



Private Duty Nursing Services

Supplemental information for Oregon Medicaid providers

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

November 5, 2010



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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 Private Duty Nursing Services (PDN) Oregon Administrative Rules (Chapter 410 Division 132). See current PDN rulebook for official policies regarding billing.

If you are a Private Duty Nurse for the department's Medically Fragile Children's Unit, this booklet does not apply to you! Instead, refer to the Medically Fragile Children's Services OARs (Chapter 411 Division 150).

Prior authorization

General information

DMAP will only pay for private duty nursing services that have been prior authorized. See OAR 410-132-0100 for complete policies relating to prior authorization.

Client eligibility and enrollment

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

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

- Automated Voice Response (AVR): Call 866-692-3864. A quick reference for verifying client eligibility via AVR is available on the DHS Web site at <http://dhsforms.hr.state.or.us/Forms/Served/OE3162.pdf>.
- Provider Web Portal: Go to <https://www.or-medicaid.gov>.
- 270/271 transaction: Available to approved Electronic Data Interchange (EDI) providers. See page 11 for EDI information.

Retroactive authorization for emergency services

Providers must submit requests for prior authorization for services relating to an emergency no later than the first business day following the emergency service. The request must include all information needed to request PA, and clear medical justification for authorizing payment.

How to request prior authorization (PA)

For clients enrolled in an OHP managed care plan, contact the plan for their PA procedures.

For OHP fee-for-service (“open card”) clients, use the DHS 3971 form or the Provider Web Portal to submit PA requests. For information on how to submit PA requests using the Provider Web Portal, go to www.oregon.gov/DHS/healthplan/webportal.shtml#authorization.

Submit documentation for PA requests using the following fax numbers:

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

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

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

Medically Fragile Children (MFC) clients	DHS Medically Fragile Children’s Unit 971-673-2974 for referrals and general information
All other clients	DMAP – Medical Management Unit 500 Summer St NE, E44 Salem, OR 97301-1078 503-945-6821 (direct) 800-642-8635 (in-state only)

Prior Authorization Notices

DMAP issues the following types of Prior Authorization Notices:

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

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

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

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

1. The date DMAP generated this notice.
2. Provider's name and address as they appear on DMAP records.
3. The client's name.
4. Description of the type of service authorized.
5. HCPCS codes for the authorized service..
6. Procedure code descriptions for the authorized service.
7. The amount and units requested by the provider on the original PA request.
8. The amount and units approved by DMAP.
 - ◆ If a specific dollar amount is printed here, that means DMAP will not pay more than this limit. DMAP may pay less depending on the actual services billed.
 - ◆ "DMAP Rate": Is printed when DMAP sets no specific dollar limit. This means DMAP will pay up to its maximum allowable rate, depending on services billed. In both cases, if there is TPR, DMAP's payment is reduced by the TPR payment.
9. Name of servicing provider.
10. The client's 8-digit ID number (for billing DMAP).
11. PA Number: When billing for the authorized service, place this number in Field 23 on the CMS-1500 or in Field 19 on the DMAP 505, when appropriate.
12. The valid date range for the authorized service. The date of service must fall between these two dates, and the client must also be eligible on the actual date of service.
13. When the prescribing or referring provider's name is listed in this field, it must be used when billing DMAP. Your billing may require a referring provider number when the client is restricted to a Primary Care Manager (PCM) or the service requires referral.
14. Additional notes: A space for notes entered by the reviewer for the provider.
15. The client's name and address.
16. The DHS branch office serving the client.
17. The DHS office and reviewer who approved the PA.
18. If DMAP sends copies of this notice to other entities, such as the the client's branch office, that information will display here.



Date of Notice: 12/09/2008 ①

Provider Name ②

Street Name

City, State ZIP

Notice of Prior Authorization

DHS authorizes the following item(s) or service(s) to Jane Doe ③ for the dates of service listed below.

