Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Provider Guide

Supplemental information for Oregon Medicaid providers

- Prior authorization
- Billing instructions and forms
- PA contacts, forms, cover sheet
- Electronic billing / EDI

Revised 11/1/2011

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NOTE: DMAP provides the Information and instructions contained in this booklet as a supplement to the program policies found in the current DMEPOS Oregon Administrative Rules (Chapter 410 Division 122). See current DMEPOS rulebook for official policies regarding billing.

Prior authorization

How to request prior authorization (PA)

For clients enrolled in an OHP managed care plan, contact the plan for their PA procedures. For OHP fee-for-service ("open card") clients, use the following contact information:

Use the DHS 3971 form or the Provider Web Portal to submit PA requests. For information on how to submit PA requests using the Provider Web Portal, go to www.oregon.gov/OHA/healthplan/webportal.shtml#authorization.

Submit documentation for PA requests using the following fax numbers:

- Routine requests: 503-378-5814
- Immediate/urgent requests: 503-378-3435

Fax required documentation accompanied by the EDMS Coversheet (DHS 3970). See Forms section for sample forms and instructions.

If you have questions about how to request PA, contact the appropriate office below.

DMAP – Medical Management Unit
500 Summer St NE, E44
Salem, OR 97301-1078

503-945-6821 (direct)
800-642-8635 (in-state only)

Client eligibility and enrollment

DMAP will automatically deny prior authorization requests for clients who are not eligible on the date of service or enrolled with an OHP managed care plan. To avoid this, verify client eligibility and enrollment before requesting PA.

To determine client eligiblity and enrollment, verify with one of the following. For more information about these options, go to www.oregon.gov/OHA/healthplan/tools_prov/electronverify.shtml.

- Automated Voice Response (AVR): Call 866-692-3864. A quick reference for verifying client eligibility via AVR is available on the DHS/OHA Web site at https://apps.state.or.us/Forms/Served/OE3162.pdf.
- Provider Web Portal: Go to https://www.or-medicaid.gov.
- 270/271 transaction: Available to approved Electronic Data Interchange (EDI) providers. See page 10 for more EDI information.

Role of Assistive Technology Professional in PA documentation

The Assistive Technology Professional (ATP) provides specific technical information to support the evaluating clinician (PT, OT, NP, MD, or DO)'s recommendations for DME equipment that requires PA.

The ATP does not perform the specialty evaluation. Instead, the ATP recommends options, based on the order and evaluation, that lead to the selection of appropriate and available equipment.

Wheelchairs (WCs)

PA requests for manual WCs (410-122-0320), power WCs (410-122-0325) and pediatric WCs (410-122-0720) must include the following documentation.

- An order and related progress notes from a licensed clinician (DO, MD, NP).
- A specialty evaluation report from a PT, OT, NP, MD, or DO *who has specific training and experience in rehabilitation and WC assessments/evaluations*. DMAP will not accept reports from Assistive Technology Professionals (ATPs) in place of this specialty evaluation.

Combined, the information in the specialty report and clinician's order/progress notes must include at a minimum all of the following:

1. Medical justification for WC
2. Needs assessment of patient
3. Specifications of WC
4. Symptoms of patient
5. Related diagnoses of patient
6. How long patient has had present condition

7. Statement reflecting clinical progression or regression of patient
8. Failure of other less costly measures to serve client

Rehab shower/commode chair-related DME

The Bath Supplies rule (410-122-0580) demonstrates that the intent of ATP involvement is not to replace a medical evaluation/justification and order from an appropriately qualified clinician or licensed professional.

The clinician or licensed professional(s) determine what equipment will best meet the client's needs. The ATP ensures that the equipment being requested is appropriate for the client's home setting, as intended by the clinician or licensed professional(s).

Prior Authorization Notices

DMAP issues the following types of Prior Authorization Notices:

- Notice of Acceptance (PAU-0101-D): The PA number is in Field 11.
- Notice of Denial (PAU-0111-D).
- Other notices that inform the provider that information is needed to complete the PA request, or that no PA is required.

The PA number will always be a **ten digit number** beginning with the number "0." 9-digit PA numbers issued before December 2008 now have a leading zero as their 10th digit.

Description of the fields of the Notice of Acceptance (PAU-0101-D):

If DMAP cannot produce a computer-generated notice of acceptance, DMAP will complete the DMAP 1072 form (the PA number is below the provider's name).

1. The date DMAP generated this notice.
2. Provider's name and address as they appear on DMAP records.
3. The client's name.
4. Description of the type of service authorized.
5. HCPCS codes for the authorized service..
6. Procedure code descriptions for the authorized service.
7. The amount and units requested by the provider on the original PA request.
8. The amount and units approved by DMAP.
   - If a specific dollar amount is printed here, that means DMAP will not pay more than this limit. DMAP may pay less depending on the actual services billed.
   - "DMAP Rate": Is printed when DMAP sets no specific dollar limit. This means DMAP will pay up to its maximum allowable rate, depending on services billed.

   In both cases, if there is TPR, DMAP's payment is reduced by the TPR payment.
9. Name of servicing provider.
10. The client's 8-digit ID number (for billing DMAP).
11. PA Number: When billing for the authorized service, place this number in Field 23 on the CMS-1500 or in Field 19 on the DMAP 505, when appropriate.
12. The valid date range for the authorized service. The date of service must fall between these two dates, and the client must also be eligible on the actual date of service.
13. When the prescribing or referring provider's name is listed in this field, it must be used when billing DMAP. Your billing may require a referring provider number when the client is restricted to a Primary Care Manager (PCM) or the service requires referral.
14. Additional notes: A space for notes entered by the reviewer for the provider.
15. The client's name and address.
16. The DHS branch office serving the client.
17. The DHS/OHA office and reviewer who approved the PA.
18. If DMAP sends copies of this notice to other entities, such as the the client's branch office, that information will display here.

Oregon

Theodore R. Kulongoski, Governor

Department of Human Services
500 Summer St NE
Salem, OR 97301-1079

Date of Notice: 12/09/2008

Provider Name
Street Name
City, State ZIP

Notice of Prior Authorization

DHS authorizes the following item(s) or service(s) to Jane Doe for the dates of service listed below.

PROVIDER: Prior authorization (PA) does not guarantee payment. All rules for service must be met. See your program's Oregon Administrative Rules (OARs). In addition:

- The client must be eligible on the date(s) of service.
- The client must receive service(s) within the dates approved below.
- When you bill DHS, any third-party payments will reduce the billable amount. You must make full use of any other resource before billing DHS.
- CAF-Child Welfare clients must receive consent for surgery from the CAF-Child Welfare branch.
- Attach all required reports and forms to your claim. See your provider rules.

This letter contains protected health information (PHI) from DHS and is covered by the Electronic Communications Privacy Act, 18 U.S.C. Sec. 2510-2521 and the Standards for Privacy of Individually Identifiable Health Information, 45 CFR Parts 160 and 164, which is intended only for the use of the individual or entity named in the letter. Any unintended recipient is hereby notified that the information is privileged and confidential, and any use, disclosure, or reproduction of this information is prohibited.

