

Hospital Services Provider Guide



Supplemental information for
Oregon Medicaid providers

- Revenue Center Codes
- Billing instructions
- Billing forms
- Electronic billing / EDI



Revised Aug. 2, 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 Hospital Services Oregon Administrative Rules (Chapter 410 Division 125). See current Hospital Services rulebook for official policies regarding billing.

Prior authorization

Client information - *See OAR 410-125-0086, 410-125-0102, 410-125-0103*

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.

- For clients in a managed care plan, contact the plan for PA requirements and procedures. To determine if a client is in managed care, use AVR or Web portal.
- Former Medically Needy program clients, Medicare clients, and other clients may have specific requirements or exceptions to the prior authorization process. Refer to the Hospital Services rulebook for additional information.

Services that require PA - *See OARs 410-125-0047, 410-125-0080, 410-125-0085, 410-125-0120, 410-125-0140*

Refer to the Hospital Services rulebook for information on the hospital services that require PA. These include:

- OHP Standard Limited Hospital Benefits
- Non-emergent procedures for OHP Plus clients (see the Medical-Surgical and Dental Services rulebooks for specific procedures that require PA)
- Some transfers, including transfers to distinct part rehabilitation units
- For outpatient services, refer to the program-specific guidelines for PA requirements. All provider guidelines are available at www.dhs.state.or.us/policy/healthplan/guides/main.html.

How to submit PA requests

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

Outpatient prescriptions

Submit all PA requests for oral nutritional supplements and fee-for-service (FFS) prescriptions (including 7/11 carve-out drugs for managed care clients) to:

Oregon Pharmacy Call Center

888-202-2126

Fax: 888-346-0178

Use the DMAP 3978 form (see Forms section for sample). The Oregon Pharmacy Call Center is staffed 9 a.m. to 6 p.m., Monday through Friday, with after-hours, on-call service during non-peak hours and weekends.

All other PA requests

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.

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

- Routine requests: 503-378-5814
- Immediate/urgent requests: 503-378-3435. For hospital dentistry, fax 503-945-9908.

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

Non-emergent hospital dentistry	DMAP Dental Coordinator 2575 Bittern St NE Salem, OR 97301 Phone: 503-945-9891
All other services	DMAP – Medical Management Unit 500 Summer St NE, E44 Salem, OR 97301-1078 503-945-6821 (direct) 800-642-8635 (in-state only)

Billing information

Client eligibility and enrollment

DMAP General Rule 410-120-1140 Verification of Eligibility and Coverage requires all enrolled providers to verify eligibility on the date of service.

- DMAP will not pay claims for clients who are not eligible on the date of service.
- For clients enrolled in an OHP managed care plan, DMAP will not pay for services covered by the managed care plan, except as provided by statute and included in Oregon Administrative Rule (OAR).

Resources

To determine client eligibility 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.

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.

Billing requirements - *See OAR 410-125-0220, 410-125-0360, 410-125-0640*

Refer to the Hospital Services rulebook for billing requirements, policies, and/or exceptions for the following services:

- Dental services
- Diagnostic and similar services provided outside the hospital
- Emergency room X-ray or EKG services
- End-stage renal dialysis facilities
- Home health services
- Hospital-operated air and ground ambulance services
- Non-contiguous out-of-state hospital services
- Observation services
- Orthotics, prosthetics, and durable medical equipment
- Outpatient and inpatient services provided on the same day
- Outpatient procedures which result in inpatient admissions
- Pharmaceutical and Home Enteral/Parenteral services
- Readmissions
- Services by physicians in a teaching setting
- Services by professional staff and other providers
- Services by residents and medical students
- Special reports, exams, and medical records
- Third party payers - Medicare, Other Insurance, Motor Vehicle Accident Fund, Liability, Adoption Agreements, Veteran's Administration benefits, trust funds, billing the client
- Transfers

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 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.

When to bill on paper

You must bill on paper for any claims that require attachments. You must submit a cover letter and attachments for the following:

- **Retroactive medical:** If the patient becomes eligible retroactive to the dates of service, the provider must attach documentation which indicates the medical appropriateness of non-emergent services.
- **Claims using unlisted lab, radiology, nuclear medicine, CT scans, MRI, and other imaging services codes:** Unlisted codes must be manually priced by the DMAP Medical Management Unit. The provider must attach documentation describing the test or procedure performed so that staff can determine the appropriate payment.

Attachments are not required on claims for obstetrical and newborn services.

Medicare-Medicaid claims

When you bill Medicare before you bill DMAP for hospital services, Medicare automatically forwards the claim to DMAP as a crossover claim. When you submit claims to Medicare that you want to crossover to DMAP:

- **For electronic claims:** Enter the client's Medicaid information on the third party payer screen.
- **For paper claims:** Enter Medicare as the primary payer, and "DMAP" as the payer of last resort in Field Locator (FL) 50; follow instructions indicated for crossover claims for each FL on the following pages.

Do not bill claims to DMAP until they have been billed to and adjudicated by Medicare.

When the client has Part B coverage only, bill the full charges to Medicaid, including any charges which were submitted to and paid by the Part B payer.

Electronic claims submissions

DMAP accepts institutional claims in the following electronic formats:

Batch claim format

If you want to submit claims electronically using the 837I 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 Institutional 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 Companion Guides 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 *Oregon Medicaid 837 Institutional Companion Guide* 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 location.

Individual claim format

Enrolled Oregon Medicaid providers authorized to access the Provider Web Portal can submit individual institutional claims at <https://www.or-medicaid.gov>. For more information, 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.

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 UB claims

DMAP cannot process multiple-page UB claims. If the claim exceeds one page, complete the claim as follows:

- **Outpatient claims:** 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.

- **Inpatient claims:** Do not use more than 22 Revenue Center Codes or line items on a single claim, and do not separate the charges into two claims. If needed, combine services under a single Revenue Center Code to reduce the total number of line items.

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.

- 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.
- 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.	<p>Type of Bill: Enter the appropriate numeric code identified in the UB-04 Users Manual. Left-align</p> <p>DMAP accepts the following codes:</p> <table border="0"> <thead> <tr> <th><i>Inpatient Codes</i></th> <th><i>Outpatient Codes</i></th> </tr> </thead> <tbody> <tr> <td>◆ 111 - For most inpatient billings, including patients with Medicare Part A coverage only</td> <td>◆ 131 - For most outpatient billings</td> </tr> <tr> <td>◆ 121 - For patients with Medicare Part B coverage only</td> <td>◆ 141 - Referenced Diagnostic Services</td> </tr> <tr> <td></td> <td>◆ 721 - Independent End Stage Renal Dialysis Facilities</td> </tr> <tr> <td></td> <td>◆ 831 - Hospital-Based Ambulatory Surgery</td> </tr> </tbody> </table>	<i>Inpatient Codes</i>	<i>Outpatient Codes</i>	◆ 111 - For most inpatient billings, including patients with Medicare Part A coverage only	◆ 131 - For most outpatient billings	◆ 121 - For patients with Medicare Part B coverage only	◆ 141 - Referenced Diagnostic Services		◆ 721 - Independent End Stage Renal Dialysis Facilities		◆ 831 - Hospital-Based Ambulatory Surgery
<i>Inpatient Codes</i>	<i>Outpatient Codes</i>										
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	◆ 721 - Independent End Stage Renal Dialysis Facilities										
	◆ 831 - Hospital-Based Ambulatory Surgery										
6.	<p>Statement Covers Period: Use MMDDYY (month, day, and year) numeric format (example: 102808). Total days in this field must equal the number of accommodation days in FL 46. Do not count the day of discharge when calculating the number of accommodation days. Left-align</p> <ul style="list-style-type: none"> ◆ <i>For Inpatient Services:</i> The “From” date is the date of admission. “Through” date is the date of discharge, transfer, or expiration. ◆ <i>For Outpatient Services:</i> “From” date is the date services began. “Through” date is the last date services were provided. 										