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

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

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

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

Additional Notes: ⑭

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

Jane Doe ⑮

Street Name

City, State ZIP

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

CC: DHS Branch, Referring Provider ⑱

Notice of Prior Authorization of Payment for Medical Services

Recipient

Date

ID Number XX#####X
Other Information

Provider

Provider Name ### Street Name City, State ZIP

Jane Doe #### Street Name City, State ZIP

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

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

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

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

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

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

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

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

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

1. The date DMAP generated this notice.
2. Provider's name and address as they appear on DMAP records.
3. The client's name.
4. Description of the type of service authorized.
5. Date the service was denied.
6. HCPCS codes for the authorized service..
7. Procedure code descriptions for the authorized service.
8. The amount and units requested by the provider on the original PA request.
9. Name of servicing provider.
10. The reason DMAP denied the PA request, with Oregon Administrative Rule references as appropriate.
11. The client's 8-digit ID number (for billing DMAP).
12. Request number: The 10-digit number referencing the PA denial..
13. The name of the prescribing/referring provider.
14. Additional notes: A space for notes entered by the reviewer for the provider. For example, if the reason for denial specifies incomplete documentation, the reviewer can use this space to explain the specific documentation required.
15. The client's name and address.
16. The DHS branch office serving the client.
17. The DHS office and reviewer who approved the PA.
18. If DMAP sends copies of this notice to other entities, such as the the client's branch office, that inforamtion will display here.



Oregon

Theodore R. Kulongoski, Governor

Department of Human Services

500 Summer St NE
Salem, OR 97301-1079



Date of Notice: 12/09/2008 ①

Provider Name ②

Street Name

City, State ZIP

Notice of Denial

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

DHS has denied the prior authorization (PA) request to provide the following item(s) or service(s) to Jane Doe: ③

PA Assignment:	Physical Therapy Services ④	Denial Date: ⑤	12/09/2008
CODES ⑥	DESCRIPTION ⑦	REQUESTED AMT/UNITS ⑧	SERVICING ⑨ PROVIDER NAME
97110	THERAPEUTIC PROC, ONE OR MORE AR	\$181.44/009	THEO THERAPIST
REASON FOR DENIAL ⑩	The information submitted does not substantiate the medical appropriateness for the service provided/requested. (OAR 410-120-0000, OAR 410-120-1200, OAR 410-120-1320, DME OAR 410-122-0080)		
CLIENT ID # ⑪	AA####A		
REQUEST # ⑫	0123456789		
Requesting/ Referring Providers ⑬	REFERRER, MD		

Additional Notes: ⑭

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

Jane Doe ⑮

Street Name

City, State ZIP

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

CC: DHS Branch, Referring Provider ⑱

Billing information

National Provider Identifier

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

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

Claims with services that require prior authorization

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

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

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

- Diagnosis code
- Procedure code
- Performing provider
- Revenue Center Codes

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

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

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

Billing for Medicare clients - *See OAR 410-132-0120 for administrative rule*

When billing for Medicare clients, do not use the DMAP 505 paper claim form. Instead, bill using the 837P, Provider Web Portal, or CMS-1500 paper claim form. When billing on the CMS-1500 form, enter the appropriate TPR explanation code in Field 9 (see page 15).

Electronic claims submissions

DHS accepts professional claims in the following electronic formats:

Batch claim format

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

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

Phone: 888-690-9888

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

Coordination of Benefits (COB)

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

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

Transaction information for EDI submitters

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

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

Individual claim format

Enrolled DHS providers authorized to access the Provider Web Portal can submit individual professional claims at <https://www.or-medicaid.gov>.