PA Assignment:	Physical Therapy Services			
CODES	DESCRIPTION	REQUESTED AMT/UNITS	APPROVED AMT/UNITS	SERVICING PROVIDER NAME
97110	THERAPEUTIC PROC, ONE OR MORE AR	$181.44/009	$181.44/009	THEO THERAPIST
CLIENT ID #	AA####A			
PRIOR AUTH #	0123456789			
Dates Valid: From	12/09/2008	Through	01/31/2009	
Requesting/Referring Providers	REFERRER, MD			

Additional Notes:
<Notes entered by the reviewer for the provider may be entered here>

Jane Doe
Street Name
City, State ZIP

DHS Branch:	Anytown		
Address:	### Street Name	Division:	DMAP - Medical Unit 800-642-8635
City/ZIP:	City, ZIP	Reviewer:	Reviewer, RN

CC: DHS Branch, Referring Provider

Description of the fields of the Notice of Denial (PAU-0111-D):

1. The date DMAP generated this notice.

2. Provider's name and address as they appear on DMAP records.

3. The client's name.

4. Description of the type of service authorized.

5 Date the service was denied.

6 HCPCS codes for the authorized service.

7 Procedure code descriptions for the authorized service.

8 The amount and units requested by the provider on the original PA request.

9. Name of servicing provider.

10 The reason DMAP denied the PA request, with Oregon Administrative Rule references as appropriate.

11 The client's 8-digit ID number (for billing DMAP).

12 Request number: The 10-digit number referencing the PA denial..

13. The name of the prescribing/referring provider.

14. Additional notes: A space for notes entered by the reviewer for the provider. For example, if the reason for denial specifies incomplete documentation, the reviewer can use this space to explain the specific documentation required.

15. The client's name and address.

16. The DHS branch office serving the client.

17. The DHS/OHA office and reviewer who approved the PA.

18 If DMAP sends copies of this notice to other entities, such as the the client's branch office, that inforamtion will display here.

Oregon

Theodore R. Kulongoski, Governor

Department of Human Services
500 Summer St NE
Salem, OR 97301-1079

Date of Notice: 12/09/2008

Provider Name
Street Name
City, State ZIP

Notice of Denial

This letter contains protected health information (PHI) from DHS and is covered by the Electronic Communications Privacy Act, 18 U.S.C. Sec. 2510-2521 and the Standards for Privacy of Individually Identifiable Health Information, 45 CFR Parts 160 and 164, which is intended only for the use of the individual or entity named in the letter. Any unintended recipient is hereby notified that the information is privileged and confidential, and any use, disclosure, or reproduction of this information is prohibited.

DHS has denied the prior authorization (PA) request to provide the following item(s) or service(s) to Jane Doe:

PA Assignment:	Physical Therapy Services	Denial Date:	12/09/2008
CODES	DESCRIPTION	REQUESTED AMT/UNITS	SERVICING PROVIDER NAME
97110	THERAPEUTIC PROC, ONE OR MORE AR	$181.44/009	THEO THERAPIST
REASON FOR DENIAL	The information submitted does not substantiate the medical appropriateness for the service provided/requested. (OAR 410-120-0000, OAR 410-120-1200, OAR 410-120-1320, DME OAR 410-122-0080)		
CLIENT ID #	AA####A		
REQUEST #	0123456789		
Requesting/ Referring Providers	REFERRER, MD		

Additional Notes:

<Notes entered by the reviewer for the provider may be entered here>

Jane Doe
Street Name
City, State ZIP

DHS Branch:	Anytown		
Address:	### Street Name	Division:	DMAP - Medical Unit 800-642-8635
City/ZIP:	City, ZIP	Reviewer:	Reviewer, RN

CC: DHS Branch, Referring Provider

Billing information

National Provider Identifier

To ensure accurate and timely claims processing, DMAP requires all providers to register their National Provider Identifier (NPI) and taxonomy code(s) with DMAP.

To find out if you need a National Provider Identifier, or how to obtain one, go to the DMAP NPI Web page at www.oregon.gov/OHA/healthplan/tools_prov/npi.shtml.

Claims with services that require prior authorization

Make sure all services requiring prior authorization are billed on a single claim. If a service is later billed for the same date range, DMAP will deny the claim as a duplicate service already paid.

The system does not look at the PA number field on claims to find the PA. Instead, it looks for PAs that have an exact match to the following on the claim (if applicable):

- Diagnosis code
- Procedure code
- Performing provider

If the system cannot find an approved PA that matches these items on your claim, or if the degree of specificity does not match for any item on a potential match, the claim will deny.

To avoid this, look up the existing PA on the Provider Web Portal before you bill, Then you can make sure you bill for the service using the same criteria listed in the PA.

Please continue to record the 10-digit PA number in the PA number field of claims submitted to DMAP. Even though the system does not use this field during claim processing, this number helps DMAP staff resolve the claim when the system cannot find a matching PA.

Claims for diabetic supplies

Report the National Drug Code (NDC) for the following supplies in the Supplemental Information field (Box 24 of the CMS-1500, Box 22 of the DMAP 505), or the NDC fields in the Professional Web claim.

- A4253 - Blood glucose test or reagent strips
- A4256 - Normal, high, low calibrator solution/chips
- A4258 - Lancing device
- A4259 - Lancets
- E0607 - Home blood glucose monitor
- S8490 - Insulin syringes

When to bill on paper

You must bill on paper for claims that require attachments, reports or manual pricing (*e.g.*, unlisted procedure codes). Submit the paper claim with a cover letter and required documentation attached.

Electronic claims submissions

DMAP accepts claims in the following electronic formats:

Batch claim format

If you want to submit claims electronically using the 837P format, you must become an approved Electronic Data Interchange (EDI) provider. To begin the authorization process, contact EDI Support Services:

E-mail: DHS.EDIsupport@state.or.us

Phone: 888-690-9888

Web site: www.oregon.gov/OHA/edi

Coordination of Benefits (COB)

The 837 professional transaction will allow you to send COB/secondary payer claims. This means that if you have a claim that Medicare, or any other insurer, has paid as primary, you can use the 837 transaction to report the other insurance and bill DMAP as secondary.

For more information, contact EDI Support Services (see above).

Transaction information for EDI submitters

The Oregon Medicaid Management Information System (OR-MMIS) Technical Specifications contain information on how registered EDI submitters need to set up and code their transactions for appropriate processing by DMAP.

- For specific instructions on how to submit an electronic claim, refer to the *OR-MMIS 837 Institutional Technical Specifications - Fee-for-Service* at www.oregon.gov/OHA/edi/resources.shtml.
- If you bill for multiple service locations, submit your taxonomy and the complete ZIP+4 code in your 837 submission to ensure payment to the appropriate service location.

Individual claim format

Enrolled Oregon Medicaid providers authorized to access the Provider Web Portal can submit indiviual professional claims at https://www.or-medicaid.gov.

For more information about submitting claims on the Web portal, go to www.oregon.gov/OHA/healthplan/webportal.shtml.

Paper claim submissions

DMAP only accepts current, commercially available versions of paper claim forms. DMAP will return all other formats with a request to resubmit the claim in a valid claim format (Web, EDI, or commercially available form).

The information listed on the following pages is necessary for processing paper claims. You can enter information in more than the required fields, but **only** the information in the required fields is absolutely necessary (unless otherwise noted).

- Check your claim for missing, incorrect or misaligned information before it's mailed. Claim processing depends upon how well your claim is completed.
- **Each claim is a complete billing document.** Do not submit multi-page claims. If you do not have enough space on the form to bill all procedures provided, complete a new billing form for the rest of the procedures, or use the Provider Web Portal. Do not "carry over" totals from one claim to another.
- Use a separate claim form for each client.

Health Insurance Claim Form (CMS-1500)

DMAP does not supply this form. This federal form is available through local business forms suppliers, the Oregon Medical Association, or by calling the U.S. Government Printing Office at 1-866-512-1800.