FL	Description				
7.	XOVR Indicator: Enter “XOVR” in this field when: <ul style="list-style-type: none"> ◆ <i>For Inpatient Services:</i> The patient has Medicare Part A. ◆ <i>For Outpatient Services:</i> The patient has Medicare Part B and the service is covered by Medicare. 				
8b.	Patient’s Name: Enter the patient’s name as it appears on the Medical Care ID. <i>Left-align</i>				
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.				
13.	Admission Hour: Enter the hour of admission, using numbers from 00 to 24. (01 = 1 a.m., 10 = 10 a.m., 13 = 1 p.m. 23 = 11 p.m., etc.).				
14.	Type of Admission or Service: Use the following codes (see pages 2-3 for definitions): <table style="width: 100%; border: none;"> <tr> <td style="width: 50%;">◆ 1 - Emergent</td> <td style="width: 50%;">◆ 3 - Elective</td> </tr> <tr> <td>◆ 2 - Urgent</td> <td>◆ 4 - Newborn</td> </tr> </table>	◆ 1 - Emergent	◆ 3 - Elective	◆ 2 - Urgent	◆ 4 - Newborn
◆ 1 - Emergent	◆ 3 - Elective				
◆ 2 - Urgent	◆ 4 - Newborn				
16.	Discharge Hour: Use numbers from 00 to 24 (as in FL 13).				
17.	Patient Status (required on inpatient claims only): Enter one of the following: <ul style="list-style-type: none"> ◆ 01 - Discharged to home or self care (routine discharge) ◆ 02 - Discharged or transferred to another acute care hospital ◆ 03 - Discharged or transferred to skilled nursing facility (SNF) ◆ 04 - Discharged or transferred to an intermediate care facility (ICF) ◆ 05 - Discharged or transferred to another type of institution (not another acute care hospital) ◆ 06 - Discharged or transferred to home under care of home health service organization ◆ 07 - Left against medical advice ◆ 08 - Discharged to home under care of Home Enteral/Parenteral Provider ◆ 20 - Expired 				
18-28.	Condition Codes: Enter “A1 EPSDT/CHAP (Medicheck)” when billing for EPSDT services.				
31-35.	Occurrence Codes and Dates of Occurrence: Enter one of the appropriate codes and date of occurrence: <ul style="list-style-type: none"> ◆ 01 (Auto accident) ◆ 04 (Employment-related accident) 				

FL	Description		
39-41	<p>Value Codes: Use these FLs to report the following information to DMAP. Do not put more than one entry in each field. For more information about accepted value codes, refer to the CMS Web site or NUBC UB-04 Manual.</p> <table border="0" data-bbox="203 315 1529 735"> <tr> <td data-bbox="203 315 812 735"> <p><i>Family Planning Percentage</i> When family planning services are part of the claim, enter Value Code “XO,” followed by an estimate of the total charges related to family planning:</p> <ul style="list-style-type: none"> ◆ Report the percentage in the cents area of the amount field. ◆ Round to the nearest whole percent (<i>e.g.</i>, 100% as 1.00, 45% as 0.45). </td> <td data-bbox="812 315 1529 735"> <p><i>Medicare Coinsurance and Deductible</i> When Medicare is the primary payer, enter the appropriate Value Code(s), followed by the dollars and cents money amount being reported.</p> <ul style="list-style-type: none"> ◆ A1 (Deductible Payer A) - For the Part A or Part B deductible amount ◆ A2 (Coinsurance Payer A) - For Part A or Part B coinsurance amounts. </td> </tr> </table> <p>Note: When Medicare coverage is present, it will normally be reported as “Payer A” on the UB. However, in situations where Medicare is “Payer B”, use Value Codes “B1” and “B2” to report Medicare coinsurance and deductible Failure to correctly report the Part A deductible may result in incorrect payment.</p>	<p><i>Family Planning Percentage</i> When family planning services are part of the claim, enter Value Code “XO,” followed by an estimate of the total charges related to family planning:</p> <ul style="list-style-type: none"> ◆ Report the percentage in the cents area of the amount field. ◆ Round to the nearest whole percent (<i>e.g.</i>, 100% as 1.00, 45% as 0.45). 	<p><i>Medicare Coinsurance and Deductible</i> When Medicare is the primary payer, enter the appropriate Value Code(s), followed by the dollars and cents money amount being reported.</p> <ul style="list-style-type: none"> ◆ A1 (Deductible Payer A) - For the Part A or Part B deductible amount ◆ A2 (Coinsurance Payer A) - For Part A or Part B coinsurance amounts.
<p><i>Family Planning Percentage</i> When family planning services are part of the claim, enter Value Code “XO,” followed by an estimate of the total charges related to family planning:</p> <ul style="list-style-type: none"> ◆ Report the percentage in the cents area of the amount field. ◆ Round to the nearest whole percent (<i>e.g.</i>, 100% as 1.00, 45% as 0.45). 	<p><i>Medicare Coinsurance and Deductible</i> When Medicare is the primary payer, enter the appropriate Value Code(s), followed by the dollars and cents money amount being reported.</p> <ul style="list-style-type: none"> ◆ A1 (Deductible Payer A) - For the Part A or Part B deductible amount ◆ A2 (Coinsurance Payer A) - For Part A or Part B coinsurance amounts. 		
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. Use an accommodation day Revenue Center Code if the patient was admitted and either discharged, transferred or expired on the same day.</p> <ul style="list-style-type: none"> ◆ <i>For inpatient services:</i> The same Revenue Center Code may not appear on more than one line of the claim. ◆ <i>For outpatient services:</i> The same Revenue Center Code may appear on multiple lines when each line is: <ul style="list-style-type: none"> - <i>Distinguished by different HCPCS codes in FL 44 and/or</i> - <i>Distinguished by different dates of service in FL 45.</i> 		
43.	<p>Revenue Description: If billing for physician-administered drugs:</p> <ul style="list-style-type: none"> ◆ Enter information about the drug in this order on the appropriate line: N4, 11-digit National Drug Code (NDC) in 5-4-2 format, Unit of Measure, NDC quantity (fractional units limited to 3 digits to the right of the decimal). ◆ Use the following qualifiers for Unit of Measure: F2 – International Unit, GR – Gram, ML – Milliliter, UN - Unit <p>See billing example below:</p>		

42 RE V. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE
0636	N412345678901UN1234.000	J##### [Enter UD for 340B drugs]

FL	Description		
44.	<p>HCPCS/Rates: Enter the five-digit code. 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"> ◆ See the Revenue Center Code Table (pages 17-33) for codes requiring HCPCS. ◆ Attach explanation of unlisted HCPCS codes, so that DMAP can price the claim. ◆ For physician-administered drugs: Enter HCPCS code; also enter modifier UD for drugs purchased for Medicaid clients through a 340B entity. 		
45.	<p>Service Date (required for outpatient services only, when applicable): Enter in MMDDYY format. See page 7 for how to bill for a series of services based on dates of service.</p>		
46.	<p>Units of Service: Enter total units of service or accommodation days.</p> <table border="0" style="width: 100%;"> <tr> <td style="width: 50%; vertical-align: top;"> <p><i>For inpatient services:</i> A Leave of Absence day counts as an accommodation day. The total number of accommodation days must equal the number of days in FL 7.</p> <ul style="list-style-type: none"> ◆ DMAP does not count the day of discharge (the “Through” date in FL 6) as a day. However, you should bill charges incurred on the day of discharge. <p>Example: Patient admitted on October 1 and discharged on October 5</p> <ul style="list-style-type: none"> ◆ FL 6: From = 1001, Through = 1005 ◆ FL 46: Units of Service = 4 </td> <td style="width: 50%; vertical-align: top;"> <p><i>For outpatient services:</i> If you provide outpatient services over a period of time, you may bill for more than one service on a single claim form.</p> <ul style="list-style-type: none"> ◆ List the units of service for each Revenue Center Code in FL 46. ◆ 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. </td> </tr> </table>	<p><i>For inpatient services:</i> A Leave of Absence day counts as an accommodation day. The total number of accommodation days must equal the number of days in FL 7.</p> <ul style="list-style-type: none"> ◆ DMAP does not count the day of discharge (the “Through” date in FL 6) as a day. However, you should bill charges incurred on the day of discharge. <p>Example: Patient admitted on October 1 and discharged on October 5</p> <ul style="list-style-type: none"> ◆ FL 6: From = 1001, Through = 1005 ◆ FL 46: Units of Service = 4 	<p><i>For outpatient services:</i> If you provide outpatient services over a period of time, you may bill for more than one service on a single claim form.</p> <ul style="list-style-type: none"> ◆ List the units of service for each Revenue Center Code in FL 46. ◆ 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.
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47.	<p>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.</p>		
48.	<p>Non-Covered Charges: Enter charges for not-covered services for each line item. Do not total these charges in line 23 of this field and do NOT include these charges in the total charges appearing in FL 47.</p>		
50.	<p>Payer Name: Enter the name(s) of the payer organizations you are billing (up to three payers). Do not enter DMAP information on lines A or B.</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). 		

FL	Description								
52	Release of Information (for crossover claims to Medicare): Enter a “Y” in this field on line C.								
53	Assignment of Benefits (for crossover claims to Medicare): Enter a ‘Y’ in this field on line C.								
54.	Prior Payments: Enter the actual amount of any payments you have received from a third party resource such as Medicare Part A, 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.								
56.	NPI: Enter your 10-digit National Provider Identifier.								
57.	Other Provider ID: Enter your 6- or 9- digit Oregon Medicaid provider number on line C. Do not put other payer identifiers (<i>e.g.</i> , Medicare) in this field.								
58	Insured’s Name (for crossover claims to Medicare): On line C, enter the patient’s name as shown on the patient’s Medical Care Identification.								
59	<p>Patient’s Relationship to Insured (for crossover claims to Medicare): On line C, enter the appropriate code:</p> <table border="0"> <tr> <td data-bbox="212 989 440 1029">◆ 01 - Spouse</td> <td data-bbox="850 989 1175 1029">◆ 39 - Organ Donor</td> </tr> <tr> <td data-bbox="212 1037 391 1077">◆ 18 - Self</td> <td data-bbox="850 1037 1149 1077">◆ 53 - Life Partner</td> </tr> <tr> <td data-bbox="212 1085 415 1125">◆ 19 - Child</td> <td data-bbox="850 1085 1268 1125">◆ G8 - Other Relationship</td> </tr> <tr> <td data-bbox="212 1134 480 1173">◆ 21 - Unknown</td> <td></td> </tr> </table>	◆ 01 - Spouse	◆ 39 - Organ Donor	◆ 18 - Self	◆ 53 - Life Partner	◆ 19 - Child	◆ G8 - Other Relationship	◆ 21 - Unknown	
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◆ 19 - Child	◆ G8 - Other Relationship								
◆ 21 - Unknown									
60.	Insured’s Unique ID: On line C, enter the patient’s Client ID number as it appears on the client’s Medical Care Identification.								
63.	Treatment Authorization Codes: For services which have been prior-authorized by DMAP, enter the 10-digit authorization number on line C.								
67.	Principal Diagnosis Code: Enter the ICD-9-CM diagnosis code best describing the principal diagnosis (the condition established after study to be chiefly responsible for causing this hospitalization).								

