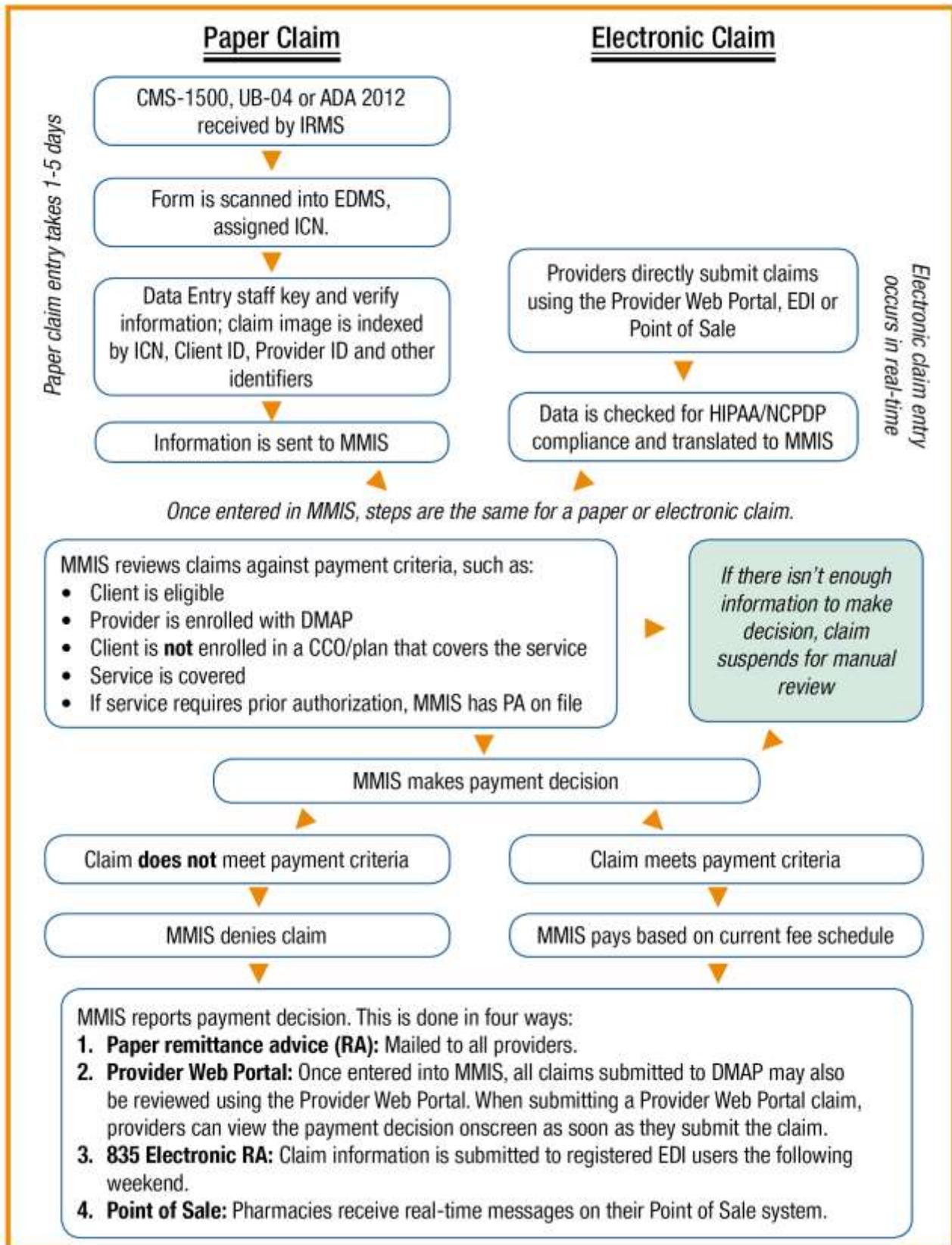
Claims also suspend when the claim's dates of service do not match the client's dates of OHP eligibility. When this happens, DMAP allows two weeks to pass. If MMIS still shows "no eligibility for patient," the system will automatically deny the claim.