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

Paper claim submissions

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

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

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

Health Insurance Claim Form (CMS-1500)

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

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

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

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

Where to mail claims

Send all completed CMS-1500 forms to:

DMAP
PO Box 14018
Salem, OR 97309

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA										PICA																																																	
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/> <small>(Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID#) (SSN or ID) (SSN) (ID)</small>										1a. INSURED'S I.D. NUMBER 1a (For Program in Item 1)																																																	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) 2										3. PATIENT'S BIRTH DATE MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>										4. INSURED'S NAME (Last Name, First Name, Middle Initial)																																							
5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code) ()										6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>										7. INSURED'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code) ()																																							
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/> b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State) _____ c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>										11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/> b. EMPLOYER'S NAME OR SCHOOL NAME c. INSURANCE PLAN NAME OR PROGRAM NAME																																							
a. OTHER INSURED'S POLICY OR GROUP NUMBER b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/> c. EMPLOYER'S NAME OR SCHOOL NAME d. INSURANCE PLAN NAME OR PROGRAM NAME										10d. RESERVED FOR LOCAL USE										d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>																																							
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____																				13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____																																							
14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)										15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY										16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY																																							
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a. _____ 17b. NPI _____										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																																							
19. RESERVED FOR LOCAL USE										20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES _____										22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. _____ 23. PRIOR AUTHORIZATION NUMBER _____																																							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 21 1. _____ 3. _____ 2. _____ 4. _____										24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPSDT Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #																																																	
1 24A 24B 24D 24E 24F 24G NPI 24J																																																											
2 24A 24B 24D 24E 24F 24G NPI 24J																																																											
3 24A 24B 24D 24E 24F 24G NPI 24J																																																											
4 24A 24B 24D 24E 24F 24G NPI 24J																																																											
5 24A 24B 24D 24E 24F 24G NPI 24J																																																											
6 24A 24B 24D 24E 24F 24G NPI 24J																																																											
25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> <input type="checkbox"/>										26. PATIENT'S ACCOUNT NO.										27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES <input type="checkbox"/> NO <input type="checkbox"/>										28. TOTAL CHARGE \$ 28										29. AMOUNT PAID \$										30. BALANCE DUE \$ 30									
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED _____ DATE _____										32. SERVICE FACILITY LOCATION INFORMATION a. NPI _____ b. _____										33. BILLING PROVIDER INFO & PH # () 33 a. NPI _____ b. _____																																							

CARRIER PATIENT AND INSURED INFORMATION PHYSICIAN OR SUPPLIER INFORMATION

8/05 CMS-1500 Claim Form Instructions

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

- Shaded boxes indicate the fields DMAP uses to process your claim (shaded on previous 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.

1a.	The eight-digit number found on the DHS Medical Care ID. <i>Left-align</i>
2.	The client’s name as it appears on the DHS Medical Care ID. <i>Left-align</i>
9.	<p>Use Third Party Resource explanation codes (pages 18-19) to indicate response received from other resources. Be sure that this code is the first entry in Field 9, followed by the name of the TPR.</p> <ul style="list-style-type: none"> ◆ If the client has other health insurance coverage, and no payment was received from that resource, this space must be used to explain why no payment was made. ◆ If using TPR code “MO” or “OT,” write “Review TPR code” at the top of the claim. Attach additional pages if needed to explain use of the code. Mail claim to Provider Services, 500 Summer St NE E44, Salem OR 97301. ◆ Be sure that this “reason” code is the first entry in Field 9, followed by the name of the TPR. <i>For “reason” code NC, Not Covered, enter: NC-Blue Cross.</i>
10a-c.	Complete as appropriate when an injury is involved.
17.	Enter the name of the referring physician.
17a.	<p>Enter the 6-or 9-digit DHS provider number for the referring physician. This information may be required if:</p> <ul style="list-style-type: none"> ◆ Your client has a Primary Care Manager (PCM), or ◆ The service being billed requires a referral (<i>e.g.</i>, Physical, Occupational, or Speech Therapy services).
17b.	Enter the PCM or referring physician’s 10-digit National Provider Identifier (NPI).
21.	<p>Enter the principal diagnosis/condition of the client indicated by current ICD-9-CM code number. Enter up to four codes in priority order.</p> <ul style="list-style-type: none"> ◆ Carry the codes out to their highest degree of specificity (fourth or fifth digit). ◆ Do not enter the decimal point or unnecessary characters.