FL	Description
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 or develop subsequently, that affect patient care. Enter the appropriate POA indicator in the shaded area for each code.</p> <ul style="list-style-type: none"> ◆ Conditions that affect patient care are those that require clinical evaluation, therapeutic treatment, diagnostic procedures, increased length of stay, increased nursing care and/or monitoring. This may affect the DRG assignment on inpatient stays. ◆ Do not enter diagnoses that relate to an earlier episode which have no bearing on the current hospital stay. <p>You must enter POA indicators and codes to indicate hospital acquired conditions. For HAC codes, go to www.dhs.state.or.us/policy/healthplan/guides/hospital/main.html). For POA indicators, see the Billing Codes section of this guide.</p>
74.	<p>Principal Procedure: Enter the ICD-9-CM procedure code which best identifies the procedure completed. The principal procedure is performed for definitive treatment rather than for diagnostic or exploratory purposes, or to treat a complication, or the procedure most related to the principal diagnosis.</p>
74a-74b.	<p>Other Procedure Codes And Dates (required on inpatient claims only, when applicable): Enter ICD-9-CM codes (up to two) for other procedures performed and the date on which the principal procedure was performed.</p> <ul style="list-style-type: none"> ◆ Coding is not required for diagnostic and therapeutic procedures such as CT scans, physical, occupational, or respiratory therapy, or radiological studies.
78.	<p>Other Physician ID: Enter the NPI, Oregon Medicaid provider number, and name of the physician who rendered service.</p> <ul style="list-style-type: none"> ◆ This information is required on all claims except for outpatient Medicare/Medicaid “crossover” claims received by DMAP directly from Medicare. <p><i>To enter NPI:</i> Enter the 10-digit NPI of the physician who rendered service.</p> <p><i>To enter Oregon Medicaid provider number:</i> Enter the 6- or 9-digit Oregon Medicaid 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 DMAP provider number.

FL	Description
80.	<p>Remarks: Enter additional information to help process this claim:</p> <p><i>Third Party Resource (TPR) codes (see Billing Codes section of this guide for accepted codes)</i></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. ◆ Using more than one TPR code on a claim can delay processing. <p><i>Other information:</i></p> <ul style="list-style-type: none"> ◆ Itemization of services provided under Revenue Center Code 512 ◆ Description of “unlisted” lab or radiology HCPCS codes for manual pricing

Billing codes

Coding guidelines for specific services

Maternity Case Management

Bill using Revenue Center Code 569 and the appropriate procedure code (see the Medical-Surgical rules for the codes).

Laboratory services, diagnostic and therapeutic radiology, nuclear medicine, CT scans, MRI, and other imaging services

Bill using the most appropriate CPT/HCPCS code. Do not use modifiers.

Technical component

Use Revenue Center Codes 300-359, 400-409, 610-619, 923 and 925.

Professional component

Use Revenue Center Codes 970 to 974. Bill the professional component for CT scans and MRIs under Revenue Center Code 972.

- Do not fragment or unbundle lab services. Refer to the Medical-Surgical rules (OAR 410 Division 130) for additional information.
- You can bill DMAP for the collection of blood through venipuncture or capillary puncture, or the collection of a urine sample by catheterization. However, DMAP will not reimburse these services more than one time per day.

Therapeutic services, durable medical equipment & supplies

Physical therapy, occupational therapy, speech-language therapy, and audiology services are subject to the limitations and prior authorization requirements established in the Physical and Occupational Therapy Services rules, Speech-Language Pathology, Audiology and Hearing Aid Services rules. Durable medical equipment and medical supplies are subject to the limitations established in the Durable Medical Equipment and Medical Supplies rules.

For services requiring prior authorization

Use one of the following ICD-9-CM codes in FL 67:

- V57.1 Physical therapy
- V57.21 Occupational therapy
- V57.3 Speech-language therapy
- V57.89 Audiology
- V58.9 Durable medical equipment

Note: Some physical therapy, occupational therapy, speech-language therapy, and audiology services do not require prior authorization. In these instances you may list the client's actual diagnosis in FL 67.

Revenue Center Code table

Use in FL 42 of the UB-04 claim form. Revenue Center Codes may be added or deleted to conform with national billing standards and changes in Medicare.

= Accommodation days * = CPT/HCPCS code required ◆ = NDC reporting required

11X ROOM AND BOARD — PRIVATE (MEDICAL OR GENERAL)	
110#	General Classification
111#	Medical/Surgical/Gyn
112#	OB
113#	Pediatric
114#	Psychiatric
115	Hospice (Not Covered)
116#	Detoxification
117#	Oncology
118#	Rehab/Private
119#	Other
12X ROOM AND BOARD — SEMI-PRIVATE (MEDICAL OR GENERAL)	
120#	General Classification
121#	Medical/Surgical/Gyn

= Accommodation days

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122#	OB
123#	Pediatric
124#	Psychiatric
125	Hospice (Not Covered)
126#	Detoxification
127#	Oncology
128#	Rehabilitation
129#	Other
13X SEMI-PRIVATE — THREE AND FOUR BEDS	
130#	General Classification
131#	Medical/Surgical/Gyn
132#	OB
133#	Pediatric
134#	Psychiatric
135	Hospice (Not Covered)
136#	Detoxification
137#	Oncology
138#	Rehabilitation
139#	Other
14X	PRIVATE (DELUXE)
140#	General Classification
141#	Medical/Surgical/Gyn
142#	OB
143#	Pediatric
144#	Psychiatric
145	Hospice (Not Covered)
146#	Detoxification
147#	Oncology
148#	Rehab/Deluxe
149#	Other
15X	ROOM AND BOARD WARD (MEDICAL OR GENERAL)
150#	General Classification
151#	Medical/Surgical/Gyn

= Accommodation days

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152#	OB
153#	Pediatric
154#	Psychiatric
155	Hospice (Not Covered)
156#	Detoxification
157#	Oncology
158#	Rehabilitation
159#	Other
16X	OTHER ROOM AND BOARD
160#	General Classification
164#	Sterile Environment
167#	Self Care
169#	Other
17X	NURSERY
170#	General Classification (Nursery)
171#	Newborn – Level I
172#	Newborn – Level II
173#	Newborn – Level III
174#	Newborn – Level IV
179#	Other
18X	LEAVE OF ABSENCE - Bill hard-copy.
180#	General Classification
181	RESERVED (Not Covered)
182	Patient Convenience (Not Covered)
183#	Therapeutic Leave
184	RESERVED (Not Covered)
185	Nursing Home (for hospitalization) (Not Covered)
189	Other Leave of Absence (Not Covered)
19X	SUBACUTE CARE (NOT COVERED)
190	General Classification (Not Covered)
191	Subacute Care Level I (Not Covered)
192	Subacute Care Level II (Not Covered)
193	Subacute Care Level III (Not Covered)
194	Subacute Care Level IV (Not Covered)

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199	Other Subacute Care (Not Covered)
20X	INTENSIVE CARE
200#	General Classification
201#	Surgical
202#	Medical
203#	Pediatric
204#	Psychiatric
206#	Intermediate ICU
207#	Burn Care
208#	Trauma
209#	Other Intensive Care
21X	CORONARY CARE
210#	General Classification
211#	Myocardial Infarction
212#	Pulmonary Care
213#	Heart Transplant
214#	Intermediate CCU
219#	Other Coronary Care
22X	SPECIAL CHARGES
220	General Classification (Not Covered)
221	Admission Charge (Not Covered)
222	Technical Support Charge (Not Covered)
223	U.R. Service Charge (Not Covered)
224	Late Discharge, Medically appropriate (Not Covered)
229	Other Special Charges - <i>This Revenue Center Code is authorized only for Administrative Reports requested by branch office staff.</i>
23X	INCREMENTAL NURSING CHARGE RATE
230	General Classification
231	Nursery
232	OB
233	ICU
234	CCU
235	Hospice (Not Covered)
239	Other

