



Home Health Services

Supplemental information for Oregon Medicaid providers

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

January 7, 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 Home Health Services Oregon Administrative Rules (Chapter 410 Division 127). See current Home Health Services administrative rules for official policies regarding billing.

Prior authorization

Prior authorization requirements

Prior authorization from DMAP is not required for clients enrolled in Medicare Part A.

- For PA related to home enteral/parenteral and IV services, refer to the Home Enteral/Parenteral and IV Services rulebook and supplemental information at www.dhs.state.or.us/policy/healthplan/guides/homeiv/main.html.
- For PA related to Group 2 pressure-reducing support surfaces, refer to the DMEPOS rulebook and supplemental information at www.dhs.state.or.us/policy/healthplan/guides/dme/main.html.

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 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/DHS/healthplan/webportal.shtml#authorization.

Required information for both paper and Web PA requests is listed on page 32 of this handbook.

Fax required documentation accompanied by the EDMS Coversheet (DHS 3970). Use the following fax numbers:

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

See Forms section for sample forms and instructions. If you have questions about how to request PA, contact the appropriate office below.

Medically Fragile Children (MFC) clients	DHS Medically Fragile Children’s Unit 971-673-2974 for referrals and general information
All other clients	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 eligibility and enrollment, verify with one of the following. For more information about these options, go to www.oregon.gov/DHS/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 Web site at <http://dhsforms.hr.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.

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 office and reviewer who approved the PA.
18. If DMAP sends copies of this notice to other entities, such as 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 ①

Provider Name ②

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 ④			
CODES ⑤	DESCRIPTION ⑥	REQUESTED AMT/UNITS ⑦	APPROVED AMT/UNITS ⑧	SERVICING PROVIDER NAME ⑨
97110	THERAPEUTIC PROC, ONE OR MORE AR	\$181.44/009	\$181.44/009	THEO THERAPIST
CLIENT ID # ⑩	AA#####A			
PRIOR AUTH # ⑪	0123456789			
Dates Valid: From ⑫	12/09/2008	Through	01/31/2009	
Requesting/Referring Providers ⑬	REFERRER, MD			

Additional Notes: ⑭

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

Jane Doe ⑮

Street Name

City, State ZIP

DHS Branch:	Anytown		
Address: ⑯	### Street Name	Division: ⑰	DMAP - Medical Unit 800-642-8635
City/ZIP:	City, ZIP	Reviewer:	Reviewer, RN

CC: DHS Branch, Referring Provider ⑱

Notice of Prior Authorization of Payment for Medical Services

Recipient

Date

ID Number	XX#####X
Other Information	

Provider

Provider Name
Street Name
City, State ZIP

Jane Doe
Street Name
City, State ZIP

Prior Authorization Number #####	Dates Valid 10/1/05 through 10/31/05
Procedure/Drug/Diagnosis (ICD-9-CM) Code(s) Approved	Approved By DHS Staff Name
Type of Service Code	Maximum Units of Service Approved
Description	Maximum Dollars Approved
	Referring Provider Number #####

Client: Please contact the provider shown above to arrange for these services.

Provider: Your request for payment of medical/dental services to the Division of Medical Assistance Programs (DMAP) client named above has been approved providing:

- (1) The services authorized are provided within the "Dates Valid" listed above.
- (2) The client is eligible for DMAP payment of medical services on the date of service.
- (3) Any and all properly completed auxiliary documents are attached to the claim when submitted; examples are: Consent to Sterilization form, Consent to Hysterectomy form, Operative report.

This prior authorization DOES NOT supersede other rules, regulations, and policies of DMAP. Enter the Prior Authorization Number listed on the claim or payment will be denied or delayed. Give the Prior Authorization Number to other providers who will be billing DMAP for services related to this medical service. These ancillary providers (assisting surgeon, anesthesia, hospital) must enter the Prior Authorization Number on their claim when billing DMAP.

All prior resources must be explored and utilized before billing DMAP. (See General Rules, 410-120-1280–Full Use of Alternate Resources).

