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Procedure Title:	Laboratory Services – OHP Coverage Verification & Waiver (OHP 3165) Workflow
Date:	07/24/2026
Version:	1.0
Department:	Laboratory / Billing
Approved By:	Cece Carvajal

1. Purpose & scope

This SOP defines how the Laboratory and Billing teams verify Oregon Health Plan (OHP) coverage for ordered lab tests and, when a test is confirmed non-covered, obtain a signed OHP 3165 and collect the time-of-service (TOS) fee before the specimen is drawn.

Applies to

- OHP plans: **Medicaid-OR (Open Card / FFS), AllCare, and CareOregon.**

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

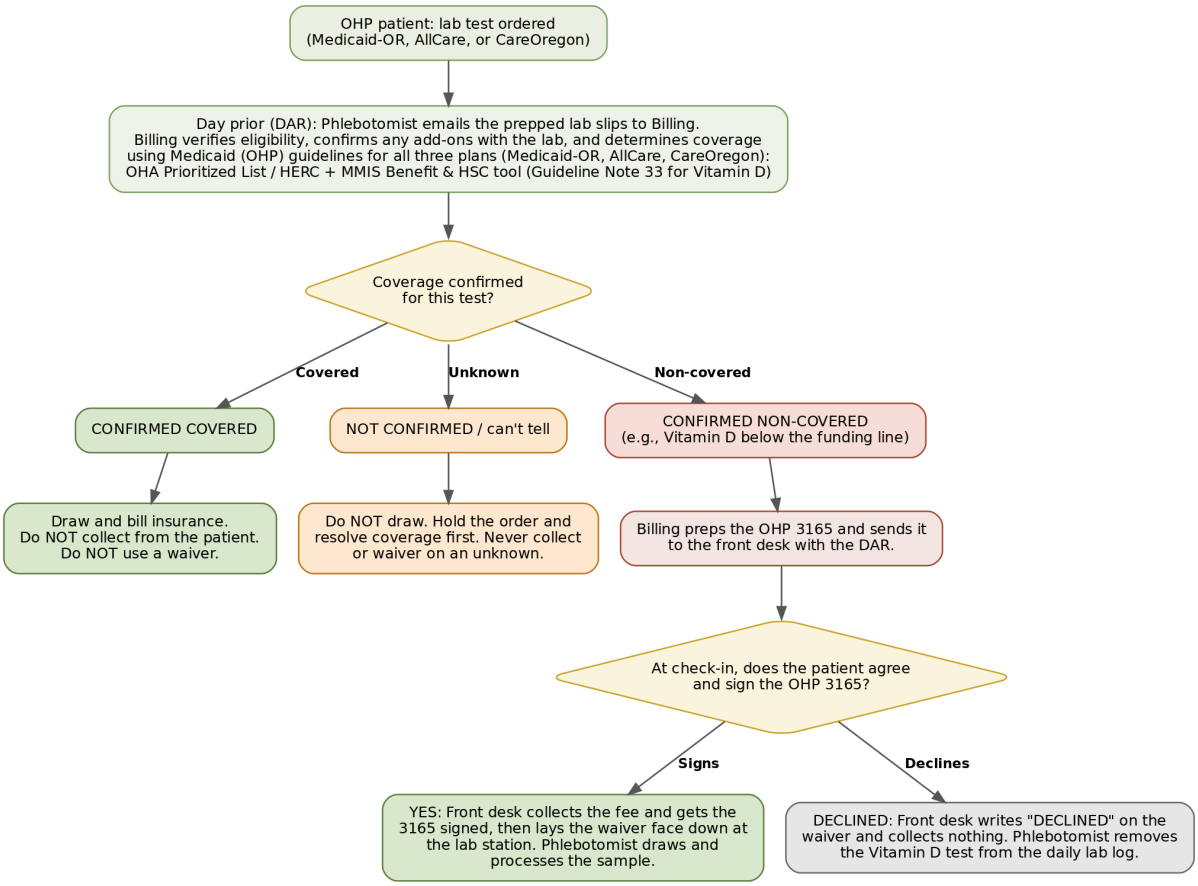
- A waiver is only valid for a service we have **confirmed in advance** is non-covered for that specific patient.
- The OHP 3165 must be signed **before** the service is provided — never after.
- The 3165 is valid only if the **estimated fee does not change** and the service is scheduled **within 30 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.