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24X	ALL INCLUSIVE ANCILLARY (NOT COVERED)
240	General Classification (Not Covered)
241	Basic (Not Covered)
242	Comprehensive (Not Covered)
243	Specialty (Not Covered)
249	Other Inclusive Ancillary (Not Covered)
25X	PHARMACY
<i>National Drug Code reporting is required for all services in this category (25X).</i>	
250	General Classification
251*◆	Generic Drugs
252*◆	Non-Generic Drugs
253*◆	Take Home Drugs
254*◆	Drugs Incident to Diagnostic Services
255*◆	Drugs Incident to Radiology
256*◆	Experimental Drugs (Not Covered)
257*◆	Non-prescription
258*◆	IV Solutions
259*◆	Other Pharmacy
26X	IV THERAPY
260	General Classification*
261	Infusion Pump*
262	IV Therapy/Pharmacy Services
263	IV Therapy/Drug/Supply Delivery
264	IV Therapy/Supplies
269	Other IV Therapy*
27X	MEDICAL/SURGICAL SUPPLIES AND DEVICES
270	General Classification
271	Nonsterile Supplies
272	Sterile Supply
273	Take Home Supplies
274	Prosthetic/Orthotic Devices*
275	Pacemaker
276	Intraocular Lens*
277	Oxygen — Take Home

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278	Other Implants
279	Other Supplies/Devices*
28X	ONCOLOGY*
280	General Classification
289	Other Oncology
29X	DURABLE MEDICAL EQUIPMENT (OTHER THAN RENAL)*
<i>Prior authorization of services is required for all outpatient services in this category (29X).</i>	
290	General Classification
291	Rental
292	Purchase of new durable medical equipment
293	Purchase of used durable medical equipment
294	Supplies/Drugs for DME effectiveness (Not Covered)
299	Other Equipment
30X *	LABORATORY
300	General Classification
301	Chemistry
302	Immunology
303	Renal Patient (Home)
304	Non-Routine Dialysis
305	Hematology
306	Bacteriology & Microbiology
307	Urology
309	Other Laboratory
31X	LABORATORY — PATHOLOGICAL
310	General Classification
311	Cytology
312	Histology
314	Biopsy
319	Other
32X	RADIOLOGY — DIAGNOSTIC
320	General Classification*
321	Angiocardiology*
322	Arthrography
323	Arteriography*

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324	Chest X-Ray*
329	Other*
33X	RADIOLOGY — THERAPEUTIC*
330	General
331	Chemotherapy — Injected
332	Chemotherapy — Oral
333	Radiation Therapy
335	Chemotherapy — IV
339	Other
34X	NUCLEAR MEDICINE (RADIOISOTOPES)*
340	General classification
341	Diagnostic - Procedures
342	Therapeutic - procedures
343	Diagnostic - Radiopharmaceuticals
344	Therapeutic - Radiopharmaceuticals
349	Other
35X	CT SCAN*
350	General classification
351	Head Scan
352	Body Scan
359	Other CT Scans
36X *	OPERATING ROOM SERVICES
360	General Classification
361	Minor Surgery
362	Organ Transplant — other than kidney
367	Kidney Transplant
369	Other Operating Room Services
37X	ANESTHESIA
370	General Classification
371	Anesthesia Incident to Radiology
372	Incident to Diagnostic Services
374	<i>Acupuncture – Covered only when procedure performed by a physician or physician's employee acupuncturist under a physician's supervision.</i>
379	Other Anesthesia

= Accommodation days

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38X	BLOOD
380	General Classification
381	Packed Red Cells
382	Whole Blood (Not Covered)
383	Plasma
384	Platelets
385	Leukocytes
386	Other Components
387	Other Derivatives (Cyroprecipitates)
389	Other Blood
39X	BLOOD STORAGE AND PROCESSING
390	General Classification
391	Blood Administration (e.g., Transfusions)
399	Other Blood Storage & Processing
40X	OTHER IMAGING SERVICES*
400	General Classification
401	Diagnostic Mammography
402	Ultrasound
403	Screening Mammography
404	Positron Emission Tomography
409	Other Imaging Services
41X	RESPIRATORY SERVICES
410	General Classification*
412	Inhalation Services
413	Hyperbaric Oxygen Therapy
419	Other Respiratory Services
42X	PHYSICAL THERAPY*
<i>Prior authorization of services is required for outpatient physical therapy services, unless Medicare part B is the primary payer. Evaluations do not require prior authorization.</i>	
420	General Classification
421	Visit Charge
422	Hourly Charge
423	Group Rate
424	Evaluation or Reevaluation

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429	Other Physical Therapy
43X	OCCUPATIONAL THERAPY*
<i>Prior authorization of services is required for outpatient occupational therapy services, unless Medicare Part B is the primary payer. Evaluations do not require prior authorization.</i>	
430	General Classification
431	Visit Charge
432	Hourly Charge
432	Group Rate
434	Evaluation or Reevaluation
439	Other Occupational Therapy
44X	SPEECH-LANGUAGE PATHOLOGY*
<i>Prior authorization of services is required for outpatient speech-language services, unless Medicare Part B is the primary payer. Evaluations do not require prior authorization.</i>	
440	General Classification
441	Visit Charge
442	Hourly Charge
443	Group Rate
444	Evaluation or Reevaluation
449	Other Speech-Language Pathology
45X	EMERGENCY ROOM
450	General Classification*
451	EMTALA Emergency Medical Screening Services
452	ER Beyond EMTALA Screening
456	Urgent Care
459	Other Emergency Room*
46X	PULMONARY FUNCTION*
460	General Classification
469	Other Pulmonary Function
47X	AUDIOLOGY*
<i>Prior authorization of services is required for outpatient audiology services, unless Medicare Part B is the primary payer. Evaluations (471) do not require prior authorization.</i>	
470	General Classification
471	Diagnostic
472	Treatment
479	Other Audiology

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48X	CARDIOLOGY
480	General Classification*
481	Cardiac Cath Lab*
482	Stress Test*
483	Echocardiology
489	Other Cardiology*
49X	AMBULATORY SURGICAL CARE*
490	General Classification
499	Other Ambulatory Surgical Care
50X	OUTPATIENT SERVICES
500	General Classification
509	Other Outpatient Services
51X	CLINIC
510	General Classification*
511	Chronic Pain Center (Not Covered)
512	Dental Clinic - <i>Prior authorization required for hospital non-emergency services.</i>
513	Psychiatric Clinic (Not Covered)
514	OB/GYN Clinic
515	Pediatric Clinic
516	Urgent Care Clinic
517	Family Practice Clinic
519	Other Clinic
52X	FREE-STANDING CLINIC
520	General Classification (Not Covered)
521	Rural Health — Clinic
522	Rural Health — Home (Not Covered)
523	Family Practice
526	Urgent Care Clinic
529	Other Freestanding Clinic — (Not Covered)
53X	OSTEOPATHIC SERVICES
530	General Classification
531	Osteopathic Therapy
539	Other Osteopathic Services

= Accommodation days

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54X	AMBULANCE
540	General Classification (Not Covered)
541	Supplies (Not Covered)
542	<p>Medical Transport</p> <p><i>This Revenue Center Code must be used to bill for medical transportation costs incurred by an admitting hospital in the transport of patients to another facility or provider if:</i></p> <ul style="list-style-type: none"> ▪ <i>The other facility or provider provides a service not available at the admitting hospital; and</i> ▪ <i>The patient is returned to the admitting hospital within 24 hours.</i> <p><i>No other transportation services may be billed on the UB-92.</i></p>
543	Heart Mobile (Not Covered)
544	Oxygen (Not Covered)
545	Air Ambulance (Not Covered)
546	Neonatal Ambulance Service (Not Covered)
547	Ambulance Pharmacy (Not Covered)
548	Telephonic EKG (Not Covered)
549	Other Ambulance (Not Covered)
55X	SKILLED NURSING (NOT COVERED)
550	General Classification (Not Covered)
551	Visit Charge (Not Covered)
552	Hourly Charge (Not Covered)
559	Other Skilled Nursing (Not Covered)
56X	MEDICAL SOCIAL SERVICES
560	General Classification (Not covered in outpatient setting)
561	Visit Charge (Not covered in outpatient setting)
562	Hourly Charge (Not covered in outpatient setting)
569	Other Medical Social Services* - <i>Covered in outpatient setting for Maternity Case Management services only.</i>
57X	HOME HEALTH AIDE (HOME HEALTH) (NOT COVERED)
570	General Classification (Not Covered)
571	Visit Charge (Not Covered)
572	Hourly Charge (Not Covered)
579	Other Home Health Aide (Not Covered)
58X	OTHER VISITS (HOME HEALTH) (NOT COVERED)
580	General Classification (Not Covered)

