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OREGON MEDICAID
MANAGEMENT INFORMATION
SYSTEM

Professional (CMS-1500) Paper Billing Instructions for Fee-for-Service Providers v1.2

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1 Introduction

The CMS-1500 Billing Instructions handbook is a guide to assist Providers who bill Oregon Medicaid for services to complete the CMS-1500 paper billing form.

1.1 About this handbook

This handbook lists the requirements for claims completion and provides helpful hints on how to avoid common billing errors. It provides step-by-step instructions on how to submit a CMS-1500 paper claim.

Providers are encouraged to use this handbook, as applicable, with the Oregon Administrative Rules (OARs) and related supplemental information for billing.

The CMS-1500 Paper Billing Instructions are designed to assist the following Providers:*

Provider Service Types	
▪ Adult Day Health	▪ Medical Transportation
▪ Adult Residential Treatment Facility/Home	▪ Mental Health Adult Foster Home
▪ Ambulatory Surgical Centers	▪ Naturopaths
▪ Certified Registered Nurse Anesthetists	▪ Non-Medical Transportation Contractors
▪ Chemical Dependency	▪ Occupational Therapist
▪ Child/Adolescent Residential Treatment	▪ Ophthalmologists
▪ Chiropractors	▪ Optometrists
▪ Community Mental Health Program	▪ Physical Therapist
▪ Doctors of Medicine	▪ Podiatrists
▪ Durable Medical Equipment	▪ Portable X-Ray Provider

Provider Service Types	
▪ Family Planning Clinics	▪ Psychologists
▪ Federally Qualified Health Centers	▪ Public Health Departments
▪ Home Delivered Meals Provider	▪ Registered/Contract Nurses
▪ Home Enteral/Parenteral IV	▪ Rural Health Clinics
▪ Independent Laboratories	▪ School-Based Health Services
▪ In Home Agency Provider	▪ Social Workers
▪ Licensed Practitioner Nurse (LPN)	▪ Speech and Language Therapists

*This list may not include all Provider types that use the CMS-1500. If in doubt of which claim form to use or if you need assistance with claims, refer to your Provider guidelines or contact DHS Provider Services at:

- **E-mail:** DMAP.Providerservices@state.or.us
- **Phone:** 800-336-6016 (8:00 a.m. to 5:00 p.m. PST, Monday through Friday)

2 Key Terms

Claim

- A request for payment of health care services to a DHS client.

Diagnosis Code

- A numeric code that documents the client's medical condition, symptom or complaint as determined by the Provider and is the basis for rendering service(s). The diagnosis coding structure uses the International Classification of Disease– Ninth Revision, Clinical Modification (ICD-9-CM).

Internal Control Number

- An Internal Control Number (ICN) is a unique 13-digit identification number assigned to every claim in order to distinguish it from all other claims received by the system. The ICN is comprised of multiple components that identify critical information about the claim.
 - The first two characters represent the region code that identifies the source (paper, electronic, claim adjustments, etc) of the claim submission.
 - The ICN also represents the date the claim was received in the year and Julian date portion of the field. This facilitates control reporting of claims for the receipt date, as well as other downstream processing, such as edit disposition.
 - The batch range portion identifies the claim type assigned to the claim, and the sequence number of its relative position within a process cycle.

Modifier

- A means by which the reporting Provider can indicate that a service or procedure performed has been modified by some specific circumstance but the service has not changed in its definition or code.

Modifiers can be found in the Current Procedural Terminology (CPT) book.

Payment Authorization

- Authorization is granted to a Provider to render specified services to a designated beneficiary. The authorization is given **after** the services are provided.

Place of Service Codes

- A two-digit code that specifies the setting in which services were rendered. The Centers for Medicare and Medicaid Services (CMS) maintains POS codes. A list of these codes can be found in the CPT book.

Prior Authorization

- Prior Authorization (PA) is requested by a Provider in order to render specified services to a designated beneficiary. The authorization is given **prior** to the services being performed.

Procedure Code

- A CPT or a Healthcare Common Procedure Coding System (HCPCS) code is a five (5)-digit code that uniquely identify a service or procedure for a professional service from physicians, nurses, chiropractors, etc. Procedure codes are used on all professional claims to describe services performed.