Providers having questions about prior authorization please refer to your provider guide.

State Office for Children, Adults and Families (CAF) clients must have consent for surgery obtained from the appropriate CAF office.

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 office and reviewer who approved the PA.
18. If DMAP sends copies of this notice to other entities, such as the client's branch office, that information will display here.



Date of Notice: 12/09/2008 ①

Provider Name ②
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: ③

PA Assignment:	Physical Therapy Services ④	Denial Date: ⑤	12/09/2008
CODES ⑥	DESCRIPTION ⑦	REQUESTED AMT/UNITS ⑧	SERVICING ⑨ PROVIDER NAME
97110	THERAPEUTIC PROC, ONE OR MORE AR	\$181.44/009	THEO THERAPIST
REASON FOR DENIAL ⑩	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 # ⑪	AA####A		
REQUEST # ⑫	0123456789		
Requesting/ Referring Providers ⑬	REFERRER, MD		

Additional Notes: ⑭

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

Jane Doe ⑮
Street Name
City, State ZIP

DHS Branch:	Anytown		
Address: ⑯	### Street Name	Division: ⑰	DMAP - Medical Unit 800-642-8635
City/ZIP:	City, ZIP	Reviewer:	Reviewer, RN

CC: DHS Branch, Referring Provider ⑱

Billing information

National Provider Identifier

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

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

Do not bill prior-authorized and non-prior-authorized services on the same claim form.

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
- Revenue Center Codes

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 DHS. Even though the system does not use this field during claim processing, this number helps DHS staff resolve the claim when the system cannot find a matching PA.

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

DHS accepts claims in the following electronic formats:

Batch claim format

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

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

Phone: 888-690-9888

Web site: www.oregon.gov/DHS/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 DHS EDI Support Services (see above).

Transaction information for EDI submitters

The DHS Companion Guides contain information on how registered EDI submitters need to set up and code their transactions for appropriate processing by DHS.

- For specific instructions on how to submit an electronic claim, refer to the *DHS 837 Professional Companion Guide - Fee-for-Service* at www.oregon.gov/DHS/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 DHS providers authorized to access the Provider Web Portal can submit individual institutional claims at <https://www.or-medicaid.gov>.

For more information about submitting claims on the Web portal, go to www.oregon.gov/DHS/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.

Uniform Billing (UB) claim form

DMAP does not supply this form. This form is available through local business forms suppliers, or by calling the Standard Register Company, Forms Division at 800-755-6405.

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

- 4 - Type of Bill
- 6 - Statement From and Through Dates
- 8b - Patient Name

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.

Multi-page claims

DMAP cannot process multi-page UB claims. If the claim exceeds one page, complete the claim as follows, or submit using the Provider Web Portal:

- Separate the charges into two claims. Do not duplicate Revenue Center Codes or HCPCS codes unless you are billing for different dates of service and the different dates of service are shown in FL 45.
- For example, if a specific Revenue Center Code appears on one claim, it must not appear on the second claim unless different dates of service show for each claim.

Billing for multiple dates of service

For each procedure, list each Date of Service in FL 45. In FL 6, enter a date range that covers all dates entered in FL 45 in which services were provided.

- Example: Outpatient physical therapy services provided from October 1 through October 31. Three separate services were provided.
- Dates of service (FL 6): 10/01/10 - 10/31/10

FL 42	FL 45	FL 46	FL 47
420	100110	1	53.00
420	101510	1	40.00
420	103110	1	40.00

Billing for multiple units of service

For each procedure, list the number of units of service provided in FL 46. In FL 6, enter the date range during which services were provided.

- Example: Outpatient physical therapy services provided from October 1 through October 31. 12 separate services were provided.
- Dates of service (FL 6): 10/01/10 - 10/31/10

FL 42	FL 45	FL 46	FL 47
420	[Leave blank]	12	600.00

Field Locators 50-66: Information listed by payer (A, B, C)

DMAP is secondary to all other insurance. When billing DMAP, enter DMAP information on line C.

