MEDFORD
Complete Integrative Care
3156 State St., Medford, OR 97504
1296 S Shasta Ave, Eagle Point, OR 97524
(541) 773-9772
(541) 773-1113

EAGLE POINT
Complete Care Health Centers
1296 South Shasta Ave, Eagle Point, OR 97524
3156 State St., Medford, OR 97504
(541) 830-4325
(541) 826-2620

Procedure Title:	Complete Integrative Care – Procedure Coverage, Prior Authorization & Waiver (OHP 3165) Workflow
Date:	07/24/2026
Version:	1.0
Department:	Complete Integrative Care / Prior Authorization / Billing
Approved By:	Cece Carvajal

1. Purpose & scope

This SOP defines how Complete Integrative Care (CIC) determines coverage for procedures performed on OHP patients. The governing rule is simple: **no procedure is performed on an OHP patient until a prior authorization request has been submitted and a coverage determination obtained.**

Applies to

- OHP plans: **Medicaid-OR (Open Card / FFS), AllCare, and CareOregon.**
- All CIC procedures ordered for OHP patients. The Prior Authorization department handles authorizations for all procedures.

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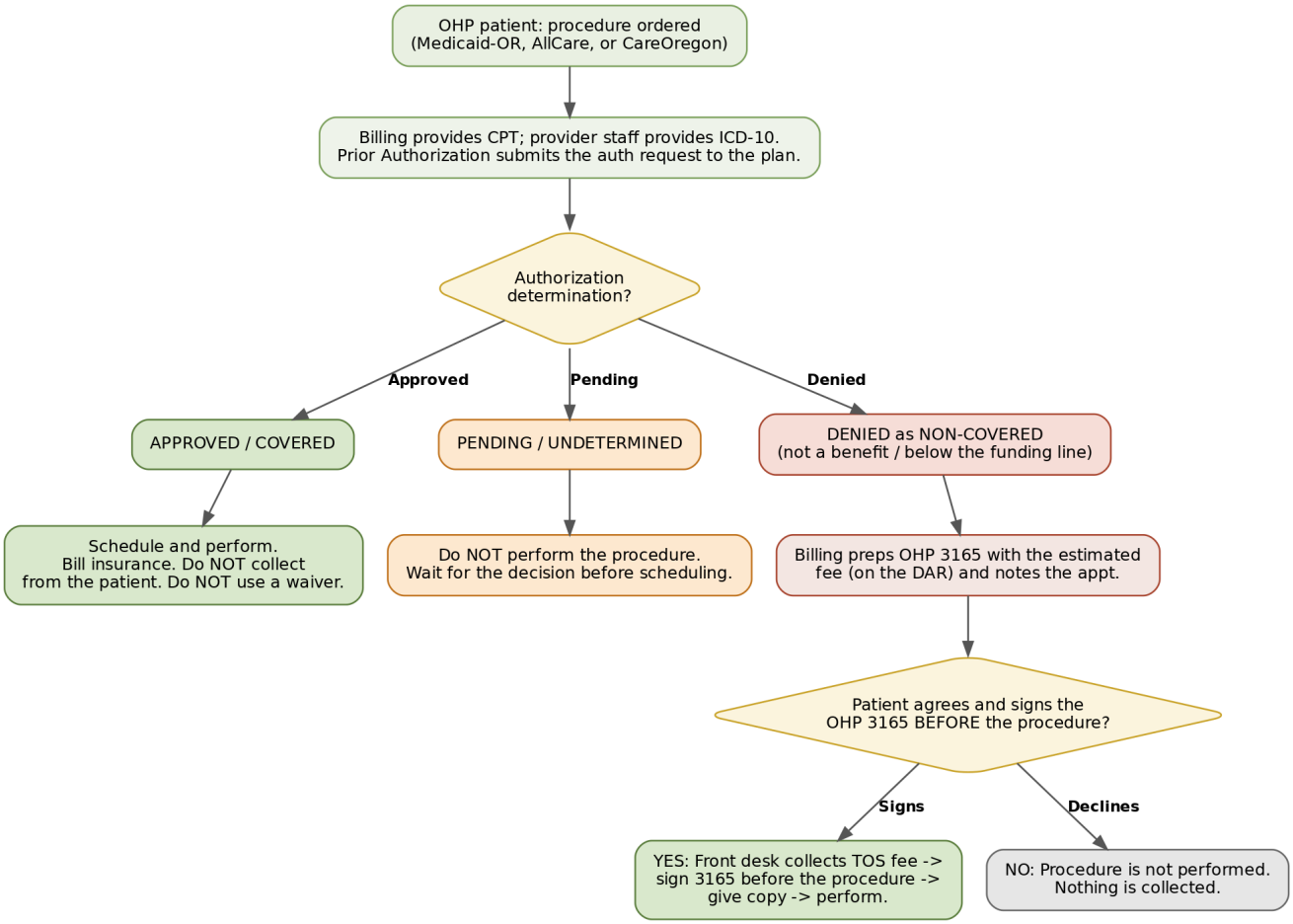
THE HARD RULE — if coverage isn't confirmed, do not provide the service

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.

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 (before scheduling / performing)

1. The provider orders the procedure. Billing supplies the **CPT code**; provider staff supplies the **ICD-10 diagnosis** when needed.
2. Prior Authorization submits the auth request to the patient's plan (AllCare, CareOregon, or Medicaid-OR) and records the determination.

3. Act on the determination:
    - **Approved / covered:** schedule and perform; bill insurance; do not collect from the patient and do not use a waiver.
    - **Denied as non-covered / not a benefit / above the funding line:** this is a confirmed non-covered service → proceed on the waiver path.
    - **Pending / undetermined:** do **not** perform the procedure at all — wait for the decision before scheduling. Never provide it as self-pay under a waiver while the auth is unresolved. (See the Hard Rule.)

Waiver path — confirmed non-covered procedure

4. Day prior (Billing, on the DAR): verify eligibility, confirm the auth/determination is on file, and prepare the OHP 3165 with the estimated fee for any confirmed non-covered procedure the patient has elected. Note the appointment and send the prepped waiver to the front desk to print.
5. Day of (Front Desk): the patient checks in; front desk reads the note, has the patient sign the OHP 3165 before the procedure, collects the TOS fee, and gives the patient a copy.
6. **If the patient declines:** the procedure is not performed and nothing is collected.

Roles at a glance

When	Who	What
Before visit	Billing	Provide CPT code; on the DAR verify eligibility, confirm auth is on file, prep OHP 3165 for confirmed non-covered procedures, note appt, send waiver to front desk.
Before visit	Provider	Provide the ICD-10 diagnosis when needed for the authorization.
Before visit	Prior Auth	Submit the auth request to the plan; record the determination (approved / denied / pending).
Day of	Front Desk	Have patient sign the 3165 before the procedure, 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, OHP/Medicaid ID, DOB.
- Provider/clinic name, signature and date.
- Witness signature, name and date. *(Front office 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.

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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

- Submit an auth for every OHP procedure first.
- Wait for the determination before performing.
- Waiver + collect only on a confirmed denial.

DO NOT

- Perform a procedure while the auth is pending or unknown — wait for the decision.
- Bill the patient for a covered procedure denied for medical necessity or provider error.
- Collect before the 3165 is signed

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.