Third-Party Liability

- Third-Party Liability (TPL) provides cost containment of the Medicaid program through the identification of services for which other insurance should be the primary payer. This includes, but is not limited to, private health insurance, any applicable Medicare coverage, worker's compensation, and accident-related liability insurance.

The amount received from third parties, TPL amount on claims sent to Medicaid, should be indicated. Medicaid deducts the TPL amount from the payable amount, which is calculated based on reimbursement rules.

3 Claims Processing

The federal government requires Medicaid claims to be processed through an automated claim processing system known as the Medicaid Management Information System (MMIS). This system is a combination of people and computers working together to process claims.

Paper claims submitted by mail go first to the DHS Office of Document Management (ODM) Imaging Unit.

- The document is scanned through an Optical Character Recognition (OCR) machine and the claim is given an ICN.
- The scanned documents are then identified and sorted by form type and indexed by identifiers such as client name, prime identification number, the date of service, and Provider number.
- Finally, the data and images are stored on an Electronic Document Management System (EDMS).

Once the claim is scanned through the OCR, DHS staff can immediately access submitted claim information by checking certain MMIS screens. The fewer edits and audits the claim goes through, the more quickly the system can process the claim.

The system performs daily edits for presence and validity of data. Once a week, the system audits all claims to ensure that they conform to medical policy. Every weekend, a payment cycle runs and the system produces checks for claims that successfully pass all edits and audits.

DHS staff will see the claim only if MMIS cannot make a payment decision based on the information submitted. The system directs the claim to DHS staff for specific medical or administrative review. This type of claim is a suspense claim or a claim that has been suspended.

DHS does not return denied claims to Providers. Instead, DHS mails a listing of all claims paid and/or denied to the Provider (with payment if appropriate). The listing is called a Remittance Advice (RA).

4 Eligibility Verification

It is the responsibility of the Provider to verify that the individual receiving medical services is, in fact, an eligible individual on the date of service (DOS) for the service provided and whether a managed care plan or DHS is responsible for reimbursement. The Provider assumes full financial risk in serving a person not identified as eligible for the service provided on the date(s) of service.

The Medical Care ID card and household's comprehensive coverage letter do not guarantee eligibility or payment and should not be used as proof of eligibility.

The Medical care ID card will not include eligibility information. Providers can verify eligibility in the following ways:

- The secure Provider Web portal
- The Automated Voice Response (AVR), which replaces the Automated Information System (AIS)
- Electronic Eligibility Verification Service (EEVS) through a vendor
- Batch and real-time verification method through EDI 270/271 transactions

Current and past client eligibility information is available through any of these methods. Future eligibility information is not available. Eligibility information is subject to change at any time.

Clients enrolled with an OHP managed care organization (MCO) must be billed to the appropriate MCO identified.

Note: It is always a good idea to keep track of when and how you verified eligibility. In addition, it is recommended to record all client eligibility information for the date of service verified, including any eligibility verification numbers.

For more information on client eligibility verification, please refer to the MMIS Provider Overview training module at:

www.oregon.gov/DHS/mmis/training-info.shtml

5 CMS-1500 Claim Form

5.1 Where to get the CMS-1500 claim form

Providers billing professional services on paper must use the standard CMS-1500 claim form. DHS does not supply the CMS-1500 form. The federal CMS-1500 form is available through:

- Local business forms suppliers
- Oregon Medical Association (503-226-1555)
- U.S. Government Printing Office (202-512-1800)

DHS processes paper claims using OCR scanning. When purchasing your claim forms use commercially available “red form” 08/05 versions of the CMS-1500. When claim forms are submitted on the standard “red form,” the red ink drops out and the OCR technology scans the claim data (black ink) directly into the claims processing system, which increases the accuracy and efficiency of claims processing.

5.2 Valid claim formats

DHS only accepts the CMS-1500 08/05 version. Claims submitted on the old 12/90 version will be returned with a request to resubmit the claim on the correct form.

5.3 Completing the CMS-1500 claim form (version 08/05)

Shaded fields are required in order to process the claim. The claim may suspend or deny if information in this field is missing or incomplete.