POA Indicators

If you have claims that require these indicators for Medicare, please make sure that there is a space between the diagnosis code and the POA indicator. OCR will pick up the POA code from the shaded area.

Where to send claims

DMAP
 PO Box 14956
 Salem, Oregon 97309

UB-04 claim form instructions

Fields on the UB claim form are called Field Locators (FLs). Information on how to obtain the UB-04 Manual can be found on the NUBC Web site at www.nubc.org/First_Final_UB-04.pdf

- 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.
- Use the Medicare Home Health Billing Manual format information on Form Locators not listed on the following pages.
- Make sure information is left-aligned and correctly placed in fields marked “*Left-align.*” Misaligned information in these fields will delay processing.

FL	Description
1.	Provider Identification: Enter provider name, mailing address and ZIP code.
3a.	Patient Control Number (optional): Enter the number you assign to the account. If you enter the patient account number here, DMAP will print this information (up to 12 characters) on your Remittance Advice.
4.	Type of Bill: Enter the appropriate numeric code identified in the UB-04 Users Manual. <i>Left-align</i> DMAP accepts the following codes: <ul style="list-style-type: none"> ◆ 321 - (Admit through discharge claim): Encompasses an entire home health span of service for which the agency expects reimbursement. ◆ 322 - (First claim): Use this code for the first of an expected series of payment claims for the same home health start of care. ◆ 323 - (Interim-continuing claim): Use when one or more claims for the same home health start of care have already been submitted, and further claims are expected to be submitted at a later date. ◆ 324 - (Interim-last claim): Use for a claim which is the last of series for a home health start of care. The “through” date of this claim (FL 6) is the discharge date or date of death for this service span.
6.	Statement Covers Period: Use MMDDYY (month, day, and year) numeric format (example: 102808). Total days in this field must correspond to the number of units in FL 46. <i>Left-align</i> <ul style="list-style-type: none"> ◆ “From” date is the date services began. ◆ “Through” date is the last date services were provided.
8b.	Patient’s Name: Enter the patient’s name as it appears on the Medical Care ID. <i>Left-align</i>

1	2	3a PAT. CNTL.#	4 TYPE OF BILL
		b. MED. REC.#	4
		5 FED. TAX NO.	6 STATEMENT FROM
			7 PERIOD THROUGH
8 PATIENT NAME	a	9 PATIENT ADDRESS	a
b	b	c	d
10 BIRTHDATE	11 SEX	12	13 HR
		14 TYPE	15 SRC
		16 DHR	17 STAT
		18	19
		20	21
		22	23
		24	25
		26	27
		28	29 ACDT STATE
		30	
31 OCCURRENCE DATE	32 OCCURRENCE DATE	33 OCCURRENCE DATE	34 OCCURRENCE DATE
a	a	a	a
b	b	b	b
38	39 VALUE CODES AMOUNT	40 VALUE CODES AMOUNT	41 VALUE CODES AMOUNT
a	a	a	a
b	b	b	b
c	c	c	c
d	d	d	d
42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			
18			
19			
20			
21			
22			
23	PAGE OF	CREATION DATE	TOTALS
50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.
A			
B			
C			
54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	57
			57
			57
58 INSURED'S NAME	59 P.REL.	60 INSURED'S UNIQUE ID	61 GROUP NAME
A		60	
B			
C			
62 INSURANCE GROUP NO.	63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
A			
B			
C			
66 DX	A	B	C
67	D	E	F
	G	H	I
	J	K	L
	M	N	O
	P	Q	R
69 ADMIT DX	70 PATIENT REASON DX	71 PPS CODE	72 ECI
A	a	b	c
B	a	b	c
C	a	b	c
74 PRINCIPAL PROCEDURE CODE	75 OTHER PROCEDURE CODE	76 ATTENDING NPI	77 QUAL
78 LAST	79 FIRST	80 QUAL	
77 OPERATING NPI	78 LAST	79 FIRST	80 QUAL
78 OTHER NPI	79 LAST	80 FIRST	81 QUAL
79 OTHER NPI	80 LAST	81 FIRST	82 QUAL
80 REMARKS	81CC a	81CC b	81CC c