Make sure information is left-aligned in the following fields:

- 1a - Client ID
- 2 - Patient Name
- 24A - Dates of Service - For detail line 1 only

If your forms are not to scale, or if the fields on your form are not correctly aligned, DMAP will manually enter your claim, which may delay processing of the claim.

Where to mail claims

Send all completed CMS-1500 forms to:

DMAP
PO Box 14955
Salem, OR 97309

8/05 CMS-1500 claim form instructions

General instructions for this form can be found on the National Uniform Claim Committee (NUCC) Web site at www.nucc.org/content/view/33/42/.

- Shaded boxes indicate the fields DMAP uses to process your claim (shaded on next page). Your claim may suspend or deny if one or more these fields are empty or incorrectly completed. Lifeline providers **do not** have to complete Fields 21 and 24E.
- Unshaded fields are optional or required only in certain circumstances.
- Make sure information is left-aligned and correctly placed in fields marked ***"Left-align."*** Misaligned information in these fields will delay processing.

1a.	The eight-digit number found on the Medical Care ID. ***Left-align***
2.	The client's name as it appears on the Medical Care ID. ***Left-align***
9.	Use Third Party Resource codes (pages 23-24) to indicate response received from other resources. Be sure that this code is the first entry in Field 9, followed by the name of the TPR. ♦ If the client has other health insurance coverage, and no payment was received from that resource, this space must be used to explain why no payment was made. ♦ If using TPR code "MO" or "OT," write "Review TPR code" at the top of the claim. Attach additional pages if needed to explain use of the code. Mail claim to Provider Services, 500 Summer St NE E44, Salem OR 97301.
10a-c.	Complete as appropriate when an injury is involved.
17.	Enter the name of the referring physician.
17a.	Enter the 6- or 9-digit Oregon Medicaid provider number for the referring physician. This information may be required if: ♦ Your client has a Primary Care Manager (PCM), or ♦ The service being billed requires a referral (*e.g.*, Physical, Occupational, or Speech Therapy services).
17b.	Enter the PCM or referring physician's 10-digit National Provider Identifier (NPI).

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA | PICA

CARRIER

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | TRICARE CHAMPUS (Sponsor's SSN) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1) — 1a

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) — 2

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED: Self, Spouse, Child, Other

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS: Single, Married, Other; Employed, Full-Time Student, Part-Time Student

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO ***If yes***, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED ____ DATE ____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED ____

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: MM DD YY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE | 17a. | 17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO | $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) — 21

1. ___ . ___ 3. ___ . ___

2. ___ . ___ 4. ___ . ___

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 24A	24B		24D	24E	24F	24G		NPI	24J
2								NPI	
3								NPI	
4								NPI	
5								NPI	
6								NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $ — 28

29. AMOUNT PAID $

30. BALANCE DUE $ — 30

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( ) — 33

a. NPI b.

PHYSICIAN OR SUPPLIER INFORMATION

21.	Enter the principal diagnosis/condition of the client indicated by current ICD-9-CM code number. Enter up to four codes in priority order. ♦ Carry the codes out to their highest degree of specificity (fourth or fifth digit). ♦ The diagnosis code must be the reason chiefly responsible for the service eing provided as shown in the medical records. ♦ Do not enter the decimal point or unnecessary characters. ♦ Lifeline providers **do not** have to include a diagnosis.
23.	If the service being billed requires prior authorization, and DMAP has authorized the service, enter the 10-digit PA number here.
24	In the shaded area across Fields 24A through 24H, enter supplemental information (*e.g.*, NDC, vendor numbers) about the service. Enter the appropriate qualifier(s), followed by the information. ♦ If entering more than one item of information on a line, make sure each item begins with a qualifier and is separated by at least 1 blank space from other items on the same line. ♦ **If billing for diabetic supplies:** Enter National Drug Code (NDC) information in the following order: N4, 11-digit NDC in 5-4-2 format, one space, unit of measure, NDC quantity (limited to 8 digits before the decimal and 3 digits after the decimal). If entering a whole number, do not use a decimal. Do not use commas. See the example below:

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
N412345678901 UN1234.567															123456789
MM	DD	YY	MM	DD	YY	1		J#####	UD [for 340B drugs]	1	### ##	20		NPI	1234567890

24A.	Enter the date (or first and last dates if consecutive days) that the service was provided. Must be numeric (100308). ***Left-align for line item 1*** ♦ If "From - To" dates are used, a service must have been provided on each consecutive day but not more than once per day. ♦ DMEPOS claims are billed on a monthly basis, except for diabetic strips, lancets, incontinence and ostomy supplies, which may be billed on a 3-month schedule. ♦ When billing for rental equipment, use a single date of service. The date the item is delivered, shipped or picked up is considered the "Date of Service."
24B.	Enter the appropriate code for the place service was provided: ♦ 04 – Homeless Shelter ♦ 12 – Home ♦ 13 – Assisted Living Facility ♦ 14 – Group Home ♦ 31 – Skilled Nursing Facility ♦ 32 – Nursing Facility ♦ 54 – Intermediate Care Facility/ Mentally Retarded

24C.	Put a "Y" in this field if the service was an emergency.
24D.	Use only the HCPCS codes listed in the DMEPOS Administrative Rules (OAR Chapter 410, Division 120), or fee schedule. Combine all units of the same code for the same dates of service on the same line. ♦ HCPCS code files are available on the CMS Web site at http://cms.hhs.gov/providers/pufdownload/anhcpcdl.asp. *Modifiers*:Enter one of the following modifiers for each procedure code entered. ♦ NU – DME Purchase ♦ RR – DME Rental, Medicare capped rental maintenance and repair ♦ RP – DME Repair ♦ UI - For wheelchair purchase or rental (for nursing facility clients only)
24E.	Enter the one-digit line number which refers to the primary diagnosis from Field 21 for each service billed. Lifeline providers **do not** have to include a diagnosis.
24F.	Enter the charge for each service billed.
24G.	Enter the number of days or units. This number must match the number of days in Field 24A or the number of units of services provided. ♦ One month rental equals one unit of service, unless otherwise specified.
24H.	Enter a "Y" if the service is related to family planning.
24I.	**Leave this field blank.** If you include a qualifier on the line for the Oregon Medicaid provider number, the system reads the qualifier as part of the provider number and denies the claim due to invalid provider number.
24J.	In the shaded half of this field, enter the 6- or 9-digit Oregon Medicaid provider number of the provider who rendered the service. Do not enter an NPI.
26.	(Optional) Enter your unique patient account number here (up to 12 characters). It will be printed on your remittance advice.
28.	Enter the total of all of the charges listed in column 24F.
29.	Enter the total amount paid by any other insurance or resource. Do not include DMAP copayments in this Field. If the client has other insurance and this amount is zero, there must be a 2-digit "reason" code in Field 9.
30.	Enter the amount due after subtracting the Amount Paid from the Total Charge (Field 28 minus Field 29). Do not include insurance write-off amounts.

33.	If you have an NPI, enter it in part "a" of this field. In part "b," enter your Oregon Medicaid provider number. ♦ These numbers identify the provider to whom the check should be sent (actual service provider *or* the provider's billing service). ♦ If you leave part "b" blank, DMAP will use the NPI in part "a" to process your claim, which may result in DMAP processing the claim under the wrong Oregon Medicaid provider number. ♦ Do not enter qualifiers in these fields. If you enter a qualifier, the system will read it as part of the provider number and deny for invalid provider number.

DMAP 505 - Medicaid - Medicare Billing Invoice

This form is used to submit claims for services to Medicare-Medicaid clients. Lifeline providers **do not** have to submit claims using this form.