1500

CARRIER ↑

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA <input type="checkbox"/>		PICA <input type="checkbox"/>	
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(L)NG <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 <small>(For Program in Item 1)</small>	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) 2		3. PATIENT'S BIRTH DATE <small>MM DD YY</small> SEX <small>M <input type="checkbox"/> F <input type="checkbox"/></small>	
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"/>	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) _____ c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	
a. OTHER INSURED'S POLICY OR GROUP NUMBER b. OTHER INSURED'S DATE OF BIRTH <small>MM DD YY</small> SEX <small>M <input type="checkbox"/> F <input type="checkbox"/></small> c. EMPLOYER'S NAME OR SCHOOL NAME d. INSURANCE PLAN NAME OR PROGRAM NAME		11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH <small>MM DD YY</small> SEX <small>M <input type="checkbox"/> F <input type="checkbox"/></small> b. EMPLOYER'S NAME OR SCHOOL NAME c. INSURANCE PLAN NAME OR PROGRAM NAME 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 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) <small>MM DD YY</small>		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE <small>MM DD YY</small>	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		17a. _____ 17b. NPI _____	
19. RESERVED FOR LOCAL USE		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM <small>MM DD YY</small> TO <small>MM DD YY</small> 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM <small>MM DD YY</small> TO <small>MM DD YY</small> 20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES _____	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. _____ 2. _____ 3. _____ 4. _____		22. MEDICAID RESUBMISSION CODE _____ ORIGINAL REF. NO. _____ 23. PRIOR AUTHORIZATION NUMBER _____	
24. A. DATES OF SERVICE From <small>MM DD YY</small> To <small>MM DD YY</small> B. PLACE OF SERVICE <small>EMG</small> C. <small>CPT/HCPCS</small> D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. SPOT Family Plan I. ID QUAL J. RENDERING PROVIDER ID #			
1 24A 24B 24D 24E 24F 24G 24J			
2 _____			
3 _____			
4 _____			
5 _____			
6 _____			
25. FEDERAL TAX I.D. NUMBER _____ SSN EIN <input type="checkbox"/> <input type="checkbox"/>		26. PATIENT'S ACCOUNT NO. _____	
27. ACCEPT ASSIGNMENT? <small>(For govt. claims, see back)</small> <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE 28 \$ _____	
29. AMOUNT PAID \$ _____		30. BALANCE DUE 30 \$ _____	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED _____ DATE _____		32. SERVICE FACILITY LOCATION INFORMATION a. NPI _____ b. _____	
33. BILLING PROVIDER INFO & PH# () 33			
NUCC Instruction Manual available at: www.nucc.org			

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

PHYSICIAN OR SUPPLIER INFORMATION ↑

5.3.1 Field descriptions and required fields

Shaded fields are always mandatory. Non-shaded fields are mandatory, if applicable to the client's claim.

Field	Field Name	Description
1 a	Insured ID Number	Use the eight (8)-digit alpha-numeric Medicaid client Identification (ID) Number. The client ID number is printed on the Medical Care ID card.
2	Patient's Name	Enter the Client name exactly as it is printed on the Medical Care ID card. DO NOT use "nicknames."
9	Other Insured's Name	If the Client has other medical coverage, enter the appropriate two (2)-digit third party resource (TPR) explanation code. This code explains insurance actions. Refer to Appendix for TPR explanation codes .
10	Is Patient's Condition Related To	Check the appropriate box when an injury is involved.
10d	Reserved For Local Use	If the service normally requires prior authorization, but the service was provided in an emergency situation, enter a "Y" in this box.
17	Name of Referring Provider or Other Source	Enter the name of the referring Provider. If the Client has a Primary Care Manager (PCM), enter the PCM's name in this field.

Field	Field Name	Description
17 a	ID Number of Referring Provider or Other Source	<p>Enter the six (6) or (9)-digit Medicaid Provider number of the referring Provider or the 10-digit National Provider Identifier (NPI).</p> <ul style="list-style-type: none"> • Existing Medicaid Providers will have a six (6)-digit Provider number. • After implementation of the replacement MMIS, newly enrolled Medicaid Providers will have a nine (9)-digit Provider number. • If the referring Provider is not enrolled with DHS, enter six (6) nines (999999). • If the Client has a Primary Care Manager (PCM), enter the PCM's six (6) or nine (9)-digit NPI or Medicaid Provider number in this field.
17 b	NPI of Referring Provider or Other Source	<p>Enter the PCM or referring physician's 10-digit National Provider Identifier (NPI).</p>