23.	If the service being billed requires prior authorization, and DMAP has authorized the service, enter the 10-digit PA number here.
24.	<p>In the shaded area across Fields 24A through 24H, enter supplemental information (e.g., NDC, anesthesia) about the service. Enter the appropriate qualifier(s), followed by the information.</p> <ul style="list-style-type: none"> ◆ If entering more than one item of information on a line, make sure each item begins with a qualifier and is separated by at least 1 blank space from other items on the same line. ◆ When entering supplemental information for NDC, add in the following order: qualifier, NDC code, one space, unit/basis of measurement qualifier, quantity. The number of digits for the quantity is limited to eight digits before the decimal and three digits after the decimal. If entering a whole number, do not use a decimal. Do not use commas. ◆ See page 22 for more information about entering supplemental information.
24A.	<p>Enter the date (or first and last dates if consecutive days) that the service was provided. Must be numeric (100308). If “From-To” dates are used, a service must have been provided on each consecutive day but not more than once per day. <i>Left-align for line item 1</i></p>
24B.	<p>Enter the appropriate code for the place service was provided (use standard CMS Place of Service codes):</p> <ul style="list-style-type: none"> ◆ 03 – School ◆ 12 – Client’s Home
24C.	Put a “Y” in this field if the service was an emergency.
24D.	Enter the most appropriate code as described in OAR 410-132-0180. Use CMS standard modifier. See CMS Web site at www.cms.gov .
24E.	Enter the one-digit line number which refers to the primary diagnosis from Field 21 for each service billed.
24F.	Enter your usual and customary charge for each service billed.
24G.	Enter the number of days or units. This number must match the number of days in Field 24A or the number of units of service provided..
24H.	Enter a “Y” if the service is related to family planning.
24I.	Leave this field blank. If you include a qualifier on the line for the DHS provider number, the system reads the qualifier as part of the provider number and denies the claim due to invalid provider number.
24J.	In the shaded half of this field, enter the 6- or 9-digit DHS provider number of the provider who rendered the service. Do not enter an NPI.

26.	(Optional) Enter your unique patient account number here (up to 12 characters). It will be printed on your remittance advice.
28.	Enter the total of all of the charges listed in column 24F.
29.	Enter the total amount paid by any other insurance or resource. Do not include DMAP copayments in this field. If the client has other insurance and this amount is zero, there must be a 2-digit “reason” code in Field 9.
30.	Enter the amount due after subtracting the Amount Paid from the Total Charge (Field 28 minus Field 29). Do not include insurance write-off amounts.
33.	<p>If you have an NPI, enter it in part “a” of this field. In part “b,” enter your DHS provider number.</p> <ul style="list-style-type: none"> ◆ These numbers identify the provider to whom the check should be sent (actual service provider <i>or</i> the provider’s billing service). ◆ If you leave part “b” blank, DHS will use the NPI in part “a” to process your claim, which may result in DHS processing the claim under the wrong DHS provider number. ◆ Do not enter qualifiers in these fields. If you enter a qualifier, the system will read it as part of the provider number and deny for invalid provider number.

Third Party Resource (TPR) explanation codes

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

Single insurance coverage

Use a single insurance code when the client has only one insurance policy in addition to Medical Assistance Program coverage

- UD Service Under Deductible
- NC Service Not Covered by Insurance Policy
- PN Patient Not Covered by Insurance Policy
- IC Insurance Coverage Cancelled/Terminated
- IL Insurance Lapsed or Not in Effect on Date of Service
- IP Insurance Payment Went to Policyholder
- PP Insurance Payment Went to Patient
- NA Service Not Authorized or Prior Authorized by Insurance
- NE Service Not Considered Emergency by Insurance
- NP Service Not Provided by Primary Care Provider/Facility
- MB Maximum Benefits Used for Diagnosis/Condition
- RI Requested Information Not Received by Insurance from Client
- RP Requested Information not Received by Insurance from Policyholder
- MV Motor Vehicle Accident Fund Maximum Benefits Exhausted
- AP Insurance mandated under administrative/court order through an absent parent not paid within 30 days
- OT Other (if above codes do not apply, include detailed information of why no TPR payment was made)

