Tulsa Medical Access Programs

Medical

Virtual Voucher

Handbook

Last Revised: January 2025

Ascension St. John

Strengthening our community

Tulsa Medical Access Programs Overview

The Tulsa Medical Access Programs (MAP) are strategies to improve access to care in the Tulsa community by ensuring low-income and underserved populations have access to healthcare and mental health services. This is done by supporting the operation of the safety net clinics in Tulsa, funding allied health organizations including mental health, giving virtual vouchers to eligible patients to receive diagnostic and specialty care, providing medications through Dispensary of Hope at no cost to eligible patients and coalescing community members quarterly to improve organizational relationships.

This program addresses the needs of uninsured adults aged 18-64 in the Tulsa area by providing access to acute medically necessary diagnostic and specialty care services. Eligible patients are those who receive primary care in the community's safety net clinics, i.e. clinics serving uninsured
patients at no charge or on an income-based sliding fee scale. This program particularly focuses on helping patients address critical health issues.

How MAP's Voucher Program Works

Safety net partner clinics use MAP's online system to request a referral authorization for each service. If approved, the clinic provides the referral and authorization number to the appropriate scheduling source (e.g. Ascension St. John Central Scheduling or the specialist office), who then contacts the patient. MAP receives and pays the resulting bill. The referring clinic acts as the patient's medical home, coordinating all care and managing the patient's health outcomes.

Patient Eligibility Criteria

1. Patients must be at least 18 and not yet 65 years of age and/or Medicare, social security disability eligible.
    a. Patients under 18 are typically Medicaid eligible
    b. Clinics are encouraged to talk to patients turning 65 and enroll in Medicare

2. Patients must reside within approved zip codes as listed in Appendix A. Post Office boxes or work addresses are not accepted. Approved zip codes are generally within Tulsa County plus those with proximity to Ascension St. John community hospitals in Sapulpa, Owasso, and Broken Arrow.

3. Patients must be currently uninsured, and ineligible for Medicaid less predefined exclusions[1] with household income of less than 250% of the Federal Poverty Level (FPL). Patients must report their income and uninsured status on an eligibility form. Failure to provide complete and accurate information may result in a denied request.

4. MAP uses MyHealth and the Oklahoma Health Care Authority websites to check for medical history and Soonercare coverage.

[1] Exclusions include those that are unable to sign up for Medicaid because of conflicts with child support, have severe cognitive impairment or mental illness and cannot successfully navigate Medicaid.

5. Patients must be established at and receive primary care from an approved safety net clinic listed in Appendix B, usually defined by two visits to the provider; phone calls from the provider do not count as a visit. Patients are strongly encouraged to remain with the same provider for continuity of care.

6. Patients must demonstrate compliance with medical recommendations, including keeping appointments, maintaining medications and dietary regimes, and following other directions indicated by the primary care provider. Patients who exhibit chronic non-compliance may have future authorizations denied.

7. Patients needing services beyond diagnostic assessments and lab work are required to be screened by Tulsa Healthcare Coverage Program prior to the authorization's approval.

Voucher Program Policies (Medical)

1. It is not intended as a payer source for self-pay patients at providers outside the MAP network. MAP authorizes services on an episodic basis.

2. MAP covers the cost of specific services not available at the safety net clinic, such as diagnostic testing, specialist consultation, and specialist intervention for acute medically necessary procedures.

3. Original requests for assistance must come from an approved safety net clinic. Specialists (including dental specialties) may submit subsequent requests for additional testing, interventions or prosthodontics.

4. Emergency Departments (EDs) are not authorized MAP referral partners. Emergency Department visits for established MAP patients may be covered if reported to the MAP Clinical Coordinator prior to sending the patient to the Ascension St. John emergency department. Authorization requests must be submitted within 24 hours from the original phone call.

5. MAP is not insurance. Each request for service requires an authorization. Payment is made only for pre-authorized services. In no case will MAP pay for services without prior authorization unless those services are considered by standard medical practice to be of reasonable expectation, such as anesthesia and pathology for approved surgeries.

6. MAP authorizations are active for 60 days. Authorizations may be extended at the discretion of the clinical coordinator.