Field	Field Name	Description
21	Diagnosis or Nature of Illness or Injury	<p>Enter the client’s primary diagnosis or condition by entering the appropriate ICD-9-CM codes. The diagnosis code must be the reason chiefly responsible for the service being provided as shown in the medical records. Carry out codes to their highest degree of specificity.</p> <ul style="list-style-type: none"> • Enter up to four (4) diagnosis codes in priority order. • DO NOT enter the decimal point. <p>Note: This field indicates 1,2,3,4. List diagnosis codes in that order.</p> <p><i>Exceptions:</i> Transportation Providers and Lifeline Providers do not need to provide diagnosis information.</p>
23	Prior Authorization Number	<p>If the service was prior/payment authorized, enter the nine (9)-digit Prior Authorization number that DHS issued for the service. DO NOT bill prior-authorized and non-authorized services on the same claim form. You must submit separate CMS-1500 claim forms for each.</p>
24	Supplemental information	<p>Refer to Appendix for more information about entering supplemental information.</p>
24 A	Dates of Service (From/To)	<p>Enter numeric dates of service. If you use “From – To” dates, a service must be on consecutive days and provided no more than once per day. As example:</p> <p>Correct.....05-01-08 thru 05-05-08.....5 units</p> <p>Incorrect.....05-01-08 thru 05-06-08.....5 units</p>

Field	Field Name	Description
24 B	Place of Service (POS)	<p>List the two (2)-digit POS code that identifies where the service was rendered. Use the standard 2-digit CMS codes that are available in the front of the CPT book.</p> <p>Note: The use of one (1)-digit POS codes has been discontinued.</p>
24 D	Procedures, Services, or Supplies and Modifier	<p>List the five (5)-digit procedure code for the service provided. Use only current CPT or HCPCS codes. You may include up to two (2) national modifiers for each line item.</p>
24 E	Diagnosis Pointer	<p>Enter ONLY one (1) number that cross-references or corresponds to the diagnosis as listed in Field 21. DO NOT enter the actual ICD-9-CM code here.</p> <p><i>Exceptions:</i> Transportation Providers and Lifeline Providers do not need to provide diagnosis information.</p>
24 F	\$ Charges	<p>Enter the total usual and customary charge for each line item. DHS will not calculate your charge if billing for more than 1 item (unit).</p>
24 G	Days or Units	<p>This number must match the number of days being provided as indicated in Field 24A.</p> <p>Unit Example: Procedure code 97110 (therapeutic exercise), 1 unit = 15 minutes. You treated the client for 45 minutes, since 1 unit equals 15 minutes then the number of units entered must be 3.</p> <p>Days: The number of days must be consecutive days.</p>

Field	Field Name	Description
24 H	EPSDT Family Planning	Enter a “Y” in this field only if the services are related to Family Planning or Early Periodic Screening Diagnosis Treatment (EPSDT).
24 J	Rendering Provider ID#	<p>List the six (6) or nine (9)-digit “performing” Provider number. When billing with a clinic or group Provider number in Field 33, this field must be completed with the rendering Providers NPI or Medicaid Provider number of who actually performed the services.</p> <ul style="list-style-type: none"> Existing Medicaid Providers will have a six (6)-digit Provider number. After the replacement MMIS goes live, newly enrolled Medicaid Providers will have a nine (9)-digit Provider number.
26	Patient’s Account No.	If a client account number is provided in this field it will print on the Remittance Advice (RA). The patient account number is for internal billing purposes and is not used by DHS for claims processing.
28	Total Charge	Enter the total amount for all charges listed in Field 24F. All lines listed under field 24F should add up to the total amount billed.
29	Amount Paid	<p>Enter the total amount paid by other insurances or third-party payers.</p> <p>DO NOT include:</p> <ul style="list-style-type: none"> DHS co-payments Previous payment amounts made by DHS Contract write-offs required by other payers

Field	Field Name	Description
30	Balance Due	Enter the total balance due. Field 28 minus field 29 equals field 30, “balance due.”
33	Billing Provider Info & PH#	<p>In part “a” of this field, if you have an NPI enter the ten (10)-digit number.</p> <p>In part “b” of this field, enter your six (6) or nine (9)-digit billing or performing Provider number. This is the Provider that DHS will pay.</p> <ul style="list-style-type: none"> • Existing Medicaid Providers will have a six (6)-digit Provider number. • After the replacement MMIS goes live, newly enrolled Medicaid Providers will have a nine (9)-digit Provider number.