FL	Description
10.	Birthdate: Use MMDDYY format.
12.	Admission Date: Use MMDDYY format. Enter the actual admission date, even if the patient was not eligible on that date.
18-28.	Condition Codes: Enter “A1 EPSDT/CHAP (Medicheck)” when billing for EPSDT services.
31-35.	<p>Occurrence Codes and Dates of Occurrence: Enter one of the appropriate codes and date of occurrence:</p> <ul style="list-style-type: none"> ◆ 01 (Auto accident) ◆ 04 (Employment-related accident)
42.	<p>Revenue Center Codes: Enter “0001” in line 23 of this field. For each remaining line on the claim, enter the Revenue Center Code which most accurately describes the service provided.</p> <p>The same Revenue Center Code may appear on multiple lines when each line is:</p> <ul style="list-style-type: none"> ◆ Distinguished by different HCPCS codes in FL 44 and/or ◆ Distinguished by different dates of service in FL 45.
44.	<p>HCPCS/Rates: Enter the five-digit code. CPT/HCPCS codes are required for most services. Do not enter a daily rate in this field; this will cause the claim to deny for an invalid procedure code.</p> <ul style="list-style-type: none"> ◆ Refer to the Revenue Center Code Table (page 24) for codes requiring CPT/HCPCS. ◆ Attach explanation of unlisted HCPCS codes, so that DMAP can price the claim.
46.	<p>Units of Service: Enter total units of service. Combine all units of the same code for the same date of service on the same line.</p> <ul style="list-style-type: none"> ◆ List the units of service for each Revenue Center Code in FL 46. One visit equals one unit of service. One supply item equals one unit of service. ◆ For services which require prior authorization, the units of service should not exceed the number of services authorized for that time period (see page 6). ◆ From and Through dates (FL 6) must reflect the range of dates on which services were provided.
47.	Total Charges: Enter the total charges for each line item. Enter the sum of all charges in Line 23 of this field. Do NOT include charges for non-covered services in this column.

FL	Description		
50.	<p>Payer Name: Enter the name(s) of the payer organizations you are billing (up to three payers). Do not include DMAP copayments in this field.</p> <ul style="list-style-type: none"> ◆ Enter Medicare on line A. ◆ Enter other TPL (including Medicare supplement/replacement plan) on line B. ◆ Enter “Medicaid” on line C (for DMAP). 		
54.	<p>Prior Payments: Enter the actual amount of any payments you have received from a third party resource such as Medicare Part B, or other insurance on the line which corresponds to that payer’s line in FL 50. Show the actual Medicare payment. Do NOT adjust the prior payment amount.</p>		
56.	<p>NPI: Enter your 10-digit National Provider Identifier.</p>		
57.	<p>Other Provider ID: Enter your 6- or 9- digit DHS provider number on line C. Do not put other payer identifiers (<i>e.g.</i>, Medicare) in this field.</p>		
60.	<p>Insured’s Unique ID: On line C, enter the patient’s Client ID number as it appears on the client’s Medical Care Identification.</p>		
63.	<p>Treatment Authorization Codes: For services which have been prior-authorized by DMAP, enter the 10-digit authorization number on line C.</p>		
67.	<p>Principal Diagnosis Code: Enter the ICD-9-CM diagnosis code best describing the principal diagnosis (the condition for which the plan of treatment was established and the patient taken into service).</p> <ul style="list-style-type: none"> ◆ The ICD-9-CM must be carried out to its highest degree of specificity—see General Rules for specific details. ◆ Do not enter decimal points or unnecessary characters. 		
67A-67D	<p>Other Diagnosis Codes: Enter the ICD-9-CM diagnosis codes (up to four) for conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received.</p> <ul style="list-style-type: none"> ◆ Do not enter diagnoses that relate to an earlier episode which have no bearing on the current services provided. ◆ “Other diagnoses” are conditions that affect patient care in terms of requiring clinical evaluation, therapeutic treatment, diagnostic procedures, extended number of visits, increased nursing care and/or monitoring. 		
78.	<p>Other Physician ID: Enter the NPI and DHS number of the attending physician.</p> <table border="0" style="width: 100%;"> <tr> <td style="width: 50%; vertical-align: top;"> <p><i>To enter NPI:</i> Enter the 10-digit NPI of the physician who rendered service.</p> </td> <td style="width: 50%; vertical-align: top;"> <p><i>To enter DHS provider number:</i> Enter the 6- or 9-digit DHS provider number or UPIN of the physician.</p> <ul style="list-style-type: none"> ◆ For patients referred by a PCM or PCO: Enter the PCM’s DHS provider number. </td> </tr> </table>	<p><i>To enter NPI:</i> Enter the 10-digit NPI of the physician who rendered service.</p>	<p><i>To enter DHS provider number:</i> Enter the 6- or 9-digit DHS provider number or UPIN of the physician.</p> <ul style="list-style-type: none"> ◆ For patients referred by a PCM or PCO: Enter the PCM’s DHS provider number.
<p><i>To enter NPI:</i> Enter the 10-digit NPI of the physician who rendered service.</p>	<p><i>To enter DHS provider number:</i> Enter the 6- or 9-digit DHS provider number or UPIN of the physician.</p> <ul style="list-style-type: none"> ◆ For patients referred by a PCM or PCO: Enter the PCM’s DHS provider number. 		