Multiple insurance coverage

Use a multiple insurance code when the client has more than one insurance policy in addition to Medical Assistance Program coverage

- MP Primary Insurance Paid – Secondary Paid
- SU Primary Insurance Paid – Secondary Under Deductible
- MU Primary and Secondary Under Deductible
- PU Primary Insurance Under Deductible – Secondary Paid
- SS Primary Insurance Paid – Secondary Service Not Covered

- SC Primary Insurance Paid – Secondary Patient Not Covered
- ST Primary Insurance Paid – Secondary Insurance Cancelled/Terminated
- SL Primary Paid – Secondary Lapsed or Not in Effect
- SP Primary Paid – Secondary Payment Went to Patient
- SH Primary Paid – Secondary Payment Went to Policyholder
- SA Primary Paid – Secondary Denied – Service Not Authorized or Prior Authorized
- SE Primary Paid – Secondary Denied – Service Not Considered Emergency
- SF Primary Paid – Secondary Denied – Service Not Provided by Primary Care Provider/
Facility
- SM Primary Paid – Secondary Denied – Maximum Benefits Used for Diagnosis/
Condition
- SI Primary Paid – Secondary Denied – Requested Information Not Received from
Policyholder
- SR Primary Paid – Secondary Denied – Requested Information Not Received from
Patient
- MC Service Not Covered by Primary or Secondary Insurance
- MO Other (if above codes do not apply, include detailed information of why no TPR
payment was made)

Supplemental information qualifiers

DMAP accepts the following types of supplemental information in field 24 of the CMS-1500, accompanied by the appropriate qualifier:

Qualifier	Information Type
7	Anesthesia duration in hours and/or minutes with start and end times
ZZ	Narrative description of unspecified codes
N4	National Drug Codes (NDC). In addition, use the following qualifiers when reporting NDC units: <ul style="list-style-type: none"> ◆ F2 – International Unit ◆ GR – Gram ◆ ML – Milliliter ◆ UN - Unit
VP	Vendor Product Number – Health Industry Business Communications Council (HIBCC)
OZ	Product Number Health Care Uniform Code Council – Global Trade Item Number (GTIN), formerly Universal Product Code (UPC)
CTR	Contract rate

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

Anesthesia Services – Payment based on 15-minute units

24. A. DATE(S) OF SERVICE	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)	E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. ICD-9-CM Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
7Begin 1245 End 1415 Time 90 Minutes			00770 P2	1	### ##	6		NPI	1234567890

Anesthesia Services – Payment based on minutes as units

24. A. DATE(S) OF SERVICE	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)	E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. ICD-9-CM Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
7Begin 1245 End 1415			00770 P2	1	### ##	90		NPI	1234567890

Unspecified Code

24. A. DATE(S) OF SERVICE	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)	E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. ICD-9-CM Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
ZZ Kaye Walker			E1399	1	### ##	1		NPI	1234567890

NDC Code

24. A. DATE(S) OF SERVICE	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)	E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. ICD-9-CM Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
N41234567890 UN2			J#### UD [for 340B drugs]	1	### ##	20		NPI	1234567890

Vendor Product Number

24. A. DATE(S) OF SERVICE	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)	E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. ICD-9-CM Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
VPA122BIC5D6E7G			A6410	1	### ##			NPI	1234567890

Remittance advice

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

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

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

Electronic remittance advice

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

Correcting claims

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

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

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

Forms

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

DMAP 1036 - Individual Adjustment Request

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

- Use the DMAP 1036 only to request adjustments for *adjudicated* claims. Do not use the DMAP 1036 for *denied* claims. If DMAP denied a claim that you think DMAP should have paid, you must correct and re-submit the claim for processing.
- To order the Individual Adjustment Request (DMAP 1036) form, complete and submit the DMAP 2420 (Provider Forms Request) to DHS Forms Distribution, 550 Airport Rd SE, Salem, OR 97310.
- This form is also available on the DHS Web site at <http://dhsforms.hr.state.or.us/Forms/Served/OE1036.pdf>.