6 Helpful Billing Tips

- READ** your provider guidelines!
- MAKE SURE** you have the most current OARs rulebook.
- VERIFY** client eligibility on the date services are provided.
- VERIFY** that the client's name and ID number on the claim matches the name and number shown on the Medical Care ID card.
- USE** only commercially available "red form" of the CMS-1500 version 08/05.
- DO NOT USE** black and white claim forms or copies.
- USE** blue or black ink and print clearly if you are hand writing your claim. **DO NOT** use red ink.
- DO NOT USE** liquid white out on the claim form.
- Do not bold data on the claim form.
- CHECK** your printer alignment. All data on a claim form must be correctly aligned within the designated data fields. CMS recommends using Arial 10 pt font type and size.
- BILL** other resources (Medicare/Third-party resources) before billing Medicaid and reported the correct dollar amount in Field 29.
- USE** the correct 2-digit third party resource (TPR) explanation code in Field 9 when the client has other insurance. Always enter a code if the client has more than one TPR available.
- REPORT** the correct TPL dollar amount on the claim.

- USE** the correct combination of procedure code and modifier appropriate for the service billed.
- USE** only one prior authorization number in Field 23.
- DO NOT** bill authorized services and services that do not require authorization on the same claim form.
- ENTER** the Provider ID number you want DHS to send payment to in Field 33. An invalid or missing Provider ID number could delay your payment, make payment to a wrong Provider or deny your payment.
- ENTER** the performing Provider NPI or Medicaid Provider ID number in Field 24J, if the performing Provider is different from the billing Provider (field 33),
- DO NOT** carry over totals from one CMS-1500 form to the other.
- BILL** multiple surgical procedures on one claim form.
- DO NOT** attach third-party resources explanation of benefits (EOB) to your claim form.
- READ** the EOB codes on the claims status screen or RA to determine the error.
- CONTACT** DHS Provider Services at 800-336-6016 or e-mail at DMAP.Providerservices@state.or.us for assistance.
- VISIT** www.oregon.gov/DHS/healthplan for additional information.

7.1 TPR explanation codes

Use in Field 9 on the CMS-1500.

7.1.1 Single insurance coverage

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

Code	Description
UD	Service Under Deductible
NC	Service Not Covered by Insurance Policy
PN	Patient Not Covered by Insurance Policy
IC	Insurance Coverage Canceled/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-and Not Paid Within 30 Days
OT	Other (if above codes do not apply, include detailed explanation of why no TPR payment was made)

7.1.2 Multiple insurance coverage

Use in Field 9 of CMS-1500. Use a multiple insurance code when the client has more than one insurance policy in addition to Medicaid.

Code	Description
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 Canceled/Terminated
SL	Primary Insurance Paid – Secondary Lapsed or Not in Effect
SP	Primary Insurance Paid – Secondary Payment Went to Patient
SH	Primary Insurance Paid – Secondary Payment Went to Policyholder
SA	Primary Insurance Paid – Secondary Denied - Service Not Authorized
SE	Primary Insurance Paid – Secondary Denied - Service Not Considered Emergency
SF	Primary Insurance Paid – Secondary Denied - Service Not Provided by Primary Care Provider/Facility
SM	Primary Insurance Paid – Secondary Denied - Maximum Benefits Used for Diagnosis/Condition
SI	Primary Insurance Paid – Secondary Denied - Requested Information Not Received from Policyholder
SR	Primary Insurance Paid – Secondary Denied - Requested Information Not Received from Patient
MC	Service Not Covered by Primary or Secondary Insurance

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

7.2 Supplemental information

In the shaded areas across fields 24A through 24H on the CMS-1500 claim form, you can enter supplemental information about the service(s) rendered.

DHS accepts the following types of supplemental information, 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

7.2.1 Supplemental information examples

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.