Only procedures that require "cost documentation" or "by report" will **suspend for medical review**. The Medical Management Unit analyzes those claims.

### ***Denied claims***

Most claims are **denied** because of incomplete or incorrect patient or provider data. Another common reason for DMAP denials is when providers incorrectly bill DMAP, instead of the client's CCO/plan. Clients need to present both their Oregon Health and plan ID cards for correct billing.

To help avoid denied claims, please be sure your case information is complete and accurate, and that clients are aware of their CCO/plan enrollment.



## Copayments and Special Requirements

### OHP Plus and OHP with Limited Drug copayments

*OAR 410-120-1230*

OHP charges some OHP clients a copayment for prescription drugs and outpatient services, depending on their eligibility level and benefit package. Copayment information is shown on page two of the client's OHP Coverage Letter. Medicare may also charge copays on the drugs it supplies through Medicare Part D.

Providers cannot deny services to a client solely because of an inability to pay an applicable copayment. This does not relieve the client of the responsibility to pay, nor does it prevent the provider from attempting to collect any applicable copayments from the client.

#### ***Exemptions***

The following clients also do not have to pay a copayment:

- Pregnant women
- Children under age 19
- Young adults in Substitute Care and in the Former Foster Care Youth Medical Program
- Clients with OHP Supplemental
- Clients with the HNA case indicator in MMIS
- Any client receiving services under the Home and Community Based waiver and Developmental Disability waiver, or is an inpatient in a hospital, nursing facility (NF), or intermediate care facility for the mentally retarded (ICF/MR)
- Clients receiving hospice care – However, because our system does not flag all clients when they initiate hospice services, you will not see this new copayment exemption when verifying eligibility using the Provider Web Portal, Automated Voice Response, or 270/271 transaction.
- Clients eligible for the BCCTP program

#### ***Copayment amounts***

Some clients must pay \$3 for outpatient services (such as office visits to see a doctor, dentist or other health care provider). The copayment is only for the visit to the provider. There is no additional copayment for services rendered by the provider, such as immunizations, lab tests, or x-rays.

#### ***Services requiring a copayment***

The following are services for which providers can charge a copayment:

- Office visits, per visit for physician/specialist, nurse practitioner, physician assistant or alternative care providers (i.e., chiropractors, naturopaths, acupuncturists)

- Dental services (except for dental diagnostic and preventive routine checkups)
- Mental health and/or chemical dependency (outpatient service)
- Preventive care, per visit for physician/specialist
- Hospital, per visit for outpatient treatments (including surgery) and non-Emergency Room visits (waived if admitted to inpatient care)
- Physical, occupational, or speech therapy services
- Home health services
- Private duty nursing visit and shift
- Enteral/Parenteral IV

### ***Services exempt from copayment***

Clients do not have to pay a copayment for the following services:

- Administrative exams and reports
- Dental diagnostic and preventive routine checkups
- DME supplies
- Emergency services
- Family planning services
- Hospice services - However, because our system does not flag all clients when they initiate hospice services, you will not see this new copayment exemption when verifying eligibility using the Provider Web Portal, Automated Voice Response, or 270/271 transaction.
- Routine immunizations
- Total blood cholesterol screenings (men age 35-65, women age 45-64)
- X-ray and lab services (i.e., mammograms, pap smears, fecal occult blood tests, diagnostic sigmoidoscopy [over age 50])

### ***Prescription copayments***

OHP Plus clients do not have to pay a copayment for the following prescriptions:

- Drugs for family planning services, such as birth control pills
- Drugs obtained through the Home-Delivery Pharmacy Program (mail order)
- Most generic medicines
- Any drugs listed on the physical health Preferred Drug List, including most generics

For drugs that require a copayment, clients will pay zero, \$1 or \$3. Amounts are listed in [OAR 410-120-1230](#). Clients may request generics to get a reduced copayment, but they are not required to use generics. Similarly, clients can still get non-preferred brand-name drugs their doctors prescribe, but clients will pay the maximum copayment.

Physical health drugs not on the PDL also require PA. The prescriber requests the PA from the Oregon Pharmacy Call Center.