FL	Description
80.	<p>Remarks: Use this space for Third Party Resource (TPR) explanation codes.</p> <ul style="list-style-type: none"> ◆ If the patient has Medicare Part B, but the service is not covered by Medicare, enter “NC” (Not Covered). ◆ 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. ◆ See pages 22-23 for accepted codes. ◆ Using more than one TPR code on a claim can delay processing.

Third Party Resource (TPR) explanation codes

Enter in FL 80 of the UB claim form. 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 patient

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 explanation of why no TPR payment as 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 explanation of why no TPR payment was made)

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/DHS/healthplan/tools_prov/read-ra.shtml.

Electronic remittance advice

Providers who submit electronic claims in the 837I format 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 DHS 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/DHS/healthplan/webportal.shtml.

Correcting claims

You have three options to adjust a claim that you submitted and DHS 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 DHS 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/DHS/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 *adjudicated* claims. Do not use the DMAP 1036 for *denied* 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 Forms Distribution, 550 Airport Rd SE, Salem, OR 97310.
- This form is also available on the DHS Web site at <http://dhsforms.hr.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.
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.	<p>This column contains possible areas you might want to correct. Only check the box you want to change.</p> <ul style="list-style-type: none">◆ Place of Service—Leave blank.◆ Quantity/Unit—To correct the number of services being billed.◆ NDC/Procedure Code—Leave blank.◆ Revenue Center Code—To correct Revenue Center Codes (FL 42 on the UB).◆ Insurance Payment/Patient Liability—To correct payments received from other sources (FL 54 on the UB).◆ Drug Name (Pharmacy Only)—Leave blank.◆ Billed Amount—To correct the amount you billed DMAP (FL 47 on the UB).

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
<input type="checkbox"/> Place of Service				
<input type="checkbox"/> Procedure Code/NDC/Rev Code				
<input type="checkbox"/> Modifier				
<input type="checkbox"/> Quantity/Unit				
<input type="checkbox"/> Diagnosis				
<input type="checkbox"/> Prescribing/Rendering Provider				
<input type="checkbox"/> Billed Amount/Total Billed				
<input type="checkbox"/> Medicare Payment				
<input type="checkbox"/> Other Insurance/Patient Liability				
<input type="checkbox"/> Co-Insurance				
<input type="checkbox"/> Other				

⑯ **Remarks**

⑰ Requester's Name	Phone #	Date
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Individual Adjustment Request Instructions