7.2.1.1 Anesthesia Services – Payment based on 15-minute units

24. A. DATE(S) OF SERVICE							B.	C.	D. PROCEDURES, SERVICES, OR SUPPLIES		E.	F.		G.	H.	I.	J.
From To							PLACE OF SERVICE	EMG	(Explain Unusual Circumstances)		DIAGNOSIS POINTER	\$ CHARGES		DAYS OR UNITS	EPSDT Family Plan	ID. QUAL.	RENDERING PROVIDER ID. #
MM	DD	YY	MM	DD	YY	SERVICE		CPT/HCPCS	MODIFIER								
7Begin 1245 End 1415 Time 90 Minutes																	
06	01	07	06	01	07	1		00770	P2		1	###	##	6		NPI	1234567890

7.2.1.2 Anesthesia Services – Payment based on minutes as units

24. A. DATE(S) OF SERVICE							B.	C.	D. PROCEDURES, SERVICES, OR SUPPLIES		E.	F.		G.	H.	I.	J.
From To							PLACE OF SERVICE	EMG	(Explain Unusual Circumstances)		DIAGNOSIS POINTER	\$ CHARGES		DAYS OR UNITS	EPSDT Family Plan	ID. QUAL.	RENDERING PROVIDER ID. #
MM	DD	YY	MM	DD	YY	SERVICE		CPT/HCPCS	MODIFIER								
7Begin 1245 End 1415																	
06	01	07	06	01	07	1		00770	P2		1	###	##	90		NPI	1234567890

7.2.1.3 Unspecified Code

24. A. DATE(S) OF SERVICE							B.	C.	D. PROCEDURES, SERVICES, OR SUPPLIES		E.	F.		G.	H.	I.	J.
From To							PLACE OF SERVICE	EMG	(Explain Unusual Circumstances)		DIAGNOSIS POINTER	\$ CHARGES		DAYS OR UNITS	EPSDT Family Plan	ID. QUAL.	RENDERING PROVIDER ID. #
MM	DD	YY	MM	DD	YY	SERVICE		CPT/HCPCS	MODIFIER								
ZZ Kaye Walker																	
06	01	07	06	01	07	4		E1399			1	###	##	1		NPI	1234567890

7.2.1.4 NDC Code

24. A. DATE(S) OF SERVICE							B.	C.	D. PROCEDURES, SERVICES, OR SUPPLIES		E.	F.		G.	H.	I.	J.
From To							PLACE OF SERVICE	EMG	(Explain Unusual Circumstances)		DIAGNOSIS POINTER	\$ CHARGES		DAYS OR UNITS	EPSDT Family Plan	ID. QUAL.	RENDERING PROVIDER ID. #
MM	DD	YY	MM	DD	YY	SERVICE		CPT/HCPCS	MODIFIER								
N400026064871 Immune Globulin Intravenous UN2																	
06	01	07	06	01	07	1		J1563			1	###	##	20		NPI	1234567890

7.2.1.5 Vendor Product Number

24. A. DATE(S) OF SERVICE							B.	C.	D. PROCEDURES, SERVICES, OR SUPPLIES		E.	F.		G.	H.	I.	J.
From To							PLACE OF SERVICE	EMG	(Explain Unusual Circumstances)		DIAGNOSIS POINTER	\$ CHARGES		DAYS OR UNITS	EPSDT Family Plan	ID. QUAL.	RENDERING PROVIDER ID. #
MM	DD	YY	MM	DD	YY	SERVICE		CPT/HCPCS	MODIFIER								
VPA122BIC5D6E7G																	
06	01	07	06	01	07	1		A6410			1		##	##		NPI	1234567890

7.2.1.6 Global Trade Item Number

24. A. DATE(S) OF SERVICE							B.	C.	D. PROCEDURES, SERVICES, OR SUPPLIES		E.	F.		G.	H.	I.	J.
From To							PLACE OF SERVICE	EMG	(Explain Unusual Circumstances)		DIAGNOSIS POINTER	\$ CHARGES		DAYS OR UNITS	EPSDT Family Plan	ID. QUAL.	RENDERING PROVIDER ID. #
MM	DD	YY	MM	DD	YY	SERVICE		CPT/HCPCS	MODIFIER								
OZ00301134678906																	
06	01	07	06	01	07	1		A6410			1	##	##	1		NPI	1234567890

7.3 Claims address mailing list

Below is the DHS claims address mailing list.