- To order this form, complete and submit the DMAP 2420 (Provider Forms Request) to DHS/OHA Forms Distribution, 550 Airport Rd SE, Salem, OR 97310. You will find a copy of the DMAP 2420 at the end of this supplement.
- This form is also available on the DHS/OHA Web site at https://apps.state.or.us/Forms/Served/OE0505.pdf.

Where to mail claims

Send all completed DMAP 505 forms to:

DMAP
PO Box 14015
Salem, OR 97309

How to complete the DMAP 505

Shaded boxes indicate the fields DMAP uses to process your claim (shaded on next page). Your claim may suspend or deny if one or more these fields are empty or incorrectly completed. Unshaded fields are optional or required only in certain circumstances.

1	Enter the client's name as printed on the Medical Care ID.
3	Enter the eight-digit number found on the Medical Care ID.
8	Enter the Medicare claim number as it appears on the client's Medicare card.
9	If no payment was received from Medicare, use this space to explain why no payment was made. Select a 2-digit "reason" code from the Third Party Resource (TPR) codes shown in this supplement. Be sure that this "reason" code is the first entry in Field 9 followed by the name of the TPR (Medicare). ♦ If there is any other TPR, be sure to use a code that shows what both insurances did. ♦ If using TPR code "MO" or "OT," write "Review TPR code" at the top of the claim. Attach additional pages if needed to explain use of the code. Mail claim to Provider Services, 500 Summer St NE E44, Salem OR 97301.
7	Complete ONLY when an injury is involved.
16a	Enter the 6- or 9-digit Oregon Medicaid provider number of the referring (requesting) practitioner.
16b	Enter the 10-digit National Provider Identifier (NPI) of the referring practitioner.
19	If the service requires prior authorization (PA), enter the 10-digit PA number issued by DMAP or the branch/unit.

Medicare/Medicaid Billing Invoice for Medical Practitioner Claims

(1) 1. Patient's Name (Last, First, MI)

2. Patient's birthdate/sex MM | DD | YY M [ ] F [ ]

(3) 3. Insured's ID # (include all letters and numbers)

4. Patient's address (number, street)

5. Patient's Relation to Insured: Self [ ] Spouse [ ] Child [ ] Other [ ]

6. Insured's Name (Last, First, MI)

City | State

7. Was condition related to:
a. Patient's employment Y [ ] N [ ]
b. Accident Auto [ ] Other [ ]

8. Insured's address (number, street)

Zip Code | Phone (Area Code)

City | State

9. Other insured's name (Last, First, MI)

a. Other insured's Plan name

Zip Code | Phone (Area Code)

Other insured's Plan address (number, street)

b. Other insured's policy number

10. Insured's group # (or group name)

City | State

Zip Code | Phone (Area Code)

12. I authorize payment of medical benefits to undersigned physician or supplier for services described below.

Signed (insured or authorized person)

11. Patient's or authorized person's signature – I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

Signed *Date*

13. Date of current: MM | DD | YY ◄ Illness (first symptom) or Injury (accident) or Pregnancy (LMP)

14. If emergency, check here [ ]

15. First date patient had same or similar illness MM | DD | YY

16. Name of referring provider or other source | 16a. | 16b. NPI

17. Dates patient unable to work in current occupation From MM | DD | YY To MM | DD | YY

18. Outside lab? Yes [ ] No [ ] $ Charges

19. Prior authorization number

20. Hospitalization dates related to current services From MM | DD | YY To MM | DD | YY

(21) 21. Diagnosis or nature of illness or injury (relate items 1, 2, 3, or 4 to item 22D by line)
1. ____.____ 2. ____.____ 3. ____.____ 4. ____.____

22. A. Date(s) of service MM DD YY To MM DD YY (22A)	B. Place of service (22B)	C. Procedures, services or supplies (explain unusual circumstances) CPT/HCPCS Modifier (22C)	D. Diagnosis code (22D)	E. Days or units (22E)	F. EPSDT Family Plan	G. Charges and Medicare (22G)	H. Medicare's allowed charges (22H)	I. Rendering DHS Provider Number
								DHS:
								NPI:
								DHS:
								NPI:
								DHS:
								NPI:
								DHS:
								NPI:
								DHS:
								NPI:
								DHS:
								NPI:

23. Federal tax ID # SSN [ ] EIN [ ]

(24) 24. Total charge

25. Total Medicare payment

26. Patient's account #

27. Accept assignment? Y [ ] N [ ]

28. Ins (not Medicaid/Medicare)

(29) 29. Balance due

30. Service facility location information
NPI #: | DHS #:

(31) 31. Billing provider information and phone number
NPI #: | DHS #:

21	Enter the primary diagnosis/condition of the client indicated by appropriate ICD-9-CM code number. Enter up to four codes in priority order. Carry the codes out to their highest degree of specificity.
22	In the shaded area across Fields 22A through 22I, enter supplemental information (*e.g.*, NDC, vendor number) about the service. Enter the appropriate qualifier(s), followed by the information. ♦ If entering more than one item of information on a line, make sure each item begins with a qualifier and is separated by at least 1 blank space from other items on the same line. ♦ **If billing for diabetic supplies** Enter National Drug Code (NDC) information in the following order: N4, 11-digit NDC in 5-4-2 format, one space, unit of measure, NDC quantity (limited to 8 digits before the decimal and 3 digits after the decimal). If entering a whole number, do not use a decimal. Do not use commas. See the example below:

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
N412345678901 UN1234.567															123456789
MM	DD	YY	MM	DD	YY	1		J#####	UD [for 340B drugs]	1	### ##	20		NPI	1234567890

22A	Use a six-digit numeric date (MM/DD/YY). If "From - To" dates are used, a service must have been provided on each consecutive day but not more than once per day. ♦ DMEPOS claims are billed on a monthly basis, except for diabetic strips, lancets, incontinence and ostomy supplies, which may be billed on a 3-month schedule. ♦ When billing for rental equipment, use a single date of service. The date the item is delivered, shipped or picked up is considered the "Date of Service."
22B	Enter where service was provided: ♦ 04 – Homeless Shelter ♦ 12 – Home ♦ 13 – Assisted Living Facility ♦ 14 – Group Home ♦ 31 – Skilled Nursing Facility ♦ 32 – Nursing Facility ♦ 54 – Intermediate Care Facility/ Mentally Retarded

22C	Enter the appropriate procedure code plus any appropriate two-digit modifier(s). Use only the HCPCS codes listed in the DMEPOS Administrative Rules (OAR Chapter 410, Division 120), or DMAP fee schedule. Combine all units of the same code for the same dates of service on the same line. ♦ HCPCS code files are available on the U.S. Health and Human Services Web site at http://cms.hhs.gov/providers/pufdownload/anhcpcdl.asp. *Modifiers:* Enter one of the following modifiers for each procedure code entered. ♦ NU – DME Purchase ♦ RR – DME Rental, Medicare capped rental maintenance and repair ♦ RP – DME Repair *For clients residing in a nursing facility:* Enter modifier U1 for wheelchair purchase or rental.
22D	Enter a single diagnosis reference number on each line as shown in Field 21.
22E	Enter the number of services or units you are billing for. ♦ One month rental equals one unit of service, unless otherwise specified.
22F	Enter a "Y" in this field if the service relates to EPSDT or family planning.
22G	Enter the total dollar amount billed to Medicare for each service.
22H	Enter the dollar amount allowed by Medicare for each service.
22I	If not used in Field 31, enter your performing provider number information here. ♦ In the top half of this field, enter the Oregon Medicaid provider number. ♦ In the bottom half of this field, enter the 10-digit NPI.
24	Add the charges in Field 24G and enter the total dollar amount Medicare was billed.
25	Enter the total dollar amount paid by Medicare for the services. Do not show Medicare or other insurance write-offs.
26	Optional. If your patient account number is entered here, DMAP will print the account number on the remittance advice.
28	Enter any amount paid by any health insurance resource, other than Medicare. If the amount is zero, put in a "0".
29	Subtract the amounts in Fields 25 and 28 from Field 24 and enter the balance in this field. You must enter an amount in this field.
31	If you have an NPI, enter it in the "NPI #" part of this field. In the "DMAP #" part of this field, enter your Oregon Medicaid billing provider number. ♦ These numbers identify the provider to whom the check should be sent (actual service provider *or* the provider's billing service).