7. MAP provides coverage for acute conditions and exacerbations of a chronic condition. Specialist care is generally only covered for 12 months of care or once the condition requires return visits every 6 months. At that time, return visits become the patient's responsibility through self-pay, charity care, or other financial means.

8. MAP does not cover chronic pain conditions or pain management. Exceptions may be made at the discretion of MAP's Clinical Coordinator in extenuating circumstances.

9. Patients accepted by Project TCMS can have their necessary workups covered by MAP.

10. This program does not cover substance abuse, mental health treatment, transplant services, prenatal care, pregnancy, abortion or fertility treatment.

11. MAP will not cover ongoing maintenance of stable chronic conditions.

12. "Family history of," "Patient requests," or "Other providers recommended" are not valid reasons for MAP coverage.

13. MAP is designed to supplement, not supplant, existing resources. MAP will generally not approve requests for services that are available through other charity programs.

14. Physicians, surgeries, procedures, and ancillary services are paid only to entities under contract with MAP. The authorization will indicate who will render services and where they will be rendered.

15. Authorizations through MAP for specialty care will be limited to one specialist at a time. If a patient has multiple needs to be addressed by different specialists, please contact the clinical coordinator for special consideration.

16. MAP payments follow Medicare guidelines, regulations, and rates.

17. MAP staff do not work with any patient or patient family directly. Physicians and their staff may contact MAP staff to discuss service-related issues.

Primary Care Clinic Responsibilities

1. The clinic is responsible for verifying a patient's uninsured and low-income status using the Eligibility Verification form in Appendix C. Proof of income is generally not required, but MAP staff reserves the right to request documentation at any time. This form must be completed *every 6 months*.

2. This program encourages a screening from Tulsa Healthcare Coverage Program (THCP) every 6 months and as needed but requires completion prior to authorizing specialist care.

3. The clinic must submit referral requests with the Eligibility Verification form and provider notes through www.Tulsa-MAP.org.

4. Annual training is required to maintain website access.

5. PCP clinics are responsible for maintaining the relationship with the patient including ongoing communication related to their MAP coverage.

6. Diagnostic testing can be requested at the patient's first visit to the PCP. However, no referral for a specialist consultation is appropriate without a THCP screening, recent relevant workup ordered and reviewed by the PCP in accordance with the specialist's requirements.

7. Since MAP may only pay entities under contract, primary care clinics must take care to consider the patient's possible treatment path when requesting a referral. For example, MAP is not able to pay for procedures performed at hospitals other than Ascension St. John. Nor will MAP pay to redo diagnostic testing at a MAP partner that has already been conducted by a non-MAP partner.

8. Providers must attach documentation reflecting the serious, acute, medically necessary issue requiring MAP assistance. Documentation must be signed by the provider authorized to order medical services per state licensure. Student requests must be co-signed by the attending provider.

9. The clinic is responsible for monitoring the website for the response to the request. Responses are posted within 3 business days. If the clinic has not received a response, they are to email the clinical coordinator.

10. Should a patient receive a bill for an authorized service, the clinic shall contact the MAP claim's specialist as soon as possible and submit a copy of the bill to the MAP office.

Specialist Clinic Responsibilities

1. If a MAP patient requires additional specialist services beyond the first consult visit, the specialist's office *must* submit a request via the website for MAP to cover any subsequent services. Patients are told in good faith their specialty care will be covered by MAP; *specialists who provide additional services without requesting MAP approval in advance will not receive payment from MAP and should not bill the patient.*

2. MAP will cover an assisted surgery in accordance with Medicare guidelines and subject to prior approval.

3. The specialist's initial contact with the patient must be through the MAP referral process. MAP will not cover costs for a patient previously seen by the specialist and directed to a MAP referral partner for payment for that same issue.

4. Specialists may not request a diagnostic test at a MAP partner that has already been conducted by a non-MAP partner generally in the last 6 months.

5. MAP legally may only pay entities with which it has a contract. Specialists requesting further services for a patient will be restricted to providers in the MAP network. MAP does not contract with any hospital outside the Ascension St. John Health System.

6. Should a patient require hospitalization as a result of a medical emergency that occurs during the provision of service, MAP can only cover costs at Ascension St. John Medical Center or the Ascension community hospitals in Broken Arrow, Sapulpa, and Owasso.