How to complete the Individual Adjustment Request (DMAP 1036)

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

1.	Check the appropriate box if this request is an underpayment (DMAP paid too little) or an overpayment (DMAP paid too much).
4.	Enter the 13-digit Internal Control Number (ICN).
5.	Enter the date printed at the top of the RA.
6.	Enter the client's name. 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 line number from the original claim you are adjusting.
13.	Enter the date you performed the service.
14.	Enter the incorrect information submitted on your original claim.
15.	Enter the corrected information.
16.	Give additional information or explain your request, if necessary.
17.	The signature of the provider or other authorized person must be in this space.

Individual Adjustment Request

DMAP Use Only

- ✓ Complete this form to request an adjustment.
- ✓ Please keep a copy and do not use red ink.

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

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

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

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

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

④ Internal Control Number		⑤ RA Date	
⑥ Recipient Name	⑦ Recipient ID Number		
⑧ Provider Name	⑨ Provider Number		
⑩ NPI			

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

⑯ **Remarks**

⑰ Requester's Name	Phone #	Date
---------------------------	---------	------

Individual Adjustment Request Instructions

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

Client _____

Private Duty Nursing Psychosocial Grid

	Minimal	Pt Sc	Moderate	Pt Sc	Extensive	Pt Sc
Medical Management	Managed by primary care provider or one specialist.	1	Requires periodic medical specialty consultation.	2	Requires multidisciplinary team approach.	3
Primary Caregivers	Other caregivers present in home to provide care.	1	Other caregivers available outside of home by arrangement.	2	No other caregivers available.	3
Wage Earner	At least 2 responsible adults in home and primary caregiver is not primary wage earner.	1	At least 2 responsible adults in the home and primary caregiver contributes to wage earnings or is primary wage earner.	2	Primary caregiver may or may not be primary wage earner. Only one responsible adult in the home.	3
Family Constellation	No other dependents/or dependents have minimal needs.	1	1 to 3 dependents with moderate medical or emotional needs.	2	Greater than 3 dependents in the home with intense medical or emotional needs.	3
Problem Solving Skills	Exhibits problem identification and problem solving skills.	1	Requires assistance in identifying problems/problem solving.	2	Requires extensive assistance to recognize problems and identify solutions.	3
Coping	Follows through with recommendations, keeps appointments.	1	Needs encouragement to follow through on recommendations. Inconsistent in keeping appointments.	2	Family follows through on recommendations only with extensive support and assistance.	3
Support Systems	Support systems present and utilized.	1	Support system present but needs encouragement to utilize.	2	Support systems absent.	3
Stressors	No history of mental illness, and/or behavior problems.	1	History of mental illness or behavior problems among family members.	2	Current diagnosis of mental illness and/or behavior problems.	3
Finances	Family's physical survival and security needs are met.	1	Family finances are inadequate, barely meets its needs for security and physical survival. Able to buy only necessities.	2	Family does not meet its needs for security and physical survival. Unable to buy the necessities.	3
Resource Utilization and/or Private Insur	Community resources and/or private insurance utilized.	1	Requires assistance in identification and utilization of resources.	2	Requires intensive assistance to identify and utilize resources.	3
Safety/Shelter	No safety hazards or health hazards identified in home environment.	1	Needs assistance to correct safety and health hazards.	2	Home inadequate to meet minimum safety and health standards.	3
ADL's	ADL's met consistently.	1	Inconsistent in meeting ADL's.	2	ADL's not met.	3
	Total		Total		Total	