Billing codes

Third Party Resource (TPR) explanation codes

Use in Field 9 on the CMS-1500 and DMAP 505. These codes can only be used on paper claims. They cannot be used on electronic claims submissions.

Single insurance coverage

Use a single insurance code when the client has only one insurance policy in addition to DMAP coverage.

UD	Service Under Deductible
NC	Service Not Covered by Insurance Policy
PN	Patient Not Covered by Insurance Policy
IC	Insurance Coverage Cancelled/Terminated
IL	Insurance Lapsed or Not in Effect on Date of Service
IP	Insurance Payment Went to Policyholder
PP	Insurance Payment Went to Patient
NA	Service Not Authorized or Prior Authorized by Insurance
NE	Service Not Considered Emergency by Insurance
NP	Service Not Provided by Primary Care Provider/Facility
MB	Maximum Benefits Used for Diagnosis/Condition

RI Requested Information Not Received by Insurance from Client

RP Requested Information Not Received by Insurance from Policyholder

MV Motor Vehicle Accident Fund Maximum Benefits Exhausted

AP Insurance mandated under administrative/court order through an absent parent not paid within 30 days

OT Other (if above codes do not apply, include detailed information of why no TPR payment was made)

Multiple insurance coverage

Use a multiple insurance code when the client has more than one insurance policy in addition to DMAP coverage.

MP Primary Insurance Paid-Secondary Paid

SU Primary Insurance Paid - Secondary Under Deductible

MU Primary and Secondary Under Deductible

PU Primary Insurance Under Deductible - Secondary Paid

SS Primary Insurance Paid - Secondary Service Not Covered

SC Primary Insurance Paid - Secondary Patient Not Covered

ST Primary Insurance Paid - Secondary Insurance Cancelled/Terminated

SL Primary Paid - Secondary Lapsed or Not in Effect

SP Primary Paid - Secondary Payment Went to Patient

SH Primary Paid - Secondary Payment Went to Policyholder

SA Primary Paid - Secondary Denied - Service Not Authorized or Prior Authorized

SE Primary Paid - Secondary Denied - Service Not Considered Emergency

SF Primary Paid - Secondary Denied - Service Not Provided by Primary Care Provider/ Facility

SM Primary Paid - Secondary Denied - Maximum Benefits Used for Diagnosis/ Condition

SI Primary Paid - Secondary Denied - Requested Information Not Received from Policyholder

SR Primary Paid - Secondary Denied - Requested Information Not Received from Patient

MC Service Not Covered by Primary or Secondary Insurance

MO Other (if above codes do not apply, include detailed information of why no TPR payment was made)

Supplemental information qualifiers

DMAP accepts the following types of supplemental information on the CMS-1500 and DMAP 505 forms, accompanied by the appropriate qualifier:

Qualifier	Information Type
7	Anesthesia duration in minutes with start and end times
ZZ	Narrative description of unspecified codes
N4	National Drug Codes (NDC). In addition, use the following qualifiers when reporting NDC units: ♦ F2 – International Unit ♦ GR – Gram ♦ ML – Milliliter ♦ UN - Unit
VP	Vendor Product Number – Health Industry Business Communications Council (HIBCC)
OZ	Product Number Health Care Uniform Code Council – Global Trade Item Number (GTIN), formerly Universal Product Code (UPC)
CTR	Contract rate

The following examples show how to enter different types of supplemental information as listed above. They are not meant to provide direction on how to code for specific services.

National Drug Codes

DMAP maintains a list of accepted National Drug Codes for diabetic supplies on the DMEPOS Web page at www.dhs.state.or.us/policy/healthplan/guides/dme/main.html.

Remittance advice

The paper remittance advice (RA) tells you about payment, denial, or other actions taken on a claim. If you are expecting a paper check, you will find it on the third page of your RA. Claims "in process" (suspended) will also appear on your RA.

- The information you see on the RA is the information our system used to process your claim. If you receive an incorrect payment, you must adjust the claim using the Individual Adjustment Request (DMAP 1036) or Provider Web Portal. If DMAP made no payment, your RA will tell you to resubmit or adjust the claim.
- It is important to distinguish between a claim and an RA. You may receive one RA for many clients. Each line on the RA indicates an individual claim. One problem claim will not delay payment for the other claims listed on the RA.

For more information about the remittance advice, go to DMAP's Remittance Advice Web page at www.oregon.gov/OHA/healthplan/tools_prov/read-ra.shtml.

Electronic remittance advice

Providers who submit electronic claims in the 837P or 837I formats can choose to receive the 835 Fee for Service Payment/Advice transaction. Like the paper remittance advice, the 835 transaction displays the number of claims and the adjudication status of your claims in Oregon's Medicaid system.

The 835 contains HIPAA Claim Adjustment Reason Codes, as well as more detailed Remittance Advice Remark Codes. A list of these codes can be found on the Washington Publishing Web site www.wpc-edi.com/content/view/180/223/.

To receive the 835 Payment/Advice transaction, you must be an approved EDI provider. To start the authorization process, contact EDI Support Services (see page 10).

Web portal claim search

Instead of waiting for the paper Remittance Advice to come in the mail, providers authorized to use the Provider Web Portal can review previously submitted claims on the Web at https://www.or-medicaid.gov and adjust, void, or resubmit claims as needed.

For more information, go to the Provider Web Portal resources page at www.oregon.gov/OHA/healthplan/webportal.shtml.

Correcting claims

You have three options to adjust a claim that you submitted and DMAP processed:

- Send a paper DMAP 1036 Individual Adjustment Request (see the Forms section);
- Adjust the claim electronically using the Provider Web Portal; or
- Submit the 837P transaction (refer to the 837 Companion Guide).

If DMAP denied your claim, you can submit a corrected claim on paper, Web, or the 837.

Forms

All DMAP forms are available electronically on the Web at
www.oregon.gov/OHA/healthplan/forms/omapforms.shtml.

DMAP 1036 - Individual Adjustment Request

Overpayments, underpayments and payments received after DMAP has paid a claim can be resolved through the adjustment process.

- Use the DMAP 1036 only to request adjustments for paid claims. If DMAP denied a claim that you think DMAP should have paid, you must correct and re-submit the claim for processing.
- To order the Individual Adjustment Request (DMAP 1036) form, complete and submit the DMAP 2420 (Provider Forms Request) to DHS/OHA Forms Distribution, 550 Airport Rd SE, Salem, OR 97310.
- This form is also available on the DHS/OHA Web site at https://apps.state.or.us/Forms/Served/OE1036.pdf.

How to complete the Individual Adjustment Request (DMAP 1036)

Most required information is printed on the RA. You must have an RA for the claim to complete this form. You may submit documentation to support your request.