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

Day prior — Phlebotomist & Billing (on the DAR)

1. The phlebotomist emails the prepped lab slips to billing every day.
2. Billing reviews the prepped lab slips the day prior during the DAR and verifies each OHP patient's eligibility. If there are any add-ons, billing reaches out to the lab to confirm which labs will be drawn.

   Determine coverage for each ordered test using the same **Medicaid (OHP) guidelines for all three plans** — Medicaid-OR, AllCare, and CareOregon:

   - Check the OHA Prioritized List / HERC line and the Benefit & HSC Inquiry tool on the MMIS provider portal. Guideline Note 33 governs Vitamin D coverage.
3. If the test is **confirmed covered**: the lab is drawn and billed to insurance — do not collect from the patient and do not use a waiver.
4. If the test is **confirmed non-covered** (e.g., Vitamin D below the funding line): billing preps the OHP 3165 with the estimated fee and the lab(s) that will not be covered.
5. If coverage **cannot be confirmed either way**: do **not** draw the test. Hold the order and resolve coverage first — never collect or have the patient sign a waiver on an unconfirmed test. (See the Hard Rule.)
6. Billing sends the prepped waivers to the front desk daily, together with the DAR.

Day of service — at check-in (Front Desk)

7. At check-in, the front desk presents the OHP 3165 to the patient and explains which lab(s) will not be covered.
8. The patient decides whether to have the lab(s) drawn:
    - **If the patient agrees:** they sign the OHP 3165 and the front desk collects the fee for the lab(s).
    - **If the patient declines:** the front desk writes "DECLINED" across the waiver and does not collect any fees.
9. Once check-in is complete and the decision is made, the front desk gives the waiver to the phlebotomist at the lab station — lay it **face down** on the workstation.
10. The phlebotomist acts on the patient's decision from check-in:
    - **If the patient agreed:** draw and process the sample.
    - **If the patient declined:** remove the Vitamin D (non-covered) test from the daily lab log and do not draw it.

> **Same-day add-ons after the DAR**
>
> If any additional OHP labs are added on **after the DAR**, they **cannot** be added without speaking with billing first. Billing must confirm coverage before the lab is drawn — no exceptions.

Roles at a glance

When	Who	What
Day prior	Phlebotomist	Email the prepped lab slips to billing every day.
Day prior	Billing	Review the prepped lab slips on the DAR, verify eligibility, confirm any add-ons with the lab, determine coverage, prep the OHP 3165 for non-covered labs, and send the waivers to the front desk with the DAR.
Day of (check-in)	Front Desk	Present the 3165 at check-in and explain the non-covered lab(s). If the patient agrees: obtain the signature and collect the fee. If the patient declines: write "DECLINED" on the waiver and collect nothing. Place the waiver face down at the phlebotomist's lab station.
Day of	Phlebotomist	If the patient agreed, draw and process the sample. If the patient declined, remove the Vitamin D (non-covered) test from the daily lab log — do not draw.

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 at check-in obtaining the waiver)*
- A clear description of the specific service or item (e.g., "Vitamin D Lab, CPT 82306").

- 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

- Phlebotomist: email the prepped lab slips to billing every day.
- Confirm coverage on the DAR the day before.
- Front desk: present the 3165 and collect the fee at check-in.
- Place the waiver face down at the lab station after check-in.

DO NOT

- Draw any test when coverage is not confirmed — hold and resolve first.
- Draw a non-covered test without a signed 3165 and paid fee.
- Draw or process a lab before the front desk has delivered the waiver to the lab station.
- Bill the patient after a "not medically necessary" denial on a covered test.

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.