Claim type	Service type	Address
CMS-1500	All professional provider	DMAP, PO Box 14955 Salem, OR 97309
	Speech/language pathology, audiology & hearing services; private duty nursing claims	DMAP, PO Box 14018 Salem, OR 97309
	SPD Contract RN claims	DMAP, PO Box 14957 Salem, OR 97309
DMAP 505	Medicare/Medicaid claims	DMAP, PO Box 14015 Salem, OR 97309
UCF 5.1 (Universal Claim Form)	Drug claims	DMAP, PO Box 14951 Salem, OR 97309
Any form used in conjunction with Death with Dignity	Death with Dignity claims	DMAP, PO Box 992 Salem, OR 97308-0992
ADA 2006	Dental claims	DMAP, PO Box 14953 Salem, OR 97309
UB-04	Hospital, Home Health, Hospice, NF/LTC claims	DMAP, PO Box 14956 Salem, OR 97309
DMAP 741 OMAP 742	Consent to hysterectomy Consent to sterilization	DMAP, PO Box 14958 Salem, OR 97309
Transplant claims	For any claim related to payment for prior authorized, covered transplant services.	DMAP CMU PO Box 14016 Salem, OR 97309
Out-of-state claims (all claim types)	For any claim from a provider located more than 75 miles beyond the Oregon border. If within 75 miles, send to the appropriate address listed above.	DHS Provider Services ATTN: Out of State Claims 500 Summer St NE, E44 Salem, OR 97301-1079

Claim type	Service type	Address
Administrative exams	For any claim related to payment for exams requested by DHS offices. Send reports to requesting DHS office; mail claims to DMAP.	DMAP, PO Box 14165 Salem, OR 97309
DMAP/DHS forms	To order DMAP or DHS forms	DHS Distribution Center 550 Airport Rd Salem, OR 97310
DMAP 1036 – Individual adjustment request	To use if you have received an incorrect payment (overpayment or underpayment) for a claim	DMAP, PO Box 14952 Salem, OR 97309
Problem claims including administrative errors and claims over one year old.	<ol style="list-style-type: none"> 1. Send copy of claim with letter explaining the problem 2. Attach paper RAs related to claim 3. Include complete documentation 	DHS Provider Services 500 Summer St NE, E44 Salem, OR 97301-1079
Appeals (Reconsideration of Non-covered services, CAWEM denials, and other appeals).	<ol style="list-style-type: none"> 1. Send a letter stating reasons for the appeal. 2. Attach the claim for denied services. 3. Include supporting medical record documentation. 	DHS Provider Services 500 Summer St NE, E44 Salem, OR 97301-1079
Addictions and Mental Health Division (AMH)	For General Correspondence	Addictions and Mental Health Division 500 Summer St. NE - E86 Salem, OR 97301-1118

7.4 Prior Authorization/Plan of Care contact list

Below are the Fee-for-Service Prior Authorization (PA)/Plan of Care (POC) contact phone numbers.

PA/POC Contacts for FFS or open card Clients	
Use the appropriate agency listed below to authorize services in each section.	
Programs	Agency Authorizing Service
DME Equipment/Supplies Hearing Aid Services Home Health (Nursing only) Home Enteral /Parenteral Services (see below for Oral Nutritional Supplements) Physical/Occupational Therapy Private Duty Nursing Speech/Hearing/Audiology Vision Services	<p>Medically Fragile Children’s (MFC) Unit:</p> <ul style="list-style-type: none"> • 971-673-2985 • 971-673-3000 <p>FFS high cost/high risk clients- Innovative Care Management 10117 SE Sunnyside Road, Box F409 Clackamas, OR 97015</p> <ul style="list-style-type: none"> • 800-862-3338 • 503-654-9447 <p>All other clients—DMAP Medical Unit:</p> <ul style="list-style-type: none"> • 800-642-8635 • 503-945-6821
Addictions and Mental Health Plan of Care	<p>Addictions and Mental Health Division:</p> <ul style="list-style-type: none"> • 503-945-5763 • 800-375-2863 TTY • 503-947-5546 Fax
Long term care and waived services for Seniors and People with Physical Disabilities (SPD).	All PA requests must go through the local office.
Dental Services	<p>DMAP Dental Coordinator:</p> <ul style="list-style-type: none"> • 800-527-5772 • 503-945-6506

**PA/POC Contacts
for FFS or open card Clients**

Use the appropriate agency listed below to authorize services in each section.