Pt - Point Sc - Score

Person Completing _____

Date Completed _____

Total points _____

Client _____

Private Duty Nursing Acuity Grid

	Pt	Sc		Pt	Sc		Pt	Sc
Weight < 100 lbs	2		Weight < 125 lbs	3		Weight 125 - 160 lbs	4.5	
Minimal ongoing assessments (less than daily)	2		Moderate ongoing assessments (Hands on every 4 - 6 hours)	4		Frequent visual monitoring (both technical and patient assessment)	9.0	
			VS/GLU/NEURO/RESP Assess < <input type="checkbox"/> 4 hr**	1.5		Continual assessments	6.0	
						VS/GLU/NEURO/RESP Assess > <input type="checkbox"/> 4 hr	1.0	
Routine meds more than <input type="checkbox"/> 4 hrs	2		Complicated med schedule > <input type="checkbox"/> 2 hrs	5.0		VS/GLU/NEURO/RESP Assess > <input type="checkbox"/> 2 hr	3.0	
			Central line	2.5		Reg blood draws/IV Peripheral site**	4.5	
			Occasional transfusion/IV < month	2.5		Reg blood draws/IV central line**	6.0	
						IV Rx less often than <input type="checkbox"/> 4 hr	4.5	
Uncomplicated tube feeding	2		Tube feeding with minimal problem	2.5		IV Rx <input type="checkbox"/> 4 hr or more often	6.0	
			Occasional reflux	0.5		Central line with TPN	6.0	
			Gastrostomy tube	0.5		Chemotherapy	6.0	
O2 via cannula low flow rate	2		Tracheostomy (routine care)	1.5		IV pain control	6.0	
Suctioning less often than <input type="checkbox"/> 2 hrs	2		Suctioning more often than <input type="checkbox"/> 2 hrs	2.5		Ventilator	9.0	
Aspiration precautions	2		Humidification	1.5		No resp effort	12.0	
						C PAP or IMV < 12 hrs/day	6.0	
						C PAP or IMV > 12 hrs/day	9.0	
						Standby	3.0	
Requires all personal care/hygiene	2		CPT or Neb Tx less than <input type="checkbox"/> 4 hr**	1.5		Rehab transition (from ventilator)	9.0	
						CPT or NEB Rx > <input type="checkbox"/> 4 hr* #	3.0	
			Mild-mod seizures (Req min intervention)	2.5		CPT or NEB Rx > <input type="checkbox"/> 2 hr* #	3.0	
			Frequency less than 4 x day	1.5		Severe seizures (req IM or IV intervention)	4.5	
			Frequency 4 - 6 x day	2		Frequency > 6 x day	1.5	
Uncontrolled incontinence	2		Intermittent straight catheter.	3.5				
Awake no more than 3 hr a night	2		Moderate sleep disturbance	3.5		Uncontrolled incontinence	6.0	
			(Awake/turned > <input type="checkbox"/> 2 hr a night)			(Frequent linen change)		
Communication deficit (not cognitive or verbal)	2		Disorientation/combative (Strikes out, attempts to hurt self)	5		Severe sleep disturbance (Awake > <input type="checkbox"/> 2 hr)	6.0	
Developmental deficit	2		< 80 lbs	1.5		Disoriented/combative > 140 lbs	6.0	
			< 110 lbs	2				
			< 140 lbs	2.5		Requires isolation	6.0	
Developmentally delayed mobility	2					Acute mobility problems	6.0	
Basic ROM (No PT or OT program)	2		Full OT (Set program <input type="checkbox"/> 4 hr)	5.5		(Potential for skin breakdown)	6.0	
Play therapy	2		Full PT (Set program <input type="checkbox"/> 4 hr)	5.0		Attends school/therapy with nurse	6.0	
Fracture or casted limb	2					Peritoneal dialysis	6.0	
Body cast	2		RN case management < 4 hrs week	2.5				
			RN case management > 4 hrs week	5.0				
TOTAL			TOTAL			TOTAL		