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581	Visit Charge (Not Covered)
582	Hourly Charge (Not Covered)
583	Assessment (Not Covered)
589	Other Home Health Visits (Not Covered)
59X	UNITS OF SERVICE (HOME HEALTH) (NOT COVERED)
590	General Classification (Not Covered)
599	Home Health Other Units (Not Covered)
60X	OXYGEN — HOME HEALTH (NOT COVERED)
600	General Classification (Not Covered)
601	Oxygen-State/Equip/Supply or contents (Not Covered)
602	Oxygen-State/Equip/Supply Under 1 LPM (Not Covered)
603	Oxygen-State/Equip/Supply Over 4 LPM (Not Covered)
604	Oxygen – Portable Add-On (Not Covered)
61X	MAGNETIC RESONANCE IMAGING (MRI)*
610	General Classification
611	Brain (including brain stem)
612	Spinal Cord (including spine)
614	MRI - Other
615	MRA - Head and Neck
616	MRA - Lower Extremities
617	RESERVED (Not Covered)
618	MRA - Other
619	MRI - Other
62X	MEDICAL/SURGICAL SUPPLIES — EXTENSION OF 27X
621	Supplies Incident to Radiology
622	Supplies Incident to Other Diagnostic Services
623	Surgical Dressing
624	Investigational Device (Not Covered)
63X	DRUGS REQUIRING SPECIFIC IDENTIFICATION
630	General Classification (Not Covered)
631	Single source drug
632	Multiple source drug
633	Restrictive prescription

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634*◆	Epoetin, under 10,000 units per administration
635*◆	Epoetin, 10,000 units or more per administration
636*◆	Drugs requiring detail coding*
637	Self-administrable Drugs
64X	HOME IV THERAPY SERVICES (NOT COVERED)
640	General Classification (Not Covered)
641	Nonroutine Nursing (Not Covered)
642	IV Site Care, Central Line (Not Covered)
643	IV Start/Change Peripheral Line (Not Covered)
644	Nonroutine Nursing, Peripheral Line (Not Covered)
645	Training Patient/Caregiver, Central Line (Not Covered)
646	Training Disabled Patient, Central Line (Not Covered)
647	Training Patient/Caregiver, Peripheral Line (Not Covered)
648	Training Disabled Patient, Peripheral Line (Not Covered)
649	Other IV Therapy Services (Not Covered)
65X	HOSPICE SERVICES (NOT COVERED)
650	General Classification (Not Covered)
651	Routine Home Care (Not Covered)
652	Continuous Home Care (Not Covered)
653	Reserved (Not Covered)
654	Reserved (Not Covered)
655	Inpatient Respite Care (Not Covered)
656	General Inpatient Care (Non-Respite) (Not Covered)
657	Physician Services (Not Covered)
658	Hospice Room and Board - Nursing Facility (Not Covered)
659	Other Hospice (Not Covered)
66X	RESPITE CARE (HOME HEALTH) (NOT COVERED)
660	General (Not Covered)
661	Hourly Charge/Skilled Nursing (Not Covered)
662	Hourly Charge/Home Health (Not Covered)
663	Daily Respite Charge (Not Covered)
669	Other Respite Care (Not Covered)
67X	OUTPATIENT SPECIAL RESIDENCE CHARGES (NOT COVERED)
670	General (Not Covered)

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671	Hospital-Based (Not Covered)
672	Contracted (Not Covered)
679	Other (Not Covered)
68X	TRAUMA RESPONSE (NOT COVERED)
680	Not Used
681	Trauma Level I (Not Covered)
682	Trauma Level II (Not Covered)
683	Trauma Level III (Not Covered)
684	Trauma Level IV (Not Covered)
689	Other Trauma Response (Not Covered)
69X	NOT ASSIGNED (NOT COVERED)
70X	CAST ROOM*
700	General Classification
709	Other Cast Room
71X	RECOVERY ROOM
710	General Classification
719	Other Recovery Room
72X	LABOR ROOM/DELIVERY
720	General Classification
721	Labor
722	Delivery
723	Circumcision
724#	Birthing Center
729	Other Labor Room/Delivery
73X	EKG/ECG (ELECTROCARDIOGRAM)*
730	General Classification
731	Holter Monitor
732	Telemetry
739	Other EKG/ECG
74X	EEG (ELECTROENCEPHALOGRAM)*
740	General Classification
749	Other EEG
75X	GASTROINTESTINAL SERVICES*
750	0 General Classification

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759	9 Other Gastrointestinal
76X	TREATMENT OR OBSERVATION ROOM*
760	General Classification
761	Treatment Room
762	Observation Room
769	Other Treatment Room
77X	PREVENTIVE CARE SERVICES
770	General
771	Vaccine Care Services*
779	Other
78X	TELEMEDICINE*
780	General Classification
789	Other Telemedicine
79X	LITHOTRIPSY*
790	General Classification
799	Other
80X	INPATIENT RENAL DIALYSIS
800	General Classification
801	Inpatient Hemodialysis
802	Inpatient Peritoneal (non-CAPD)
803	Inpatient Continuous Ambulatory Peritoneal Dialysis (CAPD)
804	Inpatient Continuous Cycling Peritoneal Dialysis (CCPD)
809	Other Inpatient Dialysis
81X	ORGAN ACQUISITION*
810	General Classification
811	Living Donor
812	Cadaver Donor
813	Unknown Donor
814	Unsuccessful Organ Bank Donor Search Charge
819	Other Organ Acquisition
82X	HEMODIALYSIS — OUTPATIENT OR HOME
820	General Classification
821	Hemodialysis/Composite or Other Rate
822	Home Supplies

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823	Home Equipment
824	Maintenance/100%
825	Support Services
829	Other Outpatient Hemodialysis
83X	PERITONEAL DIALYSIS — OUTPATIENT OR HOME
830	General Classification
831	Peritoneal/Composite or Other Rate
832	Home Supplies
833	Home Equipment
834	Maintenance/100%
835	Support Services
839	Other Outpatient Peritoneal Dialysis
84X	CONTINUOUS AMBULATORY PERITONEAL DIALYSIS (CAPD) - OUTPATIENT OR HOME
840	General Classification
841	CAPD/Composite or Other Rate
842	Home Supplies
843	Home Equipment
844	Maintenance/100%
845	Support Services
849	Other Outpatient CAPD
85X	CONTINUOUS CYCLING PERITONEAL DIALYSIS (CCPD) — OUTPATIENT OR HOME
850	General Classification
851	CCPD/Composite or Other Rate
852	Home Supplies
853	Home Equipment
854	Maintenance/100%
855	Support Services
859	Other Outpatient CCPD
86X	RESERVED FOR DIALYSIS (NATIONAL ASSIGNMENT)
87X	RESERVED FOR DIALYSIS (NATIONAL ASSIGNMENT)
88X	MISCELLANEOUS DIALYSIS
880	General Classification
881	Ultrafiltration

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882	Home Dialysis Aid Visit (Not Covered)
889	Misc. Dialysis Other
89X	OTHER DONOR BANK (RESERVED FOR NATIONAL ASSIGNMENT)*
90X	PSYCHIATRIC/PSYCHOLOGICAL TREATMENTS
900	General Classification (Not Covered)
901	Electroconvulsive Therapy
902	Milieu Therapy (Not Covered)
903	Play Therapy (Not Covered)
904	Activity Therapy (Not Covered)
905	Intensive Outpatient Services - Psychiatric (Not Covered)
906	Intensive Outpatient Services - Chemical Dependency (Not Covered)
907	Community Behavioral Health Program - Day Treatment (Not Covered)
908	Reserved For National Assignment
909	Other* - <i>Somatotherapy services and psychiatric or psychological evaluations are the only services billable under this Revenue Center Code.</i>
91X	PSYCHIATRIC/PSYCHOLOGICAL SERVICES
<i>Somatotherapy services and psychiatric or psychological evaluations are the only services billable under Revenue Center Codes 919 and 961.</i>	
910	Reserved For National Assignment
911	Rehabilitation (Not Covered)
912	Partial Hospitalization Less Intensive (Not Covered)
913	Partial Hospitalization Intensive (Not Covered)
914	Individual Therapy (Not Covered)
915	Group Therapy (Not Covered)
916	Family Therapy (Not Covered)
917	Biofeedback (Not Covered)
918	Testing*
919	Other* Other Behavior Health Treatments/Services
92X	OTHER DIAGNOSTIC SERVICES*
920	General Classification
921	Peripheral Vascular Lab
922	Electromyogram
923	Pap Smear

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924	Allergy Test
925	Pregnancy Test
929	Other Diagnostic Services
93X	MEDICAL REHABILITATION DAY PROGRAM (NOT COVERED)
931	Half Day (Not Covered)
932	Full Day (Not Covered)
94X	OTHER THERAPEUTIC SERVICES
940	General Classification*
941	Recreational Therapy (Not Covered)
942	Education/Training*
943	Cardiac Rehabilitation*
944	Drug Rehabilitation (Not Covered)
945	Alcohol Rehabilitation (Not Covered)
946	Routine Complex Equipment
947	Ancillary Complex Equipment*
949	Other Therapeutic Services*
95X	OTHER THERAPEUTIC SERVICES - Extension of 94X (NOT COVERED)
950	Reserved For National Assignment
951	Athletic Training (Not Covered)
952	Kinesiotherapy (Not Covered)
96X	PROFESSIONAL FEES*
960	General Classification
961	Psychiatric
962	Ophthalmology
963	Anesthesiologist (MD)
964	Anesthetist (CRNA)
969	Other Professional Fees
97X	PROFESSIONAL FEES* - Continued
971	Laboratory*
972	Radiology — Diagnostic*
973	Radiology — Therapeutic*
974	Radiology — Nuclear Medicine*
975	Operating Room

= Accommodation days * = CPT/HCPCS code required ◆ = NDC reporting required

976	Respiratory Therapy
977	Physical Therapy (Outpatient services require prior authorization)
978	Occupational therapy (Outpatient services require prior authorization)
979	Speech Pathology (Outpatient services require prior authorization)
98X	PROFESSIONAL FEES*- Extension of 96X & 97X
981	Emergency Room
982	Outpatient Services
983	Clinic
984	Medical Social Services (Covered in inpatient setting only)
985	EKG
986	EEG
987	Hospital Visit
988	Consultation
989	Private Duty Nurse (Not Covered)
99X	PATIENT CONVENIENCE ITEMS (Not Covered)
990	General Classification (Not Covered)
991	Cafeteria/Guest Tray (Not Covered)
992	Private Linen Service (Not Covered)
993	Telephone/Telegraph (Not Covered)
994	TV/Radio (Not Covered)
995	Nonpatient Room Rentals (Not Covered)
996	Late Discharge Charge (Not Covered)
997	Admissions Kits (Covered)
998	Beauty Shop/Barber (Not Covered)
999	Other Patient Convenience Items (Not Covered)

Present on Admission (POA) Indicators

Indicator	Description
Y	Diagnosis was present at time of inpatient admission.
N	Diagnosis was not present at time of inpatient admission.
U	Documentation insufficient to determine if condition was present at the time of inpatient admission.