1.	Check the appropriate box if this request is an underpayment (DMAP paid too little) or an overpayment (DMAP paid too much).
4.	Enter the 13-digit Internal Control Number (ICN).
5.	Enter the date printed at the top of the RA.
6.	Enter the client's name. Use the same name as is shown on the Medical Care ID.
7.	Enter the client's recipient ID number.
8.	This space is for your provider name.
9.	Enter your 6- or 9-digit provider number.
10.	Enter your 10-digit National Provider Identifier (NPI), if available.
11.	This column contains possible areas you might want to correct. Only check the box you want to change. ♦ For Quantity - See DME Administrative Rules, when applicable. ♦ Other - Use this box if none of the above boxes address your problems.
12.	Use the line number from the original claim you are adjusting.
13.	Enter the date you performed the service.
14.	Enter the incorrect information submitted on your original claim.
15.	Enter the corrected information.
16.	Give additional information or explain your request, if necessary.
17.	The signature of the provider or other authorized person must be in this space.

Individual Adjustment Request

DMAP Use Only

✓ Complete this form to request an adjustment.

✓ Please keep a copy and do not use red ink.

(1) **Type of Adjustment:** ❑ Underpayment – Request additional payment
❑ Overpayment – Please deduct from subsequent payment

(2) **Attach the following:**
- ✓ Claim (corrected copy)
- ✓ Remittance Advice (copy)
- ✓ Financial planner (NH only)

(3) **Return nursing home adjustment requests to:**
DMAP – NH
PO Box 14954
Salem, OR 97309

Return all other adjustment requests to:
DMAP
PO Box 14952
Salem, OR 97309

Enter the following data from your Remittance Advice (RA):

(4) **Internal Control Number** | | | | | | | | | | | | | (5) **RA Date**

(6) **Recipient Name** (7) **Recipient ID Number** | | | | | | | | |

(8) **Provider Name** (9) **Provider Number** | | | | | | | | | |

(10) **NPI** | | | | | | | | | | |

(11) Description of original error	(12) Line No.	(13) Service Date	(14) Wrong Information	(15) Right Information
☐ Place of Service				
☐ Procedure Code/NDC/Rev Code				
☐ Modifier				
☐ Quantity/Unit				
☐ Diagnosis				
☐ Prescribing/Rendering Provider				
☐ Billed Amount/Total Billed				
☐ Medicare Payment				
☐ Other Insurance/Patient Liability				
☐ Co-Insurance				
☐ Other				

(16) **Remarks**

(17) Requester's Name	Phone #	Date

DHS 3970 - EDMS Coversheet

This sheet is required as the cover for most mailed or faxed correspondence sent to DMAP for processing. To avoid delays in processing:

- **Do not submit paper claims or adjustment requests with this coversheet.** Mail them to the appropriate PO Box with any required documentation attached.
- **Make sure to submit each request you send to DMAP with its own EDMS Coversheet.** This allows DMAP to track each request as a separate document. You cannot send multiple requests under a single coversheet or combine document types.

This form is also available on the DHS/OHA Web site at https://apps.state.or.us/Forms/Served/DE3970.pdf.

How to complete the DHS 3970

This sheet allows DMAP to scan your correspondence into the Electronic Document Management System (EDMS). To ensure appropriate processing of your PA request:

- **Always enter your National Provider Identifierand the client's ID number in the "Documentation Identification Numbers" section of this form.**
- **Always mark the "Prior Authorization" box in the "Document Type" section of this form for all PA-related submissions.** This is the only way the EDMS will recognize your PA request for automatic entry into the system.
- **For requests to revise existing PAs, enter the PA number in the "Documentation Identification Numbers" section of this form.** This is the only way EDMS will know to associate your revised PA request with an existing PA.

Requests for expedited PA

If you want to expedite your initial or revised request, mark the expedited timeframe you are requesting on the EDMS Coversheet and DHS 3971:

- "Urgent" processing (within 72 hours)
- "Immediate" processing (within 24 hours)

In addition to required information for the initial or revised request, submit written justification for expedited processing. A space to write this information is at the top of the EDMS Coversheet and DHS 3971.

Using the coversheet button in the Provider Web Portal

If you want to complete the coversheet while submitting your PA request on Provider Web Portal, make sure you click the "Submit" button before you complete the coversheet.

This enters your PA into the system and gives you the PA number you will need to enter in the "Documentation Identification Numbers" section of the coversheet.

EDMS COVERSHEET

Requester Information:

Name: ______________________ **Date:** __________

Phone: ______________________ **No. of Pages:** __________
(Including this coversheet)

Document Type: *(Ensure the correct Document Type is checked)*

- ☐ Provider Enrollment (PE)
- ☐ Claim Documentation
- ☐ Prior Authorization (PA)
- ☐ Hearing Documentation
- ☐ Grievance Documentation
- ☐ Correspondence

- ☐ PA Routine Processing
- ☐ PA Urgent Processing
- ☐ PA Immediate Processing

} *Additional supporting documentation & justification is required for this level of processing.*

Justification: ____

____

DMAP Services
Criteria for PA's is found on the DHS Web site. Go to the following address and select the appropriate program rules:
http://www.dhs.state.or.us/policy/healthplan/guides/main.html
If your PA request does not support expedited processing, it will receive routine processing. DHS will inform the provider for requests (meeting expedited criteria) with missing information, within the expedited time frame.

Documentation Identification Numbers (if applicable):

(If documentation is to be linked to pre-existing records, enter the applicable identification number(s) below)

PE Application Tracking Number (ATN): ☐☐☐☐☐☐☐☐☐

Provider ID: ☐☐☐☐☐☐☐☐☐☐

Recipient ID: ☐☐☐☐☐☐☐☐

Prior Authorization Number (PAN): ☐☐☐☐☐☐☐☐☐☐

Claim ICN: ☐☐☐☐☐☐☐☐☐☐☐☐☐

Hearings/Grievances Number (HGN): ☐☐☐☐☐☐☐☐☐

Contact Tracking Number (CTN): ☐☐☐☐☐☐☐☐☐☐ ☐☐ ☐☐
Include question number and notes number, as applicable, in separate boxes.

Confidentiality Notice:
The information contained in this packet is confidential and legally privileged. It is intended only for use of the individual named. If you are not the intended recipient, you are hereby notified that the disclosure, copying, distribution, or taking of any action in regards to the contents of this fax - except its direct delivery to the intended recipient - is strictly prohibited. If you have received this packet in error, please notify the sender immediately and destroy this cover sheet along with its contents, and delete from your system, if applicable.

DHS 3971 - Oregon DHS Prior Authorization Request

Submit each PA request with required documentation and a completed EDMS Coversheet.

This form is also available on the DHS/OHA Web site at https://apps.state.or.us/Forms/Served/DE3971.pdf.

Information needed to request PA

DMAP may automatically deny requests that do not include one or more of the following pieces of information. Information in **bold** is required for correct processing.