Pt - Point Sc - Score * Give points for each type of assessment and each Neb or CPT Rx ** Give points for each IV Rx or blood draw ordered to a max of 10 points

Person Completing _____ Date Completed _____ Total points _____

DHS 3970 - EDMS Coversheet

DHS now requires this sheet as the cover for most mailed or faxed correspondence sent to DMAP for processing. To avoid delays in processing:

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

This form is also available on the DHS Web site at <http://dhsforms.hr.state.or.us/Forms/Served/DE3970.pdf>.

How to complete the DHS 3970

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

- **Always enter your National Provider Identifier and the client's ID number in the "Index Field & Values" 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 "Index Field & Values" 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 "Index Field & Values" section of the coversheet.

DHS 3971 - Oregon DHS Prior Authorization Request

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

This form is also available on the DHS Web site at <http://dhsforms.hr.state.or.us/Forms/Served/DE3971.pdf>.

Information needed to request PA

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

Information needed	New PA	Existing PA	
		Continue	Change
Section I - Provider number (NPI)	X		
Section II - Type of PA request - Mark "Other" and enter "Private Duty Nursing"	X		
Section III ◆ Client ID and client's name	X	X	X
Section IV ◆ Frequency of service ◆ ICD-9-CM Diagnosis Code – to the highest specificity, obtained from the prescribing practitioner – The diagnosis code must be the reason chiefly responsible for the service being provided as shown in the medical records.	X		
Section V - Procedure codes , U&C (usual and customary charge), units of service	X		
Section VIII - Performing provider name and NPI	X		
Section IX - Date of request and expected service begin/end dates			

Attachments needed to request PA

Describe attachments in the "Attachments" section of the 3971 and attach as follows:

New PA

Written justification and a proper written order from the prescribing practitioner, dated within 7 days of the date of the PA request:

- The plan of care (dated within one week of the PA request) with short-term goals, long-term goals, objectives, and timelines for meeting the goals and objectives.
- A comprehensive assessment

- A completed Acuity Grid (DMAP 591) and
- A completed Psychosocial Grid (DMAP 590), if needed

Request to continue existing PA

- Daily nursing notes and flowsheets from the past month, if applicable
- Updated plan of care
- Progress reports
- Recent clinic summaries and significant clinical findings from physician
- New written order from the prescribing practitioner, dated within 7 days of the request for continued services
- New Acuity Grid (DMAP 591), completed within 7 days of the request

Request to change existing PA

Visit notes and a written order to support the change.

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 _____ | <input type="checkbox"/> Physical Therapy | |

III

Client ID _____ DOB _____

Last Name _____ First Name, MI _____

IV

Service Information

Estimated length of treatment _____ Frequency _____

Length of time per session _____

Primary diagnosis _____ Primary ICD-9 diagnosis code _____

Other pertinent diagnosis _____

Facility: Name _____ Provider # _____

Revenue Center Codes _____

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

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

VI DENTAL

Tooth Number _____ Quad _____

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

Pharmacy: Drug Name _____ Strength _____
 Quantity _____ NDC _____

Directions:

VIII

Performing Provider _____ Provider # _____

Contact Name _____ Contact Phone # _____

Contact Fax # _____ Billing Provider # _____

IX Date Information

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

Expected Service Begin Date ____ / ____ / ____

Expected Service End Date ____ / ____ / ____

Notes:

Attachments:

Document Control Number (DCN) _____

Report Type _____

Description of attachments:

DMAP Forms Request

Instructions:

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

Provider Name		
Street Address (NOT PO Box)		
City	State	ZIP

Area Code & Phone

Forms available in packages of 50

CMS 1500 billing forms are available through business forms suppliers.

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

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

DMAP 2420 (Rev. 02/08)

Place
Postage
Here

DAS Distribution Center
550 Airport Rd SE
Salem OR 97310