7. Once stabilized, the specialist must return the patient to the primary care clinic for continuing oversight. MAP may support specialist coverage for up to 12 months or when follow-up visits are being scheduled more than 6 months out.
8. Specialist services available through MAP are listed in Appendix D.

Claims Processing Procedures

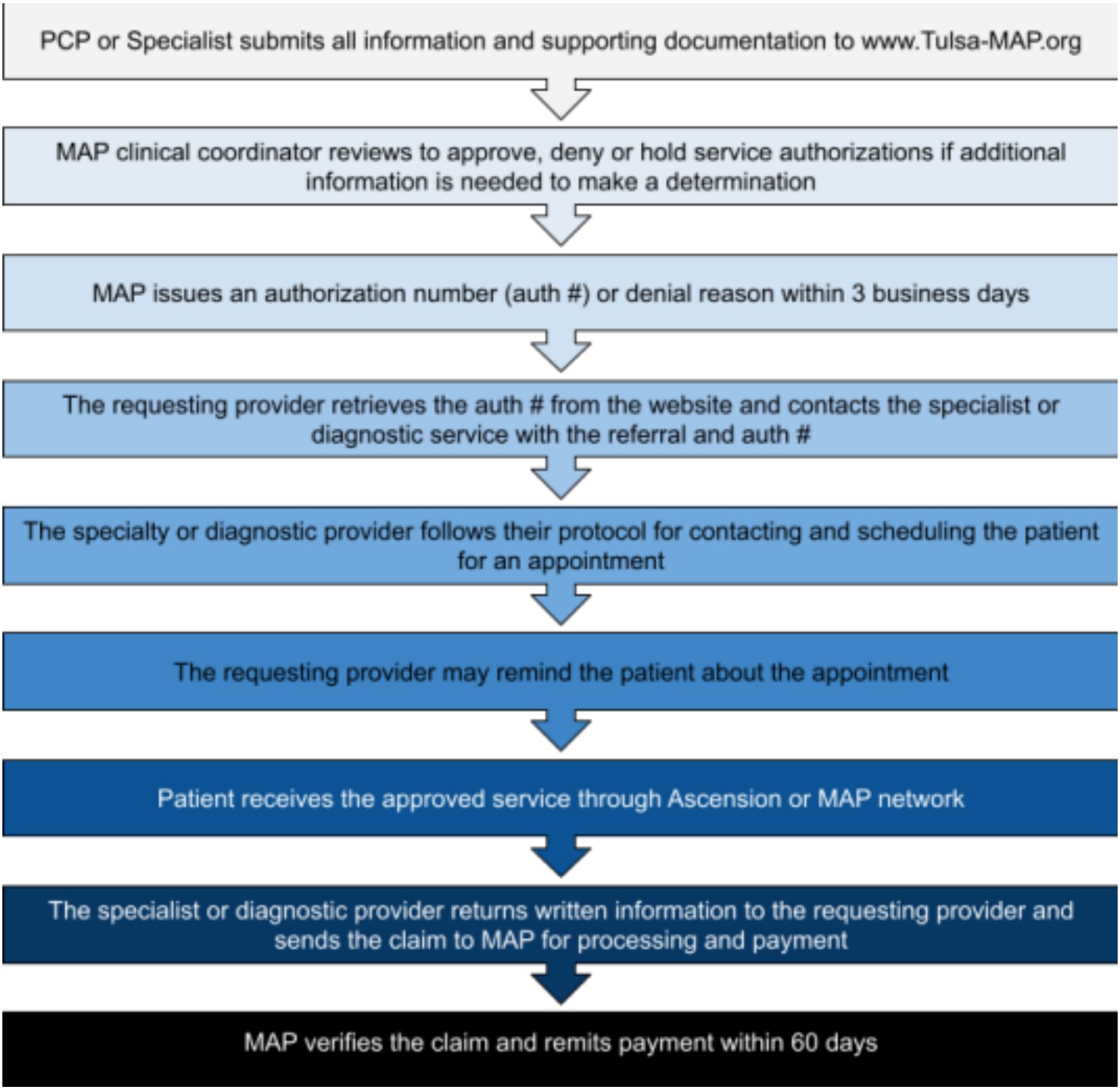
1. Claims for MAP payment must be on Medicare approved form and filled in properly:
    a. Hospital UB04
    b. Outpatient 1500
2. Claims must contain the MAP authorization number provided for the billed service. MAP recommends using the authorization number as the Insurer's unique ID.
3. Providers shall mail properly executed claims to:

    Tulsa Medical Access Programs
    1923 S. Utica Ave.
    Holliman Building, Suite 300
    Tulsa, OK 74104

4. MAP reviews each claim received to ensure:
    a. Correct patient name and demographic information.
    b. Correct authorization number, date(s) of service, and service(s) provided,
    c. That the request originated with an approved requestor and that the service was performed by a contracted provider.
5. Claims will be denied if:
    a. There is no valid authorization on file with the Tulsa MAPs website for the services being billed
    b. The date of service is either prior to MAP approval or after the 60-day authorization period
    c. The service was provided by a non-contracted provider
    d. The claim does not otherwise comport with MAP policies and procedures.
6. If the patient obtained insurance that was in effect on the date of a MAP-approved service, MAP is no longer the appropriate payer. The provider shall bill the insurance, and the patient will be responsible for any copays or deductibles per terms of the insurance coverage. If possible, please notify MAP of the patient's coverage and effective date.
7. MAP never serves as secondary coverage.
8. Approved MAP claims are paid at Medicare allowable rates effective on the date of service identified and for the CPT code listed. Patients are not to be billed for any MAP-approved service.
9. Claims received by the 5th of the month are processed by month's end for payment the following month. MAP generally remits payment within 60 days of claim receipt.

10. Explanation of Benefits (EOBs) are sent separately from payment. EOBs will delineate individual patients, services paid, and services denied (along with denial reason).

MAP Process


PCP or Specialist submits all information and supporting documentation to www.Tulsa-MAP.org
MAP clinical coordinator reviews to approve, deny or hold service authorizations if additional information is needed to make a determination
MAP issues an authorization number (auth #) or denial reason within 3 business days
The requesting provider retrieves the auth # from the website and contacts the specialist or diagnostic service with the referral and auth #
The specialty or diagnostic provider follows their protocol for contacting and scheduling the patient for an appointment
The requesting provider may remind the patient about the appointment
Patient receives the approved service through Ascension or MAP network
The specialist or diagnostic provider returns written information to the requesting provider and sends the claim to MAP for processing and payment
MAP verifies the claim and remits payment within 60 days

Frequently Asked Questions

1. ***Will MAP pay for ongoing health care for patients with chronic illness?*** No, not at this time. MAP covers acute medically necessary issues or exacerbations. With prior approval MAP may cover services to stabilize a patient newly diagnosed with a chronic condition; contact the Clinical Coordinator for guidance.

2. ***Will MAP cover costs for an insured patient who cannot cover their copayment or deductible?***
   No. Currently MAP is available only to persons who do not have any insurance, including Soonercare. If, after a screening with the Tulsa Healthcare Coverage Project (THCP) it is determined that the patient is eligible to purchase insurance but cannot afford the premiums, the patient may be considered for MAP eligibility.

3. **Will MAP require someone to sign up for Medicaid if they're eligible?** This program is intended for those that are ineligible for insurance. If we find that the patient is eligible for Medicaid, we will strongly encourage them to sign up and provide coverage only until Medicaid coverage begins. If someone is eligible but meets certain exceptions related to alimony/child support and mental illness needs, we will evaluate for an exception to coverage.

4. ***How does MAP determine a patient's age?***
   MAP follows Medicare protocols, which set the patient's age at the beginning of the birth month. A patient turning 18 in the same month as the date of service is eligible for MAP. A patient turning 65 in the same month as the date of service is not.

5. ***What does "established patient" mean?***
   A patient is considered established once the clinic has taken "ownership" of the patient's primary care. This might entail at least two in-person visits by the patient; or it might entail a visit followed by diagnostic screenings that are reviewed and acted upon by the primary care clinic. MAP only authorizes specialist consults for patients established at a primary care partner in Appendix B.

6. ***What is a "medical home?"***
   A medical home is a source of ongoing care. MAP supports its clinic partners as medical homes who are responsible for managing and coordinating the overall care of their patients.