Information needed	New PA	Existing PA
Section I - Provider number - Enter the NPI.	X	
Section II - Type of PA request - Mark the "DME" box.	X	
Section III ♦ **Client ID** - The 8-digit Medicaid ID number. ♦ Client's name	X	X
Section IV ♦ ICD-9-CM Diagnosis Code – obtained from the treating practitioner – The diagnosis code must be the reason chiefly responsible for the service being provided as shown in the medical records.	X	
Section V ♦ **Procedure codes** ♦ Modifiers (if applicable) ♦ Description (use this field to enter diabetic supply NDC) ♦ **Units of service** ♦ Usual and customary charge (U&C)	X	
Section IX ♦ **Date of request** ♦ **Expected service begin date** - Beginning date of service ♦ **Expected service end date** - Ending date of service	X	
Notes ♦ The needed change ♦ Reason for change		X
Attachments Describe and attach the following: ♦ A proper written order from the prescribing practitioner ♦ Any other required documentation.	X	X

Oregon DHS Prior Authorization Request Form

For Internal Use Only: PA Number

I

Requesting Provider Name ____________________ Provider # __________

Contact Name ____________________ Contact Phone # ____________________

Contact Fax # ______________ Processing Time Frame: ☐ Routine ☐ Urgent ☐ Immediate

Supporting Justification for Urgent/Immediate Processing Time Frame:

____

II

Type of PA Request

Assignment Code (check appropriate box)

☐ Audiology
☐ Chemical Dependency Treatment Services
☐ Dental Hospital Referral
☐ DME
☐ Gambling Treatment Services
☐ Hearing Aid
☐ Home EPIV
☐ Home Health
☐ Imaging
☐ Inpatient Rehab
☐ Medical Transportation
☐ Mental Health
☐ Occupational Therapy
☐ Pharmacy
☐ Physical Therapy
☐ Physician
☐ SPD – CIIS (MFCU, CHN and Nursing)
☐ Speech Services
☐ Supplies
☐ Surgery
☐ Transplant
☐ Vision

☐ Other ______________________________

III

Client ID ____________________ DOB ____________________

Last Name ____________________ First Name, MI ____________________

IV

Service Information

Estimated length of treatment ______________ Frequency ______________

Length of time per session ______________

Primary diagnosis ______________ Primary ICD-9 diagnosis code ________

Other pertinent diagnosis ______________________________

Facility: Name ____________________ Provider # ______________

Revenue Center Codes ______________________________

Please attach appropriate dental/medical/clinical justification for services requested (attach any plan of treatment, progress notes, invoices, etc. as needed).

V

Line Item	Procedure Code	Modifier	Description	Units	U&C	MSRP	Total Dollars
1					$	$	$
2							
3							
4							
5							
6							
7							
8							
9							
10							
			Total Units		**Total Cost**		$

VI **DENTAL**

Tooth Number ________ Quad ________

VII ***Fax all pharmacy PA requests to the Oregon Pharmacy Call Center at 888-346-0178.***

Pharmacy: Drug Name ______________________________ Strength __________________

Quantity ____________________________ NDC __________________

Directions:

____

VIII

Performing Provider _____________________________________ Provider #____________

Contact Name _______________________ Contact Phone # ________________________

Contact Fax # _______________________ Billing Provider # _______________________

IX **Date Information**

Date of Request (MM/DD/CCYY) ____ / ____ / ______

Expected Service Begin Date ____ / ____ / ______

Expected Service End Date ____ / ____ / ______

Notes:

Attachments:

Document Control Number (DCN) ____________________

Report Type ____________________

Description of attachments:

DMAP 2461 - Evaluation of Respiratory Assist Device

Use when required according to OAR 410-122-0205. Complete and submit as an attachment with your completed DHS 3970 (EDMS Coversheet) and DHS 3971 (Oregon DHS PA Request Form).

EVALUATION OF RESPIRATORY ASSIST DEVICE

Client Name	
Client Phone Number ( )	Client Birth Date

The Supplier may not answer any of the following questions.

1. Are you now using a machine that helps you take your breaths while you are asleep (separate from a machine that may be giving you oxygen or medicine)?	Circle one YES NO
2. How many hours a day do you usually use this machine?	Hours
3. How many months have you been using this machine?	Months
4. Will you keep using this treatment in the future?	Circle one YES NO
5. Did you personally answer questions 1 - 5?	Circle one YES NO

If you did not answer these questions, who did answer them and what is their relationship to you (for example: wife, husband, caregiver, supplier of machine, etc.)?

Name ____________________

Relationship ____________________

Client Signature ____________________ Date of Signature ____________________

DMAP 3155 - Positioner Justification

Use when required according to OAR 410-122-0365. Complete and submit as an attachment with your completed DHS 3970 (EDMS Coversheet) and DHS 3971 (Oregon DHS PA Request Form).

POSITIONER JUSTIFICATION
Positioners for Standing

Name ______________________________ Date ____________________

Date of Birth ____________________________ Recipient ID Number __________

Sex ❑ Male ❑ Female Height ___________ Weight ___________

All clients are evaluated as individuals. Each piece of equipment has certain functional uses which may be the same from client to client. This similarity of function allows the development of this form which is filled out specifically for the client indicated.

Diagnosis and ICD-9-CM codes from the physician ____________________________

____

Significant medical complications ____________________________________

____

Contracture, scoliosis, and/or kyphosis (indicate degrees) ______________________

____

Physical capabilities ____

____

Present positioner and problems __________________________________

____

List all positioning equipment currently in use by client

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

❑ Accessibility: living situation evaluated for compatibility with equipment

This client will need:

- ❑ Vertical standing frame
  - ❑ Hydraulic
  - ❑ Manual
- ❑ Prone positioner
- ❑ Supine positioner
- ❑ Modifications

Reason

- ❑ Client has outgrown positioner
- ❑ Positioner is worn out or broken
- ❑ Client's capabilities have changed
- ❑ Client has no positioner

JUSTIFICATION

- ❑ Aid in the prevention of atrophy in the trunk and leg muscles
- ❑ Improve circulation to trunk and lower extremities
- ❑ Prevent formation of decubiti (pressure ulcers) through changing positions
- ❑ Help maintain bone integrity
- ❑ Improve bowel function and regularity
- ❑ Reduce swelling in lower extremities
- ❑ Improve range of motion
- ❑ Aid kidney and bladder functions
- ❑ Decrease muscle spasms
- ❑ Strengthen cardiovascular system and build endurance
- ❑ Improve strength to trunk and lower extremities
- ❑ Prevent or decrease joint/muscle contractures
- ❑ Lessen or prevent the progression of scoliosis
- ❑ Aid normal skeletal development

Additional information:

____

____

____

____

____

____

____

SPECIAL CONSIDERATIONS OF CHOSEN STANDING EQUIPMENT

1. Is the patient able to operate that stander independently? ❑ yes ❑ no
2. Does the patient use a wheelchair for mobility? ❑ yes ❑ no
3. Does the stander have adequate supports anterior and posterior as well as laterally to position the person in a symmetrical aligned standing? ❑ yes ❑ no
4. Does the stander have enough adjustment to allow for individual fit and for growth changes? ❑ yes ❑ no
5. What is the height range and weight capacity of the stander?
   Height range From____________________ To __________________________
   Weight capacity From____________________ To __________________________
6. Is it relatively easy to modify to meet the individual's position needs? ❑ yes ❑ no
7. What are the environmental factors to consider (i.e., room size in residence)
   ____
   ____
8. Transfer considerations/caregiver constraints. What makes the model chosen advantageous in changing positions?____
   ____
   ____
9. Other ____
   ____
   ____

SPECIFIC ACCESSORIES JUSTIFICATION

- ❑ Back support:
  - ❑ Needed for balance, stability, or positioning assistance
  - ❑ Has extensor tone of the trunk muscles
  - ❑ Does not have trunk stability to support him/herself while being raised or while completely standing
- ❑ Tall back:
  - ❑ The client is over 5' 11" tall
  - ❑ The client has no trunk control at all and needs additional support
  - ❑ The client has more involved need for assistance with balance, stability, or positioning

Continued next page . . . .