Programs	Agency Authorizing Service
Drugs/Pharmacy Home Enteral/Parenteral – (Oral meds & Nutritional Supplements only)	PBM Technical and Prior Authorization Center <ul style="list-style-type: none"> • 888-202-2126
Surgical Procedures	High cost/high risk clients—Innovative Care Management: <ul style="list-style-type: none"> • 800-862-3338 • 503-654-9447 All other clients- Acumentra Health: 2020 SW Fourth St. Ste 520 Portland, OR 97201-4960 <ul style="list-style-type: none"> • 800-452-1250 • 503-279-0159 Outside Oregon—non-emergent services: <ul style="list-style-type: none"> • 800-325-8933
Transplants Out-of –State Services	High-cost/high-risk clients- Innovative Care Management: <ul style="list-style-type: none"> • 800-862-3338 • 503-654-9447 All other clients- DHS Provider Services: <ul style="list-style-type: none"> • 800-336-6016 Mental Health- <ul style="list-style-type: none"> • 503-945-5763 • 800-375-2863 TTY • 503-947-5546 Fax

**PA/POC Contacts
for FFS or open card Clients**

Use the appropriate agency listed below to authorize services in each section.

Programs	Agency Authorizing Service
Non-Emergent Transportation	Contact the local branch office/brokerage

7.5 DHS Support Phone Numbers

Department	Phone Number	Hours
<p>Automated Voice Response (AVR)</p> <ul style="list-style-type: none"> ✓ Client eligibility, TPR, benefit packages, managed care, and more. ✓ Vision service history ✓ Claims & payment inquiry ✓ Prior Authorization 	866-692-3864	24 hours, 7 days a week
<p>RN Benefit Hotline</p> <ul style="list-style-type: none"> ✓ Information about OHP diagnosis/treatment pairs <p><i>If the client is in a managed care plan and you have a question about whether the treatment is covered, call the client's plan.</i></p>	800-393-9855	Mon-Fri – 8 a.m. to 5 p.m. PST
<p>Claims Management Group</p> <ul style="list-style-type: none"> ✓ Information about transplant claims 	800-527-5772	Mon-Fri – 8 a.m. to 5 p.m. PST
<p>Electronic Data Interchange Support Team</p> <ul style="list-style-type: none"> ✓ Information about submitting claims electronically 	888-690-9888	Mon-Fri – 8 a.m. to 5 p.m. PST
<p>PBM Technical and Prior Authorization Center</p> <ul style="list-style-type: none"> ✓ Prior Authorization for providers calling for prescriptions 	<p>888-202-2126</p> <p>Fax: 888-346-0178</p>	24 hours per day, seven days per week, 365 days per year

Department	Phone Number	Hours
<p>OHP Application Center</p> <ul style="list-style-type: none"> ✓ Clients may call to receive an OHP Application ✓ Provides general assistance in completing the OHP Application ✓ Clients may call to receive a Senior Prescription Drug Assistance Program Application 	<p>800-359-9517 or TTY 800-621-5260</p>	<p>Mon–Fri, 8 a.m. to 5 p.m. PST</p>
<p>Provider Services</p> <ul style="list-style-type: none"> ✓ Answers billing questions ✓ Processes provider appeals ✓ Discusses claim status ✓ Reviews out-of-state claims 	<p>800-336-6016</p>	<p>Mon–Fri, 8 a.m. to 5 p.m. PST</p>

7.6 DHS Fax Numbers

Document Type	Fax Number
<p><i>Immediate/Urgent Prior Authorizations</i></p> <ul style="list-style-type: none"> • PA • Supporting Docs <p>*A DHS approved cover sheet is required for <u>each</u> PA submitted.</p>	503-378-3435
<p><i>Routine Prior Authorizations</i></p> <ul style="list-style-type: none"> • PA • Supporting Docs <p>*A DHS approved cover sheet is required for <u>each</u> PA submitted.</p>	503-378-5814
<p>Contract RN Claims</p> <ul style="list-style-type: none"> • Claims <p>*Do not use a fax coversheet.</p>	503-373-1237
<p>Provider Enrollment</p> <ul style="list-style-type: none"> • Applications • Supporting Docs <p>*A DHS approved cover sheet is required.</p>	503-378-3074

Correspondence <ul style="list-style-type: none">• Solicited• Un-Solicited <p>*A DHS approved cover sheet is required.</p>	503-378-3086
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