7. ***What does "requesting provider" mean?***
   The requesting provider is either an authorized provider at an approved referral clinic per Appendix B or an approved specialist seeking additional services for the patient through MAP.

8. ***I am a provider with an affiliation with a hospital other than Ascension St. John and work with other providers not currently part of MAP. If needed, can I send my MAP-eligible patient to my other affiliation and bill MAP?***
   No. MAP can only pay for services provided through an Ascension St. John facility or other contracted provider. Any services provided by a non-contracted provider will not be paid. Contact the Clinical Coordinator for guidance before submitting any requests. All providers MAP contracts with must have an exhibit B signed by the provider.

9. ***I am a specialty provider seeing a self-pay patient. Can I refer my patient to a safety net clinic so that MAP can pay my patient's bills?***
   No. MAP generally will not cover services for a treatment or condition that has been treated within the past 6 months.

10. ***What do I tell my patient if they receive a bill on accident?***
The patient needs to send or bring a copy to the clinic and the clinic can verify the authorization of services and coordinate with the MAP claims specialist to have the bill paid timely. If the bill is from a specialist that is not contracted with MAP, the clinic and patient need to address why they went there for services and the patient will be responsible for care rendered.

11. ***How does MAP handle emergency room visits?***
The clinical coordinator must be called prior to the ER visit for coverage to be considered. MAP will generally cover ER visits directed by the primary or specialty provider if the clinical coordinator was notified and an authorization request is submitted within 24 hours. MAP can only pay for ER visits to Ascension St. John Medical Center, Broken Arrow, Sapulpa, and Owasso.

12. ***Does MAP cover women who are covered by Soon-to-be-Sooners?***
Not at this time. We cannot cover patients with alternative coverage even if their coverage is limited in scope. Once the patient's status is 'uninsured' they become eligible for MAP coverage.

Appendix A - Approved Zip Codes as of January 2025

Zip	City	County
74008	Bixby	Tulsa
74011	Broken Arrow	Tulsa
74012	Broken Arrow	Tulsa
74014	Broken Arrow	Wagoner
74015	Catoosa	Rogers
74021	Collinsville	Tulsa
74033	Glenpool	Tulsa
74037	Jenks	Tulsa
74039	Kellyville	Creek
74041	Kiefer	Creek
74044	Mannford	Creek
74047	Mounds	Tulsa
74055	Owasso	Tulsa
74063	Tulsa	Tulsa
74066	Sapulpa	Creek
74070	Skiatook	Osage
74073	Sperry	Tulsa
74103	Tulsa	Tulsa
74104	Tulsa	Tulsa
74105	Tulsa	Tulsa
74106	Tulsa	Tulsa
74107	Tulsa	Tulsa
74108	Tulsa	Tulsa

Zip	City	County
74110	Tulsa	Tulsa
74112	Tulsa	Tulsa
74114	Tulsa	Tulsa
74115	Tulsa	Tulsa
74116	Tulsa	Tulsa
74117	Tulsa	Tulsa
74119	Tulsa	Tulsa
74120	Tulsa	Tulsa
74126	Tulsa	Tulsa
74127	Tulsa	Tulsa
74128	Tulsa	Tulsa
74129	Tulsa	Tulsa
74130	Tulsa	Tulsa
74131	Sapulpa	Creek
74132	Tulsa	Tulsa
74133	Tulsa	Tulsa
74134	Tulsa	Tulsa
74135	Tulsa	Tulsa
74136	Tulsa	Tulsa
74137	Tulsa	Tulsa
74145	Tulsa	Tulsa
74146	Tulsa	Tulsa

Appendix B - Approved Referral Clinics as of January of2025

- A&M Healthcare
- Arubah Community Clinic
- Community Health Connection
- Crossover Clinic
- CURA Medical Clinic
- Good Samaritan Health Services (includes The Dream Center, Asbury and the mobile clinics)
- Morton Comprehensive Health Services
- Neighbors Along the Line
- OSU Health Care Center
- OU Bedlam Evening and Longitudinal Clinics
- OU Primary Care Clinics at Tisdale
- Square One Clinic
- Tulsa County Social Services
- Tulsa Day Center
- Trujillo Multi-Healthcare
- Youth Services of Tulsa - CHC Clinic