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Procedure Title:	Complete Care Chiropractic & Massage – OHP Coverage & Waiver (OHP 3165) Workflow
Date:	07/23/2026
Version:	1.0
Department:	Complete Care Chiropractic & Massage / Billing
Approved By:	Cece Carvajal

1. Purpose & scope

This SOP defines how Complete Care Chiropractic & Massage (CCHC) verifies OHP coverage and, for confirmed non-covered services, obtains a signed OHP 3165 and collects the TOS fee before the service is provided.

Applies to

- OHP plans seen at CCHC: **AllCare and CareOregon only.** CCHC does **not** see Medicaid-OR (Open Card / FFS) patients.
- Known non-covered services at CCHC: **X-Rays & Modalities** (i.e., Ultrasound, Combination Therapy, and/or Cold Laser) — always time-of-service with a signed OHP 3165.
- One billing team member submits authorizations and checks benefits/policies online for CCHC.

2. The rules that changed our process

Under Oregon Administrative Rule **OAR 410-120-1280 (Billing)** and **ORS 414.066**, a provider may ***not*** bill an OHP patient for a service that OHP covers. A signed OHP 3165 waiver only lets us bill the patient for a service that is **genuinely non-covered and known to be non-covered before it is provided**.

Having the patient sign a waiver, billing insurance, and then billing the patient when it was *denied as "not medically necessary"* — is not allowed. A covered service that is denied for medical necessity or provider error cannot be passed to the patient (OAR 410-120-1280(3)(d)(C) and (4)(c)).

Non-negotiables

- A waiver is only valid for a service we have **confirmed in advance** is non-covered for that specific patient.
- The OHP 3165 must be signed **before** the service is provided — never after.
- The 3165 is valid only if the **estimated fee does not change** and the service is scheduled **within 30 days** of the patient's signature.
- Give the patient a copy of the signed 3165, and keep a copy available to the plan (MCE) or the Authority on request.
- Never use a waiver to bill the patient for a covered service that was simply denied as not medically necessary, or denied because of a provider/authorization error.
- Verify eligibility before every date of service.

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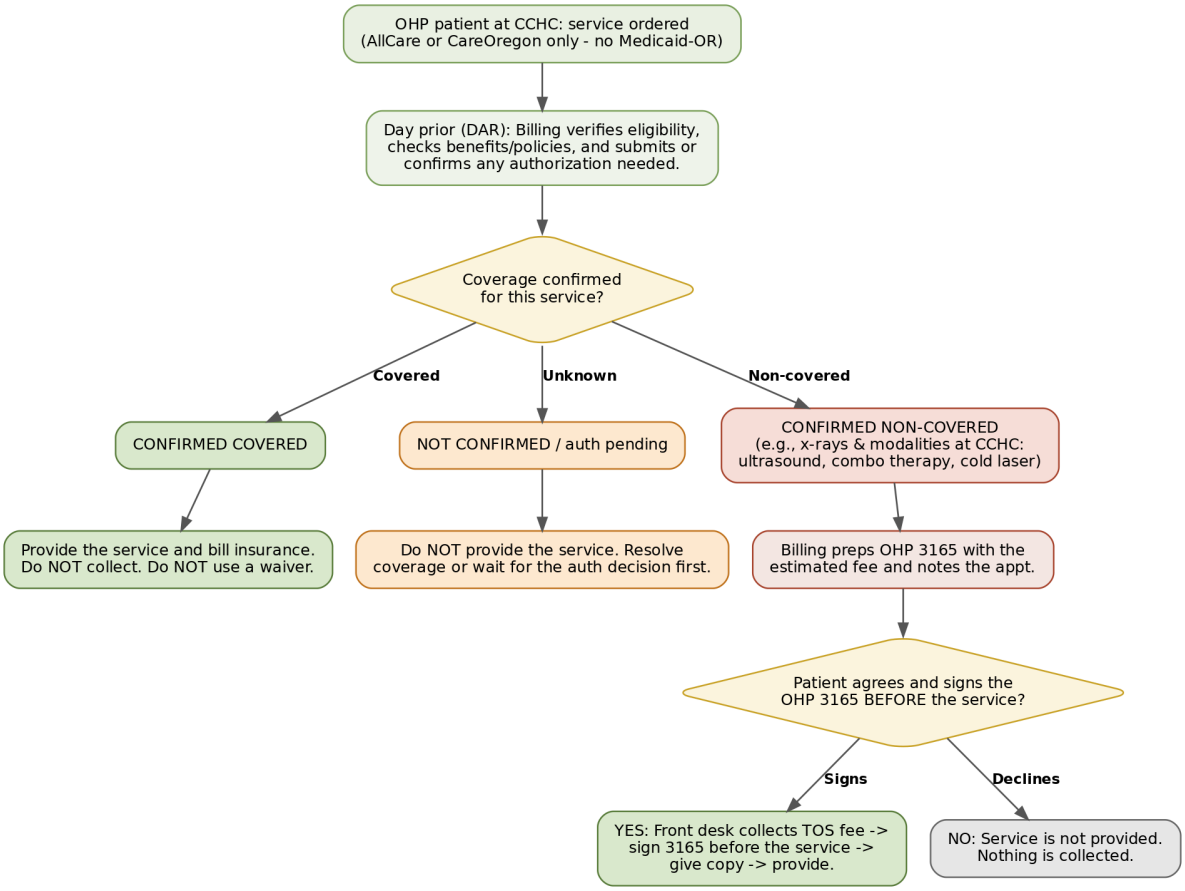
THE HARD RULE — if coverage isn't confirmed, do not provide the service