## Home-Delivery Pharmacy Program (mail order)

Fee-for-service clients who have ongoing prescription needs and a stable medication regimen may receive their prescriptions through the OHP Home-Delivery Pharmacy Program. Clients do not have to make copayments on drugs ordered through this program. Clients can use this program even if they are restricted to one walk-in pharmacy through the Pharmacy Management Program (i.e., they can use both). Clients may use the home-delivery services only for drugs that their mental health or medical plan does not cover.

Home-Delivery Pharmacy Program is currently contracted through Wellpartner. Prescription order forms are available on the [OHP website](#). Mail first-time prescriptions and completed order forms to:

Wellpartner, Inc.  
P.O. Box 5909  
Portland, OR 97228-5909

Clients may enroll themselves by calling Wellpartner at 1-877-935-5797. Health care providers can fax the prescription to 1-866-624-5797. (This fax number should only be used by the doctor or health care provider.)

## Pharmacy Management Program (Lock-in)

### Overview

The purpose of the Pharmacy Management Program is to maximize patient safety and minimize risk of medication misuse. Some clients will be restricted to one walk-in pharmacy of their choice to receive prescription drugs. Although clients will be enrolled in a single walk-in pharmacy or chain, they can use the Home-Delivery (Mail Order) Pharmacy Program and a specialty pharmacy, in addition to the walk-in store.

### Pharmacy assignment

Clients using three or more pharmacies, using multiple prescribers to obtain the same or comparable prescriptions, having patterns of prescription misuse, or having altered a prescription are candidates for the Pharmacy Management Program. Those clients will be mailed a notice explaining the program and designating the name and address of one pharmacy (based upon the pharmacy the client used most often and most recently), and a notice of hearing rights. The client has 45 days to appeal, or to change their pharmacy. Clients remain in the program beginning the first day of the month, following their notice date, for a period of 18 months.

### Exemptions from the Pharmacy Management Program

Enrollment into the Pharmacy Management Program will be mandatory unless the client:

- Enrolled in a prepaid health plan;
- Has a major medical insurance policy;

- Enrolled in Medicare drug coverage plan and no other third party pharmacy benefits;
- Is a child in DHS care and custody; or
- Is an inpatient in a hospital, long-term residential care facility, or another medical institution.

### ***Changing an assigned pharmacy***

Initially, the client has 45 days to change their pharmacy assignment. Thereafter, the client may change their pharmacy up to once every three months. Circumstances such as moving, reapplying for OHP benefits, pharmacy denies service to client, or goes out of business are reasons to change their pharmacy.

Client Enrollment Services (CES) needs to be informed of pharmacy choice changes as soon as possible, therefore, it is best to send an email using the following instructions:

#### **DO:**

- Send change requests to [ces.dmap@state.or.us](mailto:ces.dmap@state.or.us)
- Include the clients' full name and prime ID numbers. Including a secondary identifier like a case number or DOB can help CES find clients in MMIS if there's a typo in the client's name or prime ID.
- Select the High Importance red exclamation point or put URGENT as the first word in the subject line if the client's situation includes access to care or other emergent needs.

#### **DO NOT:**

- Send multiple requests for the same client. If a client's situation becomes urgent after a routine request has been sent, recall that email (if possible) and re-send the request as URGENT. Please note in the new email that a previous request was sent.

Staff and clients can also call OHP Customer Service at 1-800-699-9075 or Client Services Unit (CSU) at 1-800-273-0557. CSU is responsible to inform CES if a client requests to change their pharmacy.

### ***One time exception:***

Pharmacists may contact the Oregon Pharmacy Call Center if a recipient needs to change to another pharmacy temporarily or permanently. Reasons for a one-time exception include:

- Selected pharmacy is closed at the time medication is needed
- Selected pharmacy does not have the prescribed medication in stock
- Client is 50 miles or more away from selected pharmacy at the time the prescription needs to be filled.
- Workers who have access to MMIS will find the name of the client's lock-in pharmacy in the MMIS Recipient Maintenance panel (choose Lock-in Details). The Lock-in Details panel will show the selected pharmacy's name, effective dates, and National Provider Identifier (NPI).