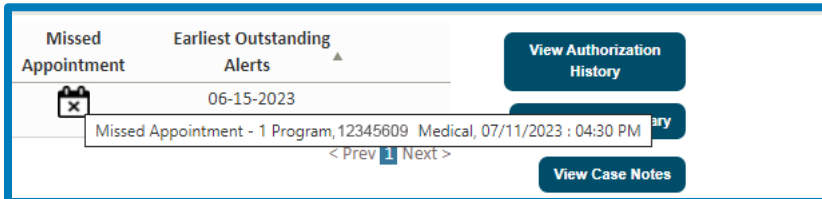


Case Manager Steps to Take Before Marking Alerts as Complete

Before completing any of the steps below, hover over the alert icon in ONE to see the tool tip with more information about the alert. This information includes the effective date of the change that triggered the case alert. This date is helpful when reviewing the case for more details about the alert.

See the example below, in this case the individual missed an appointment that was scheduled for their medical benefits. Look at the case to see why the individual needed the appointment in July and if they have rescheduled or completed an appointment since this date. Review ongoing service benefits for any Notice Reasons or RFIs that may cause benefits to close.



Alerts are list below in the order they should be worked, from highest priority to lower priority.

Benefit Termination

1. Use View Authorization History to see when the medical TOA is ending and why the case is closing
2. Call the individual to discuss the case and program requirements*(for example income/resources)
3. Coordinate the end date for the service benefit/plan and send timely notice for the closure. See [APD-AR-23-017](#) for closure information and dates.
4. Evaluate or refer individual to other programs as appropriate (for example OPI or ADRC)
5. Narrate in Oregon ACCESS

*See the [Medical Denials and Terminations with Long-Term Services and Supports Report QRG](#) for more details on what to do based on the reason for the termination.

Pending for Service Eligibility (for ongoing case)

1. Review current service plan and ONE for medical eligibility
2. Request service benefit extension if unable to complete CA/PS assessment before service benefit end date
3. Complete CA/PS assessment
4. Check ONE to make sure the medical and service TOAs are approved and authorized
5. Set up the service plan with the correct start date and authorize provider payment (512, 546N, POC)
6. Send SPAN as required – refer to [SPAN flowchart](#)
7. Review and authorize Special Needs/Medical Related Payments (MRPs) as necessary
8. Narrate in Oregon ACCESS

Disqualifying Transfer Penalty

If individual is a new applicant for long term care services:

1. Review View Disqualification hyperlink on Eligibility Summary screen in ONE.
2. Complete the CA/PS assessment. A disqualifying transfer penalty cannot be served unless the individual meets all the financial and non-financial eligibility requirements, including nursing facility level of care SPL 1 – 13.
3. Follow local process to notify eligibility worker of the assessment results.
4. Depending upon length of disqualification in ONE, you may be able to approve the service benefit with service begin date of the day after disqualification ends.

If individual is currently receiving long term care services:

1. Review View Disqualification hyperlink on Eligibility Summary and/or Authorization History screens in ONE.
2. Close services effective day before the disqualification starts.
3. Close service payment authorization effective day before disqualification starts.
4. Remind individual that they may need to contact ODHS to reapply for medical/services.

Liability Change

1. Review Patient Liability Summary

- If the individual is in a Community Based Facility (CBF), update (touch) the 512
- If the individual is in a NF, check MMIS to make sure the liability updated as expected

2. Narrate in Oregon ACCESS

Note: With liability changes, ONE will send out a Notice of Eligibility with the calculated client obligation. If the case is Cost of Care, the case manager will need to send a 541 Notice of Eligibility and Responsibility with the correct amount the individual is required to pay.

Medical TOA Transition

1. Review Authorization History to see what changed

2. Review SELG record, update to match service TOA in ONE

- If, MAGI TOA->NMAGI TOA:
 - 1) End current service benefit/plan and create a new one with compatible service TOA (new SELG record)
 - 2) If CBF, update (touch) 512 and review 512 for liability
 - 3) If the individual is in a NF, check MMIS to make sure the liability updated as expected
 - 4) Review for Special Needs/MRP eligibility and update ONE as applicable
- If NMAGI TOA->MAGI TOA:
 - 1) End current service benefit/plan and create a new one with compatible service TOA (new SELG record)
 - 2) Update/ Touch 512 (no liability) and review for no liability
 - 3) If the individual is in a NF, check MMIS to make sure the liability updated as expected
 - 4) Review OSIPM Special Needs/Medical Related Payments and make sure all have end dates in ONE
- If Service TOA transition
 - 1) Review service TOA and see if the SELG record needs to be updated
 - 2) See Medical TOA Transition above
 - NMAGI->LTCSEV, no action needed
 - MSERV->NMAGISERV, create SELG
 - NMAGISERV->MSERV, create SELG

3. Narrate in Oregon ACCESS

Incompatible TOA (for Medical Related Payments)

1. Review Authorization Summary to see what changed
2. Review Special Need Payments/MRPs and end Special Need Payments/MRP to match end date of compatible TOA
3. If necessary, override the Special Need Payments/MRPs to allow for timely notice
4. Narrate in Oregon ACCESS

Change in Address / Living Situation

1. Update Oregon ACCESS using the download tab on the IE/ME information screen
2. Update service benefit/plan, if necessary, by ending the current service plan effective the day before the move and starting new service plan effective the date of the move
3. Update other systems as necessary:
 - If in CBF setting, touch or create a 512
 - If in a Nursing Facility (NF), create a Plan Of Care (POC) if one has not already been created and enter a line item in the Medicaid Management Information System (MMIS)
 - If In Home Care (IHC), send out a new task list
4. Narrate in Oregon ACCESS

Medical Renewal

1. When making direct contact with individuals, remind them they have a medical review due
2. Offer to connect them with an eligibility worker or support staff
3. Narrate in Oregon ACCESS

Missed Appointment

1. Review the tool tip to see if the missed appointment was for a medical program or for SNAP (or another program). A missed appointment may impact eligibility and provider payments.
 - Check if the renewal or RFI due date is within 30 days. If within 30 days, reach out to the individual as soon as possible to make sure they reschedule the appointment, so they do not potentially lose benefits.

- If the renewal or RFI due date is more than 30 days out, remind them to reschedule the appointment during your next contact with them. Also remind them that they may receive mail and/or phone calls from department requesting information and it is important to respond. If they do not respond their benefits can close.

2. Narrate in Oregon ACCESS.

Pending Case

1. When making contact with the individual, remind them that they may receive mail and/or phone calls from department requesting information and it is important to respond. If they do not respond their medical and service benefits can close.
2. Narrate in Oregon ACCESS

Important Reminder:

Case Managers should check for alerts in ONE daily.

This document was created by [APD Medicaid Financial Eligibility Training](#). Please contact us with any questions or clarification needs.