Indicator	Description
W	Clinically undetermined. Provider unable to clinically determine whether the condition was present at the time of inpatient admission.

Third Party Resource (TPR) explanation codes

Use in FL 84 on the UB-04. These codes can only be used on paper claims. They cannot be used on electronic claims submissions.

Single Insurance coverage

Select the most appropriate code below when patient has only one insurance policy in addition to Medicaid.

- 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 Medicaid.

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

Electronic remittance advice

Providers who submit electronic claims in the 837 format can choose to receive the 835 Fee for Service Payment/Advice transaction. Like the paper RA, the 835 transaction displays the number of claims and the adjudication status of your claims in Oregon’s Medicaid system. It does not contain suspended claim information.

The 835 contains HIPAA Claim Adjustment Reason Codes. A list of these codes can be found on the Washington Publishing Web site www.wpc-edi.com/content/view/180/223/. For more detailed codes, refer to the paper RA.

To sign up for the 835 transaction, contact EDI Support Services.

Web portal claim search

Instead of waiting for the paper Remittance Advice to come in the mail, authorized providers can review previously submitted claims on the Provider Web Portal 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 *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/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. ◆ Other - Use this box if none of the above boxes address your problems.
12.	Use the FL line number from the original UB 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

DMAP now requires this sheet as the cover for most mailed or faxed correspondence. 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.usForms/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 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 PA 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)

Hearing Documentation

Claim Documentation

Grievance Documentation

Prior Authorization (PA)

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

Use this form when submitting PA requests for inpatient services to OHP fee-for-service clients. Include required documentation and a completed EDMS Coversheet (see previous page): Fax to one of the following numbers:

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

To ensure appropriate processing of your PA request, make sure to complete the following required fields on new PA requests.

- Section I: Provider Number
- Section II: Type of PA Request
- Section III: Client ID
- Section IV: Revenue Center Code (if applicable)
- Section V: Procedure Code and Units (if applicable)
- Section VII: NDC (if applicable)
- Section IX: Date of Request, Service Begin and End Dates

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



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 3978 - Pharmacy Prior Authorization Request

Prescribers should submit their PA requests for fee-for-service prescriptions and oral nutritional supplements with required documentation to:

Oregon Pharmacy Call Center

888-202-2126

Fax: 888-346-0178

This form is also available on the DHS/OHA Web site at <https://apps.state.or.us/Forms/Served/OE3978.pdf>.

Information needed to request PA

Complete the form as follows. The Oregon Pharmacy Call Center may ask for some or all of the following information, depending upon the class of the drug requested:

DMAP 3978 section	Information needed
Section I:	Requesting provider name and National Provider Identifier.
Section II	Type of PA Request: Mark "Pharmacy."
Section III:	Client name and recipient ID number;
Section IV:	Diagnosis code (ICD-9-CM);
Section V:	Drug name, strength, size and quantity of medication. ◆ Participating pharmacy: Include the dispensing pharmacy's name and phone number (if available).
Section VI:	Date of PA Request Begin and End Dates of Service
Section VII:	Complete for EPIV and oral nutritional supplements only.
Section VIII:	Complete for oral nutritional supplements only.



Prior Authorization Request for Prescriptions & Oral Nutritional Supplements

To: Oregon Pharmacy Call Center
888-346-0178 (fax); 888-202-2126 (phone)

Confidentiality Notice:

The information contained in this Prior Authorization Request is confidential and legally privileged. It is intended only for use of the recipient(s) 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 document- except its direct delivery to the intended recipient - is strictly prohibited.

Complete all fields marked with an asterisk (*), if applicable.

I Requesting Provider

* Name * NPI
Contact Name Contact Phone
Contact Fax Processing Time Frame: [] Routine
Supporting Justification for Urgent/Immediate Processing: [] Urgent [] Immediate

II PA Request - Assignment Code (check appropriate box)

* [] Pharmacy [] Home EPIV [] Other

III Client Information

* Client ID DOB / /
* Last Name * First Name, MI

IV Service Information

Estimated length of treatment Frequency
Primary diagnosis * Primary ICD-9 diagnosis code
Other pertinent diagnosis
(For prescriptions and oral nutritional supplements, list all applicable ICD-9 codes or contributing factors)

V Drug/Product Information

* Name * Strength
* Quantity * NDC

Participating Pharmacy:

Name Phone Number - - Date / /

VI Date Information

* Date of Request / / * Expected Service Begin Date / /
* Expected Service End Date / /

VII Code and Cost Information – Required for EPIV and oral nutritional supplements

Line Item	Procedure Code	Modifier	Description	Units	U&C	MSRP	Total Dollars
1					0.00	0.00	0.00
2					0.00	0.00	0.00
3					0.00	0.00	0.00
4					0.00	0.00	0.00
5					0.00	0.00	0.00
			Total Units	0			\$0.00

VIII Patient Questionnaire – Complete for oral nutritional supplements only

Question	Yes	No
Is the patient fed via G-tube?	<input type="checkbox"/>	<input type="checkbox"/>
Is the patient currently on oral nutritional supplements? - If Yes, date product started: _____ - How is it supplied (e.g., self-pay, friends/family supply, etc)? _____	<input type="checkbox"/>	<input type="checkbox"/>
Does the patient have Failure to Thrive (FTT)?	<input type="checkbox"/>	<input type="checkbox"/>
Does the patient have a long history (more than one year) of malnutrition and cachexia?	<input type="checkbox"/>	<input type="checkbox"/>
Does the patient reside in a: - Long-term care facility? - Chronic home care facility? - If Yes, list name of residence: _____	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
Does the patient have: - Increased metabolic need from severe trauma (e.g., severe burn, major bone fracture)? - Malabsorption difficulties (e.g., Crohn’s Disease, cystic fibrosis, bowel resection/removal, Short Gut Syndrome, gastric bypass, renal dialysis, dysphagia, achalasia)? - A diagnosis that requires additional calories and/or protein intake (e.g., cancer, AIDS, pulmonary insufficiency, MS, ALS, Parkinson’s, cerebral palsy, Alzheimer’s)?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

Date of last MD assessment for continued use of supplements: _____

Date of Registered Dietician assessment indicating adequate intake is not obtainable through regular or liquefied pureed foods: _____

- Serum Protein level: _____ Date taken: _____
- Albumin level: _____ Date taken: _____
- Current weight: _____ Normal weight: _____

Written Justification and Attachments:

Requesting Physician’s signature: _____

Hospital Hold Request (OHP 3261)

When hospitals admit individuals for inpatient stays with no OHP coverage, they can submit the individual's information on the OHP 3261 form. The individual's OHP application request will then be dated the hospital admission date. If the individual qualifies for OHP coverage, the effective date of coverage will be the hospital admission date.

Hospitals must fax hospital hold information on the OHP 3261 form or a reasonable facsimile containing the same information as the OHP 3261. Requests must be submitted within 24 hours of the admission time.

Inpatient Hospital Hold Request for OHP Application

Hospital	Phone	Fax	Contact Person
Address		City State ZIP	

FAX TO: 503-378-2771 PHONE 1-800-359-9517

- **Use this form only for patients who are admitted for inpatient hospitalization, NOT for outpatient emergency room visits.**
- **Make sure you have the patient's permission to provide this information to the state before listing his/her name on this form.** You may submit a hospital hold on an unconscious person without his/her permission if there is no one else available to give consent. We do not require a copy of this consent, but you need to keep a copy for your own records.
- **FAX hospital holds daily.** The hospital must submit the hospital hold form within 24 hours of admission, or the next working day.
 ➤ ***Please type or print legibly. Thank you!***

Inpatient Admit Date	Name Last, First	Date of Birth	Address	City ZIP	Language if not English
/ /		/ /			
/ /		/ /			
/ /		/ /			
/ /		/ /			
/ /		/ /			
/ /		/ /			
/ /		/ /			
/ /		/ /			
/ /		/ /			
/ /		/ /			

Calculation of Reasonable Cost (Form 42) - *See OAR 410-125-1020*

The DMAP form 42 is used to cost settle Title XXI (CHIP), Family Planning (FP), Native American (NA), State Funded (SF), and Title XIX covered charges for Oregon acute care hospitals.