- ❑ Hip guides:
  - ❑ Lacks motor control and/or strength to center hips
  - ❑ Has asymmetrical tone which causes hips to pull to one side
  - ❑ Spasticity
  - ❑ Low tone or high tone
  - ❑ Need for balance, stability, or positioning assistance
  - ❑ Shoulder retractor or harness:
  - ❑ Cannot maintain erect posture without support due to lack of motor control or strength
  - ❑ Kyphosis
- ❑ Lateral supports
  - ❑ Lacks trunk control to maintain lateral stability
  - ❑ Has scoliosis which requires support
  - ❑ Needs a guide to find midline
- ❑ Head rest:
  - ❑ Lacks head control and cannot hold head up without support
  - ❑ Has strong extensor thrust pattern that requires inhibition
- ❑ Independent adjustable knee pads:
  - ❑ Has severe leg length discrepancy
  - ❑ Has contractures in one leg greater than the other
- ❑ Actuator handle extension:
  - ❑ No care giver, and
able to transfer independently into standing frame, and
has limited range of motion in arm and/or shoulder and cannot reach actuator in some positions
- ❑ Arm troughs:
  - ❑ Has increased tone which pulls arms backward so hands cannot come to midline
  - ❑ Tone, strength, or control is so poor that arms hand out to side and backward, causing pain and risking injury
  - ❑ For posture
- ❑ Tray:
  - ❑ Positioning
- ❑ Abductors:
  - ❑ Reduce tone for alignment so bear weight properly
- ❑ Sandals (shoe holders):
  - ❑ Dorsiflexion of the foot or feet
  - ❑ Planar flexion of the foot or feet
  - ❑ Eversion of the foot or feet
  - ❑ Safety
- ❑ Other:

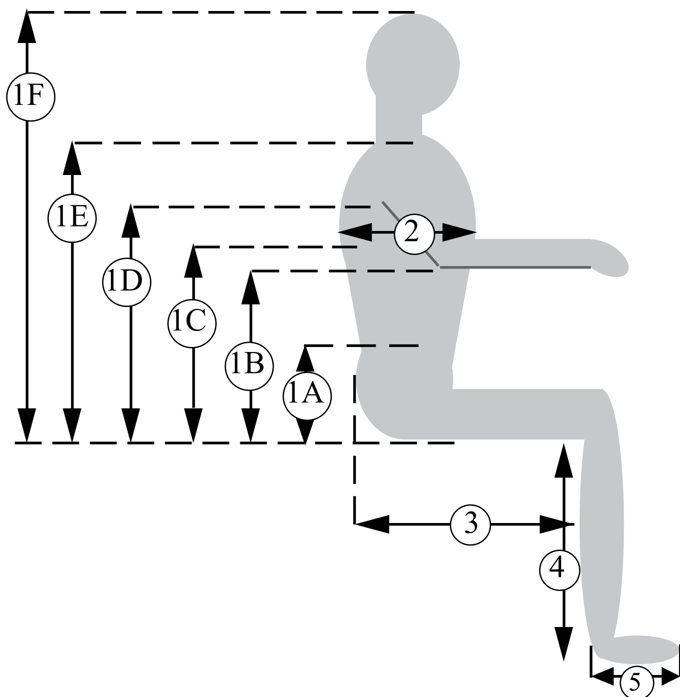
____

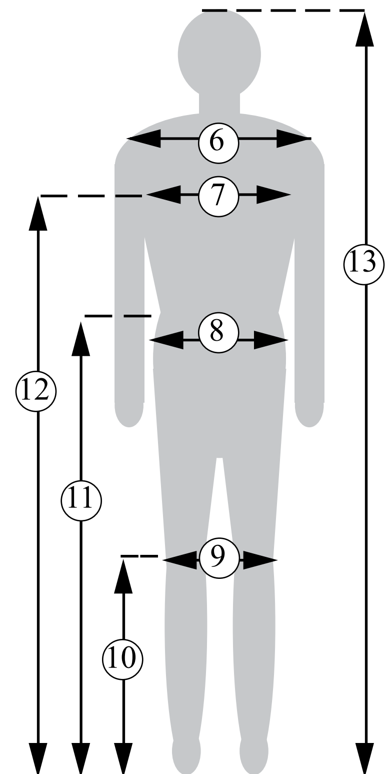
____

MEASUREMENT IN SITTING AND STANDING

1. Seat surface (the contact point of the buttocks) to:	Left	Right	Standing
A. PSIS			
B. Elbows			
C. Inferior angles of scapula			
D. Armpit			
E. Top of shoulder			
F. Top of head			

	Standing
2. Trunk depth (back surface to front of the ribs)	
3. Leg length (from where the hips touch backrest to potential angle of knee)	
4. Back of knee to heel (or weight-bearing area)	
5. Foot length (with shoes & AFOs if applicable)	
6. Shoulder width	
7. Trunk width (across chest)	
8. Hip width	
9. Outer knee width (relaxed, with knees apart)	
10. Knee height	
11. Hip height	
12. Chest height	





EQUIPMENT TRIAL AND OUTCOME

1. Trial date ____________________

Stander style ____________________

Stander manufacturer ____________________

Outcome ____________________

____

____

____

____

2. Trial date if needed ____________________

Stander style ____________________

Stander manufacturer ____________________

Outcome ____________________

____

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____

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3. Trial date if needed ____________________

Stander style ____________________

Stander manufacturer ____________________

Outcome ____________________

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SPECIFICATIONS

Equipment trial outcome (from previous page) ______________________________

____

Make and model number ______________________________

____

Standard model includes ______________________________

____

Attach copy of manufacturer's information and suggested price.

Less costly alternatives considered ❑ yes ❑ no

Explain ______________________________

____

How long (in years) will this positioner be used? ______________________________

How long is the positioner expected to last? ______________________________

REQUESTOR INFORMATION

____

Therapist completing form ______________________________
PLEASE PRINT Date

Therapist Signature ______________________________

Physician ______________________________
PLEASE PRINT Date

Physician Signature ______________________________

Rehabilitation technology supplier ______________________________
Date

Oregon Health Authority

Division of Medical
Assistance Programs

DMAP Forms Request

Instructions:

1. Fill in the Provider information at right (type or print clearly).
2. Order only those forms listed in the chart below. CMS 1500 Billing Forms are NOT available through DAS printing or DMAP.
3. Fill in the number of packages column.
4. Fold page in thirds, seal with adhesive strip, affix postage. Mail to:
   DAS Distribution Center
   550 Airport Rd SE
   Salem OR 97310

Provider Name		
Street Address (NOT PO Box)		
City	State	ZIP
Area Code & Phone		

Forms available in packages of 50

CMS 1500 billing forms are available through business forms suppliers.

Form #	Title	Qty	Packages
DMAP 2420	DMAP Forms Request cards (5 max)		
DMAP 405T	Med. Transportation Order		
DMAP 406	Med. Transport. Eligibility Screening & Med. Transportation Order		
DMAP 505	Medicare/Medicaid Billing Inv. (cont.)		
DMAP 741	Hysterectomy Consent English Spanish		
DMAP 742A	Consent to Sterilization English Spanish		
DMAP 742B	Ages 15-20 Consent to Sterilization English Spanish		
DMAP 1036	Individual Adjustment Request		

The above forms and other DMAP forms are available on OHA Web site at www.oregon.gov/OHA/healthplan

DMAP 2420 (Rev. 7/11)

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Place
Postage
Here

DAS Distribution Center
550 Airport Rd SE
Salem OR 97310