Oregon Health Authority

Billing Oregon Medicaid (OHP and CWM) members: Do's and don'ts

Providers should **not** bill Medicaid members for services covered by their Medicaid or Medicare benefits. Oregon Health Authority (OHA) issues coverage letters and Oregon Health IDs to members with the following benefit packages:

- **Medicaid coverage** is shown by benefit packages BMH, BMP, CWX, CWM. Providers cannot bill these members for Medicaid-covered services.
- **Full Medicare-Medicaid coverage** is shown by benefit packages BMM and BMD. Providers cannot bill these members for Medicare **or** Medicaid-covered services. In addition, they cannot bill BMM members for Medicare cost-sharing.
- **Medicare Savings Program enrollment**[1] is shown by benefit package MED. Providers cannot bill MED members for Medicare cost-sharing or Medicare-covered services.

Help prevent billing issues

Please do the following to make sure that you bill appropriately for services to Oregon Health Plan (OHP) and Citizenship Waived Medical (CWM) members:

- **Collect all health coverage information**, including the member's Oregon Health ID, CCO ID, Medicare ID and any other health insurance IDs.
- **Report any third party liability** (*e.g.,* private health insurance) to ODHS/OHA, and bill TPL before both Medicaid and Medicare. To report TPL, go to www.reportTPL.org.
- **Bill Medicare first for services Medicare covers.** Report third party liability (TPL) and Oregon Medicaid (CCO or OHA) information as secondary.
- **For claims that do not crossover from, or are not covered by, Medicare/TPL, bill Oregon Medicaid.** The following chart explains whom to bill based on what you see when verifying member eligibility and enrollment.

Type of service	Bill to
Dental	CCOA, CCOG, DCO
Physical health Physical health prescriptions	CCOA, CCOB
Mental health	CCOA, CCOB, CCOE, CCOG
Mental health prescriptions Other services not covered by member's CCO or DCO	OHA

Medicare cost-sharing

For Medicare coinsurance or copayments, providers cannot charge Qualified Medicare Beneficiaries (QMBs: BMM and MED) any Medicare cost-sharing. Medicare providers who balance bill QMB patients may be subject to sanctions based on federal requirements established in

[1] Other Medicare Savings Programs are SMB and SMF. These are not OHP programs. Providers can bill SMB and SMF members for Medicare cost-sharing.

Sections 1902(n)(3)(C) and 1905(p)(3) of the Social Security Act. Medicare providers who violate these billing restrictions are violating their Medicare provider agreement.

To learn more about Medicare billing prohibitions, read OHA's fact sheet about OHP and QMBs.

If a service is not covered, and the member still wants to have the service:

The member must agree to pay for the service before you provide it.

To bill a member for services that OHP or CWM doesn't cover, the member needs to sign an Agreement to Pay form that shows:

- The estimated cost of the service, and;
- That OHP does not cover the service, and;
- That the member agrees to pay the bill himself or herself.

OHA has three kinds of Agreement to Pay forms:

- OHP 4109 for planned community births,
- OHP 3166 for prescriptions, and
- OHP 3165 for other health care services.

To bill a member for services that Medicare doesn't cover, the member needs to sign a notice that outlines the member's financial responsibility for the service, as well as the member's appeal rights and protections. To learn more about these notices, visit the Centers for Medicare & Medicaid Services website.

Who to call for help

For services covered by the CCO, call the CCO. For other services, call Provider Services.