Submitting your completed DMAP form 42 to DMAP provides necessary information that is used by DMAP to determine final Fee For Service (FFS) and Managed Care Organization (MCO) Medicaid cost settlements for the period. Since the DMAP form 42 calculates an estimated amount for the cost settlement period, the hospital may want to budget accordingly for the expected revenue or expense that will be due upon final cost settlement.

DMAP will send hospital providers the DMAP 42 to complete when it is needed. It is also available on the DMAP Web site at www.oregon.gov/OHA/healthplan/forms/omapforms.shtml#misc.

Filing the DMAP Form 42

Approximately 13 months after the hospital's FYE, DMAP will send a diskette to the hospital that contains the DMAP form 42 template file and the hospital claim data files.

The DMAP form 42 can be completed using the Excel DMAP form 42 template, the hospital data files, and the hospital's "as filed" Medicare Cost Report (Form 2552). Completed DMAP form 42s are due submission to DMAP within 90-days from the date of receiving the data disk.

Final cost settlement

Approximately two years after the provider's FYE, the Medicare intermediary completes their audit on the Medicare cost report and forwards the finalized report to DMAP. After DMAP receives the finalized Medicare cost report, DMAP will calculate the final Medicaid cost settlement that is due for the period and will send a letter notifying the hospital of the proposed balance due. Hospital providers have 30 days from receipt of the letter to review the proposed cost settlement and request changes or to appeal the settlement.

Revisions

Additional worksheets have been added to the DMAP 42 template in order to calculate Managed Care Organization (MCO) cost settlements. These worksheet pages only apply to type A, B, or CAH hospitals having eligible MCO claims that qualify for cost settlement. See separate instructions below for completing the MCO cost worksheets to determine the MCO estimated cost settlement.

Hospital Fee For Service Form 42 instructions

From the DMAP diskette open the Excel DMAP42 template file. Open the hospital Medicare cost report file. Follow the steps outlined below to complete the DMAP form 42 template worksheets.

Medicare Cost Report worksheets

1. Open the Medicare cost report worksheets (S-3,1, A-8-2, B pt1, C pt1, D-1 pt2, D-1 pt1) for the period.
2. Copy and paste data from these worksheets into the blank DMAP form 42 template worksheets with the same tab names (copy wks B pt1 only if you are a teaching hospital).

RevCode to WksCpt1 Line No worksheet

The purpose of this worksheet is to serve as a look up table for all the IP/OP worksheet formulas to map the proper Medicare Cost Report (MCR) wks C pt 1 line number to each Medicaid Revenue Center Code charge on the IP/OP cost worksheets.

1. The RevCodeList file contains every Revenue Center Code that is cost settled on the IP/OP cost worksheets. Open the RevCodeList Excel file and copy & paste values for all Revenue Center Codes and descriptions into the RevCode to wks C pt 1 Line No worksheet below the column headings.
2. Enter the proper wks C pt 1 line assignment numbers for each Revenue Center Code listed. Please use the same line assignments as were used to file your MCR. If more than one hospital department utilizes the same Revenue Center Code, assign the line number that reflects the most utilization.
3. This table must be sorted ascending by Revenue Center Code in order for the look up functions on each IP/OP cost worksheet to reference them properly.

C pt 1 Adjustments worksheet

This worksheet calculates Medicaid adjusted Cost to Charge Ratios (CCR) for use in determining Medicaid cost. Costs and charges for Professional Component and Intern & Residency that are not included in Medicare Wks C, pt1 CCR calculations need to be entered on this worksheet in order to compute a Medicaid adjusted CCR.

From the Medicare cost report WKS C pt1, fill in the cost center line numbers, descriptions, costs and charges for all cost centers with a CCR calculated or refer to the optional method outlined below.

Fill in costs and charges for Professional Component and Intern & Residency (if any) that are not included in the Medicare WKS C, pt1 CCR.

When this worksheet is complete a Medicaid adjusted CCR is calculated by formula. The adjusted CCR will be looked up from this table and applied to each respective Revenue Center Code charge on the IP/OP cost worksheets.

1. From the DMAP 42 worksheet C pt 1 copy & paste values for each cost center line number and description that has a CCR calculated into the C pt 1 Adjustments worksheet. Insert or delete extra rows as necessary.
2. Formulas in columns 1-8 “look up” figures from the various Medicare cost report

worksheets, total costs & charges and calculate the adjusted CCR.

Col. 1 costs are looked up from worksheet C pt 1.

Col. 2 looks up the professional component cost from worksheet A-8-2 (note: line items on worksheet A-8-2 must be sorted ascending by line number for lookup function to work properly).

Col. 3 - If you're a teaching hospital enter the Intern & Residency costs from worksheet B pt 1.

Col. 4 formula totals costs from Col. 1-3.

Col. 5 formula looks up charges for each cost center on worksheet C pt 1.

Col. 6 needs the professional component charges from the hospital's General Ledger manually entered for each cost center with a professional component cost in Col. 2.

Col. 7 totals costs from Col. 5-6.

Col. 8 calculates the adjusted CCR by dividing Col. 4 by Col. 7.

Copy the formulas down as necessary for each cost center on this worksheet.

Inpatient Routine (FFS) Cost worksheet

1. Enter the routine average per diem rate (this comes from Wks D-1 pt 2 if the hospital has no additional sub-providers). If the hospital has sub-providers then Wks D-1 pt 1 routine costs for each provider are totaled and divided by the total routine days to calculate an average per diem rate.
2. Enter the Nursery per diem rate. This can be calculated by taking the Nursery cost from Wks C pt 1 and dividing it by the total number of nursery days reported on Wks S-3, 1.
3. Enter Intensive Care Unit per diem rate from Wks D-1 pt 2.
4. Enter Coronary Care Unit per diem rate from Wks D-1 pt 2.
5. If your hospital has other IP Unit per diems (psychiatric, burn, etc.) calculated on Wks D-1 pt 2 then insert row(s) into this worksheet and enter the name and per diem rate for each.
6. Total and enter the number of IP day counts (Units) for each fund group by the corresponding revenue centers listed on the RevCodeSum file.
7. Type A or B hospitals - formulas calculate the total allowable routine cost for each fund group and totals are linked to the settlement summary worksheet line number 1. IP routine for type DRG hospitals is not cost settled and is only calculated in order to determine the cost outlier conversion rate (see Rates worksheet below).

Inpatient (FFS) Cost worksheets

Title XXI (21), Family Planning (FP), Native American (NA), State Funded (SF) and Title XIX (19)

1. All Inpatient worksheets are completed in the same manner. Fill in the worksheets to calculate Medicaid allowable cost.
2. From the DMAP diskette open the Excel RevCodeSum file and copy and paste values for all ancillary Revenue Center Codes, descriptions, and covered charges for each fund group into each appropriate IP fund group worksheet. Insert or delete additional rows as necessary. Note: Routine Revenue Center Codes 110 - 249 are not included on these worksheets as routine costs are calculated on the on the IP routine worksheet.
3. Each IP worksheet contains look up formulas to reference the Medicare cost report line number assigned and the adjusted CCR that applies to each Revenue Center Code charge.
4. IP allowable cost will be calculated via formula (covered charges times the adjusted CCR).
5. Total allowable cost for each worksheet will transfer to the settlement summary page line 2. IP ancillary cost for type DRG hospitals is not cost settled and is only calculated in order to determine the cost outlier conversion rate (see rates worksheet below).

Outpatient (FFS) Cost worksheets

Title XXI (21), Family Planning (FP), Native American (NA), State Funded (SF) and Title XIX (19)

1. All Outpatient worksheets are completed in the same manner. Fill in the worksheets to calculate Medicaid allowable cost.
2. From the DMAP diskette open the Excel RevCodeSum file and copy and paste values for all Revenue Center Codes, descriptions and covered charges for each fund group into each appropriate OP fund group worksheet. Insert or delete additional rows as necessary.
3. Each OP worksheet contains look up formulas to reference the Medicare cost report line number assigned and the adjusted CCR that applies to each Revenue Center Code charge.
4. OP allowable cost will be calculated via formula (covered charges times the adjusted CCR).
5. Total allowable cost for each worksheet will transfer to the settlement summary page line 7.

Type DRG hospitals - The total calculated outpatient cost is reduced by 41% to leave 59% allowable cost (effective 3/10/03 the total calculated outpatient cost is reduced by 48% to leave 52% allowable cost). Separate Excel RevCodeSum files will be sent for these time periods.

Type A/B hospitals - 100% of cost is allowable.

Rates worksheet

It is only necessary to complete this worksheet if you are a type DRG hospital and you have outlier claims in the cost settlement period. If outlier claims are present in the settlement period, an Excel outlier claim file will be included on the DMAP diskette that is sent to the hospital.

