

State Managed Services Program



Program Instructions & Request Form

The following information highlights the State Managed Service program policies and Request Form instructions. However, it is recommended that you read the State Managed Services Program, Policies and Procedures for complete information on the program's requirements. www.healthoregon.org/hiv

SMS Services:

The State Managed Services program assures equal access for clients living within the Part B service area to services that are otherwise impossible for local jurisdictions to financially provide to clients. The SMS program will pay up to the authorized funding amount for Dental Services, Mental Health Services, Substance Abuse Treatment and Home Health Care (see Request Form for capped funding amounts).

Eligibility:

Clients are eligible for State Managed Services if they are assessed and found to be eligible for local support services in accordance with the HIV Case Management Standards of Service. Requested services must meet the service definitions as described in the HIV Case Management and Support Services Program, Program Policies, Services Definitions and Guidance.

Request for State Managed Services:

A completed "Request Form" must be submitted to the State Managed Services Program by an HIV case manager. All information is required before we will process and authorize this request.

If you are requesting more than one service, please use a separate form for each service requested. Make copies of the request form as necessary or you can download additional forms at www.healthoregon.org/hiv.

→ For Dental Services Only:

In order to guarantee equitable access to a highly utilized service, each county will receive a Dental Services funding allocation (allocated and tracked by the HIV Care and Treatment Program, Fiscal Coordinator). HIV Case Managers will be responsible for assessing client needs and prioritizing services based on the needs of the agency caseload. All requests will be drawn from the agency's Dental Services Funding Allocation; approving extensive services for one client will reduce the number of available funds for all clients served by the agency. Unlike other State Managed Services, you may also use local support service funds to assist with oral health care

costs (see Program Policies, Services Definitions and Guidance document for more information).

A dental treatment plan must be received by the SMS-Payment Processor before services will be authorized. The SMS program will pay up to \$300 for the initial assessment resulting in a Treatment Plan. The assessment must be approved separately from the approval for the actual service. The service will not be authorized until the program receives the services/treatment plan. In this case, the case manager will receive two Service Authorization forms (one for the assessment and then one for the service) but an additional application to SMS is not necessary.

→ ***For Mental Health, Substance Abuse Treatment and Home Health Services Only:***

A Service Plan form must be received by the SMS-Payment Processor before services will be authorized. The SMS program will pay up to \$300 for the initial assessment resulting in a Service Plan. The assessment must be approved separately from the approval for the actual service. The service will not be authorized until the program receives the services/treatment plan. In this case, the case manager will receive two Service Authorization forms (one for the assessment and then one for the service) but an additional application to SMS is not necessary.

Service Authorization:

Within two days of receiving a completed Request Form, the SMS-Payment Processor will send a "Funding Authorization" form indicating whether the requested service was accepted or denied. If the Request Form is not complete, the SMS-Payment Processor will send back a "Request For Additional Information".

Service Expiration Date:

All Service Authorizations are valid between July 1, 2009 and June 30, 2010, beginning with the authorization date. All authorizations expire on June 30, 2010.

Invoice Requirements:

SMS services are intended to address an emergent service need. Therefore, it is expected that SMS services would begin immediately after authorization is received. Invoices for service(s) must be received within 90 days from the date of authorization. If the invoice is not received within 90 days, the authorization will be cancelled and the case manager will be notified. The service provider must include their Federal Tax Identification Number on their invoice(s) unless VISA is accepted as a payment method. If the primary insurance provider is billed first, the provider must submit an Explanation of Benefits (EOB)/Summary of Benefits (SOB)/Medicare Summary with the invoice(s).

Changes in Services Provider:

If more than one provider will be used for the same service please remember that ALL service providers must be authorized by the SMS Program. For changes during mid-service, you should submit the additional service provider for authorization by submitting a Request Form and marking the "Yes" check box that asks "Is this an UPDATE to a previously authorized request?" In this case you will only need to complete questions 1, 2, 7 and 8. An email will be sent to the requesting case manager by the SMS Program indicating that the revision was received. The services cap is applied to the client, and is not based on the number of authorized providers. The HIV Case Manager is responsible for assuring that the client and the service providers understand that they are sharing a single maximum service capped amount. The program will only pay up to the authorized services capped amount on a "first-billed first-paid" basis, and will not pay invoices over the authorized maximum amount.

Data Entry Requirement:

Do not enter the service requested into CAREWare. However, you should enter the case management time to facilitate access to SMS in CAREWare.

SMS Will Not Pay For:

- Any service provided that does not meet the definition outlined in the "HIV Case Management and Support Services Program, Program Policies, Services Definitions and Guidance" document.
- Any service provided before the funding approval date.
- Any dollar amount that exceeds the identified service "cap" authorized.
- No-show appointment charges when the client does not show up for the appointment.
- Contractual adjustment fees charged by the provider after primary insurance.
- Services requests for a family member of the requesting case manager.

Request Form Instructions:

Please print legibly. Mark the check box indicating whether or not this is an update to a previously authorized request.

1. CLIENT NAME: Provide your client's name.
2. DATE OF REQUEST: Write in the date of this request.
3. a. FUNDING REQUESTED FOR: Check the box that indicates the service you are requesting for your client.
3. b. Check the box that indicates whether you are requesting funds for the initial assessment in order to obtain a treatment/service plan. If payment for an initial

assessment is requested for Mental Health, Substance Abuse or Dental Services the assessment must be received by the program before the service will be authorized. In this case the case manager will receive two Service Authorization forms, one for the assessment and one for the service.

4. If the service requested is for dental services mark the appropriate box indicating the Dental Acuity level. The Dental Acuity level will be found on the most recent Acuity performed.

5. Indicate whether the client has another insurance provider that would pay a portion of the requested service. If the answer is "Yes" list the insurance provider(s) and indicate whether they will pay a portion of this requested service. *Due to the Mental Health Parity Act mental health and substance use treatment services are covered by most insurance plans. Ryan White funds are the funds of last resort and must be utilized after insurance coverage. Remember- Oregon Health Plan (Medicaid) and Medicare are insurance providers. The Oregon Health Plan will cover Mental Health, Substance Abuse Outpatient and Emergency Dental Services.*

6. Indicate whether there is a Federally Qualified Community Health Clinic, Community Health Clinic, Dental Clinic or other community resource in your service area where the client could receive this service? If the answer is yes, and the service is not being performed by this provider, please explain in detail why.

7. Complete the contact information for the service provider identified. Indicate whether this service provider will accept VISA® as a method of payment or not. Visa® is the preferred method of payment for the program. Please make sure to ask the provider if they will accept VISA®.

8. Please read the statement and complete all of the case manager contact information.

9. Tier 1 providers must receive approval from the HIV Alliance Clock Tower Dental Clinic Coordinator prior to submitting this application. Tier 1 includes those providers served through the HIV Alliance Clock Tower Dental Clinic. The Clock Tower Dental Clinic provides free comprehensive dental care to persons living with HIV/AIDS in a 15 county area. <http://www.hivalliance.org/dentalclinic.html>. Please contact the Dental Coordinator at 541-342-5088. Tier 1: Benton, Coos, Crook, Curry, Deschutes, Douglas, Harney, Jackson, Jefferson, Josephine, Klamath, Lake, Lane, Linn and Malheur.

**Fax the request form to: 971-673-0177
Attention: SMS**

If you have any questions please call Karen Smith at 971-673-0084.