1. **Type of Adjustment** – Check the appropriate box.
4. **Internal Control Number (ICN)** – Enter the 13-digit ICN from the Remittance Advice (RA).
5. **RA Date** – Enter the date printed on the RA.
6. **Recipient Name** – Enter the recipient's name.
7. **Recipient ID Number** – Enter the recipient's ID number.
8. **Provider Name** – Enter your provider name.
9. **Provider Number** – Enter your nine-digit DHS provider number.
10. **National Provider Identifier (NPI)** – Enter your NPI number.
11. **Description of original error** – This column lists possible errors to be corrected.
12. **Line Number** – Enter the line number from the RA.
13. **Service Date** – Enter the date, or date range, of service for the service provided.
14. **Wrong Information** – Enter the incorrect information submitted on your original claim.
15. **Right Information** – Enter the correct information.
16. **Remarks** – Enter any other information you think necessary to accurately adjust your claim.
17. **Requester's Name** – Enter the provider or authorized representative's name.

	◆ Other–Use to correct ICD-9-CM codes appearing on the RA or use if none of the above 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.

DHS 3970 - EDMS Coversheet

DHS now requires this sheet 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 DHS 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 Web site at <http://dhsforms.hr.state.or.us/Forms/Served/DE3970.pdf>.

How to complete the DHS 3970

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

- **Always enter your National Provider Identifier and 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.

DHS 3971 - Oregon DHS Prior Authorization Request

Use this form when submitting other PA requests to DMAP. Submit your PA request with required documentation and a completed EDMS Coversheet (see previous page).

This form is also available on the DHS Web site at <http://dhsforms.hr.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	
		Continue	Change
Section I - Provider number	X		
Section II - Type of PA request - "Home Health"	X		
Section III <ul style="list-style-type: none"> ◆ Client ID -The 8-digit Medicaid ID. ◆ Client's name 	X	X	
Section IV <ul style="list-style-type: none"> ◆ ICD-9-CM diagnosis code - The reason chiefly responsible for the service being provided as shown in the medical records; provided for each diagnosis for which the patient receives home care ◆ Revenue Center Codes ◆ Frequency of service 	X		
Section V - Procedure codes; units of service	X		
Section VIII - Performing provider number	X		
Section IX - Date of request; service begin/end dates	X		
Notes <ul style="list-style-type: none"> ◆ New PA: Goals and objectives; assessment of availability of other resources to care for the client ◆ Change to PA: The needed change and reason for change 	X		X
Attachments Describe and attach the following medical justification from the prescribing practitioner: <ul style="list-style-type: none"> ◆ Assessments/reassessments for which the patient is receiving home care. ◆ Reason home care is the most medically effective service. ◆ Most recent visit notes to support the PA 	X	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)

- | | | |
|---|---|---|
| <input type="checkbox"/> Audiology | <input type="checkbox"/> Home Health | <input type="checkbox"/> Physician |
| <input type="checkbox"/> Chemical Dependency Treatment Services | <input type="checkbox"/> Imaging | <input type="checkbox"/> SPD – CIIS (MFCU, CHN and Nursing) |
| <input type="checkbox"/> Dental Hospital Referral | <input type="checkbox"/> Inpatient Rehab | <input type="checkbox"/> Speech Services |
| <input type="checkbox"/> DME | <input type="checkbox"/> Medical Transportation | <input type="checkbox"/> Supplies |
| <input type="checkbox"/> Gambling Treatment Services | <input type="checkbox"/> Mental Health | <input type="checkbox"/> Surgery |
| <input type="checkbox"/> Hearing Aid | <input type="checkbox"/> Occupational Therapy | <input type="checkbox"/> Transplant |
| <input type="checkbox"/> Home EPIV | <input type="checkbox"/> Pharmacy | <input type="checkbox"/> Vision |
| <input type="checkbox"/> 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 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 DMAP's Web site at
www.oregon.gov/DHS/healthplan

DMAP 2420 (Rev. 02/08)

Place
Postage
Here

DAS Distribution Center
550 Airport Rd SE
Salem OR 97310