1. This worksheet has formulas that summarize totals from the IP Routine cost worksheet and from each IP cost worksheet. Enter the total IP charges for fund groups (XXI, FP, NA, SF, XIX) from the Hospital Claim Summary report on the Rates worksheet. A formula calculates the outlier conversion rate that is used on the Outlier worksheet.

Outlier worksheet

Complete this worksheet if you are a hospital that receives DRG IP payments and you have outlier claims for the settlement period. Outlier claims that were paid based on an interim payment rate during the provider's fiscal year period are cost settled. These claims are recomputed using the outlier conversion rate calculated on the Rates Worksheet and the adjustment is part of the cost settlement for the period.

1. Open the Excel outlier claim data file and copy and paste values (patient name through outlier overflow fields) into each fund group section of the Outlier worksheet. Insert rows as needed and copy formulas down.
2. Formulas in the worksheet will compute the under or overpayment amount due for the outlier claims in the settlement period. Cost outlier settlement totals by fund group on this worksheet are linked to the Settlement Summary worksheet line 5.

Hospital (FFS) Cost Settlement Summary worksheet

This worksheet summarizes all Medicaid allowable Inpatient & Outpatient costs and payments for Title XXI, FP, NA, SF, and Title XIX fund groups. Formulas on this worksheet are linked to the IP/OP cost totals of each worksheet that computes allowable cost. Total allowable cost minus net payments for the period equals the cost settlement amount due.

1. Fill in the hospital name, type (A, B, CAH, or DRG), settlement period and DMAP provider number in the appropriate boxes on the worksheet.
2. Line 1: Allowable cost totals are linked from the Inpatient Routine worksheet totals.
3. Line 2: Allowable cost totals are linked from the inpatient XXI, FP, NA, SF, and XIX cost worksheets.

4. Line 3: Formula subtotals line 1 and 2.
5. Line 4: Lower of cost or charges rule - Type A, B, or CAH hospitals need to compare the cost subtotal determined in Line 3 above against the covered charges totals from the IP RevCodeSum file for each fund group.

If the cost determined in Line 3 above is less than the total covered charges by fund group, no adjustment is necessary, enter zero on this line.

If the covered charges by fund group is less than the allowable costs determined in Line 3 above, an adjustment is necessary to reduce costs to the lower covered charges figure by subtracting the difference out on this line.

Please refer to OAR 410-125-0155 for lower of allowable costs or charges adjustment.
6. Line 5: This only applies to DRG hospitals that have cost outlier claims to be cost settled. The total outlier adjustments by fund group are linked from the Outlier worksheet totals.
7. Line 6: Formulas total the allowable Inpatient Costs by fund group.
8. Line 7: Allowable cost totals are linked from the outpatient XXI, FP, NA, SF, and XIX cost worksheets.
9. Line 8: Lower of Cost or Charges rule - If the cost determined on line 7 above is less than the total covered charges by fund group, no adjustment is necessary and the formula enters zero on this line. If the covered charges are less than costs, the formula calculates and enters the difference to reduce costs to the lower covered charges figure on this line. Please refer to OAR 410-125-0155 for lower of allowable costs or charges adjustment.
10. Line 9: Formulas calculate the Total Allowable OP Costs.
11. Line 10: Specify any other necessary adjustment amounts.
12. Line 11: Formulas calculate the Total Allowable IP and OP cost.
13. Line 12: Open the Excel PmtTotalSum file and enter the IP/OP Paid Totals as negatives for fund groups XXI, FP, NA, SF, and XIX. Open the Excel RefundPmt file and offset the refund payment total amount against the payment totals for the Title XIX fund group (manual refunds are not credited back to specific fund groups so they default to Title XIX). Type DRG hospitals are cost settled only for OP so enter only the OP total payments from the PmtTotalSum file on this line.
14. Line 13: Formulas calculate Subtotals by fund group.
15. Formula calculates the Total Amount (Due DMAP) or Due the Provider for the settlement period.
16. Save the file on diskette or CD and send it to DMAP along with your printed copies.

Print only the worksheets that contain data and that are used to determine allowable cost. A & B hospitals print all wks except the Rates and Outlier wks. DRG hospitals print the settlement summary wks, OP cost wks, and if applicable the Outlier wks). The responsible officer must sign and date on the bottom of the Cost Settlement Summary page.

Hospital Type A & B MCO Form 42 instructions

The MCO Excel files referred to in the following worksheet instructions will be sent to the provider as soon as possible after DMAP receives contract information and determines claim eligibility for the period. The Hospital FFS worksheets must be completed prior to completing the MCO worksheets in order for linked formulas to reference and calculate the MCO worksheets on the DMAP form 42.

Inpatient Routine (MCO) Cost worksheet

1. The routine average per diem rates are linked to those that were entered on the FFS Inpatient Routine wks.
2. Total and enter the number of IP day counts (Units) for each fund group by the corresponding revenue centers listed on the RevCodeSumMCO file.
3. Formulas calculate the total allowable routine cost for each fund group and totals are linked to the MCO settlement summary worksheet line number 1.

Inpatient (MCO) Cost worksheets

Title XXI (21), Family Planning (FP), Native American (NA), State Funded (SF) and Title XIX (19)

1. Open the RevCodeSumMCO file and copy and paste values for all ancillary Revenue Center Codes, descriptions, and covered charges for each fund group into each appropriate IP fund group worksheet. Insert or delete additional rows as necessary. Note: Routine Revenue Center Codes 110 - 249 are not included on these worksheets as routine costs are calculated on the on the IP routine worksheet.
2. Each IP worksheet contains look up formulas to reference the Medicare cost report line number assigned and the adjusted CCR that applies to each Revenue Center Code charge.
3. IP allowable cost will be calculated via formula (covered charges times the adjusted CCR).
4. Total allowable cost for each worksheet will transfer to the MCO settlement summary page line 2.

Outpatient (MCO) Cost worksheets

Title XXI (21), Family Planning (FP), Native American (NA), State Funded (SF) and Title XIX (19)

1. Open the RevCodeSumMCO file and copy and paste values for all Revenue Center Codes, descriptions, and covered charges for each fund group into each appropriate OP fund group worksheet. Insert or delete additional rows as necessary.
2. Each OP worksheet contains look up formulas to reference the Medicare cost report line number assigned and the adjusted CCR that applies to each Revenue Center Code charge.
3. OP allowable cost will be calculated via formula (covered charges times the adjusted CCR).
4. Total allowable cost for each worksheet will transfer to the MCO settlement summary page line 7.

Hospital (MCO) Cost Settlement Summary worksheet

This worksheet summarizes all Medicaid MCO allowable Inpatient & Outpatient costs and payments for Title XXI, FP, NA, SF, and Title XIX fund groups. The worksheet contains formulas that are linked to the IP/OP cost totals of each MCO worksheet that computes allowable cost. Total allowable cost minus net payments for the period equals the cost settlement amount due.

1. The hospital name, type, settlement period and DMAP provider are linked to the FFS Settlement Summary wks.
2. Line 1: Allowable cost totals are linked from the MCO Inpatient Routine worksheet totals.
3. Line 2: Allowable cost totals are linked from the MCO Inpatient XXI, FP, NA, SF, and XIX cost worksheets.
4. Line 3: Formula subtotals line 1 and 2.
5. Line 4: Lower of cost or charges rule - Type A or B hospitals need to compare the cost subtotal determined in Line 3 above against the covered charges total from the RevCodeSumMCO file for each fund group. If the cost determined in Line 3 above is less than the total covered charges by fund group, no adjustment is necessary, enter zero on this line. If the covered charges by fund group are less than the allowable costs determined in Line 3 above, an adjustment is necessary to reduce costs to the lower covered charges figure by subtracting the difference out on this line. Please refer to OAR 410-125-0155 for lower of allowable costs or charges adjustment.
6. Line 5: For cost outlier adjustment - not applicable, enter zero.
7. Line 6: Formulas total the allowable inpatient Costs by fund group.

8. Line 7: Allowable cost totals are linked from the MCO outpatient XXI, FP, NA, SF, and XIX cost worksheets.
9. Line 8: Lower of Cost or Charges rule - If the cost determined on line 7 above is less than the total covered charges by fund group, no adjustment is necessary and the formula enters zero on this line. If the covered charges are less than costs, the formula calculates and enters the difference to reduce costs to the lower covered charges figure on this line. Please refer to OAR 410-125-0155 for lower of allowable costs or charges adjustment.
10. Line 9: Formulas calculate the Total Allowable OP Costs.
11. Line 10: Specify any other necessary adjustment amounts.
12. Line 11: Formulas calculate the Total Allowable IP and OP cost.
13. Line 12: Open the ClaimDetailMCO file. Enter the MCO and Third party payments received for each claim detail. Total all payments received in the ClaimDetailMCO file by fund groups XXI, FP, NA, SF, and XIX and enter amounts on this line.
14. Line 13: Formulas calculate Subtotals by fund group.
15. Formula calculates the Total Amount (Due DMAP) or Due the Provider for the settlement period.
16. Save the file on diskette or CD and send it to DMAP along with your printed copies. Print only the worksheets that contain data and that are used to determine allowable cost. The responsible officer must sign and date on the bottom of the Cost Settlement Summary page.