If we have **not confirmed coverage** — meaning we do not **100% know** the service is either covered or non-covered — we do **not** provide the service. We do **not** have the patient sign a waiver and we do **not** collect any money.

No additional services should be provided at a New Patient or Re-Evaluation appointment without authorization. (e.g., spinal manipulations)

Resolve coverage first: finish the eligibility and benefit / Prioritized List check, or wait for the authorization decision. Only once coverage is confirmed do we proceed — provide and bill insurance if it is covered, or use the OHP 3165 and collect the TOS fee if it is confirmed non-covered.

3. Decision flowchart



4. Step-by-step workflow

How coverage is determined (day prior, on the DAR)

1. The billing team member reviews the next day's CCHC schedule, verifies eligibility, and submits or confirms any authorization needed for AllCare / CareOregon, checking benefits and policies online.
2. If the service is **confirmed covered**: provide it and bill insurance — do not collect and do not use a waiver.

3. **For known or confirmed non-covered services (e.g., x-rays, modalities such as ultrasound, combination therapy, and/or cold laser, or a denied PA):** prepare the OHP 3165 with the estimated fee, note the appointment, and send the prepped waiver to the front desk to print.

If the provider chooses to perform additional services that were not originally scheduled and you are unsure whether a waiver is required, please reach out to billing before providing the service.

4. **If coverage is unknown or an auth is still pending:** do **not** provide the service. Resolve coverage or wait for the auth decision first — never collect or have the patient sign a waiver on an unconfirmed service. (See the Hard Rule.)

Day of service (Front Desk)

5. The patient checks in; front desk sees the note and the prepped OHP 3165.
6. For the non-covered service, review it and the estimated cost with the patient, have the patient sign the OHP 3165 before the service, collect the TOS fee, and give the patient a copy.
7. **If the patient declines:** the non-covered service is not performed and nothing is collected.

Roles at a glance

When	Who	What
Day prior	Billing	Verify eligibility, submit/confirm auth where needed, check benefits/policies, prep OHP 3165 for known non-covered services, note appt, send waiver to front desk.
Day of	Front Desk	Review the non-covered service with the patient, obtain the signature before the service, collect the TOS fee, give a copy; do not proceed if unsigned/unpaid.

5. Completing the OHP 3165 correctly

Billing prepares the OHP 3165 ("OHP Client Agreement to Pay for Health Services") before the visit. For a waiver to hold up, every field below must be complete **before the patient signs and before the service is provided**:

- Patient (client) name and OHP/Medicaid ID, DOB.
- Provider/clinic name, signature and date.
- Witness signature, name and date. *(Front office or CA staff obtaining the waiver)*
- A clear description of the specific service or item (and CPT code where known).
- The specific reason it is not covered (e.g., below the funding line / not a covered benefit / prior authorization denied as non-covered).
- The estimated cost the patient will owe. This estimate must not change after signing.
- The statement that the patient understands OHP will not pay and voluntarily agrees to pay, followed by the patient's signature and date. Give the patient a signed copy and retain a copy in the patient record.

6. Records, retention & quick reference

- File the signed OHP 3165 in the patient record; it must be produceable to AllCare, CareOregon, or the Authority on request.
- A new 3165 is required if the fee changes or the service is not performed within 30 days of signature.

DO

- Route x-rays & modalities (ultrasound, combination therapy, cold laser) to the waiver path (known non-covered).
- Verify eligibility and check benefits the day prior.
- Sign the 3165 before the service; give a copy.

DO NOT

- See Medicaid-OR (Open Card) patients at CCHC.
- Provide a service when coverage is unknown or auth is pending — hold and resolve first.
- Bill the patient after a medical-necessity denial on a covered service.
- Provide additional services at a new patient or re-eval appointment (e.g., spinal manipulations).

7. References

- OAR 410-120-1280 — Billing (esp. sections (3), (4), and (5)(h)).
- ORS 414.066 — Billing patient for services covered by medical assistance prohibited.
- OHP 3165 — Client Agreement to Pay for Health Services; OHP 3166 — Pharmacy.
- OHA Prioritized List of Health Services (HERC) and the Benefit & HSC Inquiry tool on the MMIS provider portal.