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To: Providers of OMAP
Hospice Services

From: Joan M. Kapowich, Manager
OMAP Program and Policy

Subject: Hospice Services Program, Rulebook Revision 2

Effective: October 1, 2004

OMAP updated the Hospice Services Program Rulebook with the following administrative rule revisions:

OMAP revised 410-142-0300 to update OMAP's website address and to clarify billing information. OMAP temporarily revised this rule, to include the updated hospice payment rates in compliance with federal regulation pursuant to communications received from the Centers for Medicare and Medicaid Services.

- If you are reading this letter on OMAP's website: (www.dhs.state.or.us/policy/healthplan/rules/), this Rulebook contains a complete set of administrative rules for this program, including revision(s).

- If you do not have web access and receive hardcopy of revisions, this letter is attached to the revised rule to be used as replacement in your Hospice Rulebook. Each rule is individually numbered for easy replacement.

If you have billing questions, contact a Provider Services Representative toll-free at 1-800-336-6016 or direct at 503-378-3697. TR570 10/1/04

DEPARTMENT OF HUMAN SERVICES
MEDICAL ASSISTANCE PROGRAMS

DIVISION 142

Hospice Services

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410-142-0000 Purpose

The OMAP administrative rules for Hospice Programs are to be used in conjunction with the Oregon Health Plan Administrative Rules and the General Rules for Oregon Medical Assistance Programs. Hospice benefits are available only to OMAP clients eligible for the Oregon Health Plan benefit package ("Basic Health Care Benefit Package").

Stat. Auth.: ORS 409
Stats. Implemented: ORS 409.010
2-1-94

410-142-0020 Definitions

(1) "Accredited": The Hospice Program has received accreditation by the Oregon Hospice Association (OHA).

(2) "Ancillary Staff": Staff who provide additional services to support or supplement hospice care.

(3) "Assessment": Procedures by which strengths, weaknesses, problems, and needs are identified and addressed.

(4) "Attending Physician": A physician who is a doctor of medicine or osteopathy and is identified by the individual, at the time he or she elects to receive hospice care, as having the most significant role in the determination and delivery of the individual's medical care.

(5) "Bereavement Services": Supportive services provided to the individual's family after the individual's death.

(6) "Coordinated": When used in conjunction with the phrase "hospice program", means the integration of the interdisciplinary services provided by patient-family care staff, other providers and volunteers directed toward meeting the hospice needs of the patient.

(7) "Coordinator": A registered nurse designated to coordinate and implement the care plan for each hospice patient.

(8) "Counseling": A relationship in which a person endeavors to help another understand and cope with problems as a part of the hospice plan of care.

(9) "Curative": Medical intervention used to ameliorate the disease.

(10) "Dying": The progressive failure of the body systems to retain normal functioning, thereby limiting the remaining life span.

(11) "Family": The relatives and/or other significantly important persons who provide psychological, emotional, and spiritual support

of the patient. The "family" need not be blood relatives to be an integral part of the hospice care plan.

(12) "Hospice": A public agency or private organization or subdivision of either that is primarily engaged in providing care to terminally ill individuals, is certified for Medicare and/or accredited by the Oregon Hospice Association, and is listed in the Hospice Program Registry.

(13) "Hospice Continuity of Care": Services that are organized, coordinated and provided in a way that is responsive at all times to patient/family needs, and which are structured to assure that the hospice is accountable for its care and services in all settings according to the hospice plan of care.

(14) "Hospice Home Care": Formally organized services designed to provide and coordinate hospice interdisciplinary team services to individual/family in the place of residence. The hospice will deliver at least 80 percent of the care in the place of residence.

(15) "Hospice Philosophy": Hospice recognizes dying as part of the normal process of living and focuses on maintaining the quality of life. Hospice affirms life and neither hastens nor postpones death. Hospice exists in the hope and belief that through appropriate care and the promotion of a caring community sensitive to their needs, patients and their families may be free to attain a degree of mental and spiritual preparation for death that is satisfactory to them.

(16) "Hospice Program": A coordinated program of home and inpatient care, available 24 hours a day, that utilizes an interdisciplinary team of personnel trained to provide palliative and supportive services to a patient-family unit experiencing a life threatening disease with a limited prognosis. ORS 443.850.

(17) "Hospice Program Registry": A registry of all certified and accredited hospice programs maintained by the Oregon Hospice Association.

(18) "Hospice Services": Items and services provided to a patient/family unit by a hospice program or by other individuals or

community agencies under a consulting or contractual arrangement with a hospice program. Hospice services include acute, respite, home care, and bereavement services provided to meet the physical, psychosocial, spiritual and other special needs of the patient/family unit during the final stages of illness, dying and the bereavement period. ORS 443.850.

(19) "Illness": The condition of being sick, diseased or with injury.

(20) "Medical Director": The medical director must be a hospice employee who is a doctor of medicine or osteopathy who assumes overall responsibility for the medical component of the hospice's patient care program.

(21) "Medicare Certification": Certification by the Oregon Health Division as a program of services eligible for reimbursement.

(22) "Pain and Symptom Management": For the hospice program, the focus of intervention is to maximize the quality of the remaining life through the provision of palliative services that control pain and symptoms. Hospice programs recognize that when a patient/family are faced with terminal illness, stress and concerns may arise in many aspects of their lives. Symptom management includes assessing and responding to the physical, emotional, social and spiritual needs of the patient/family.

(23) "Palliative Services": Comfort services of intervention that focus primarily on reduction or abatement of the physical, psychosocial and spiritual symptoms of terminal illness. Palliative Therapy:

(a) Active: Is treatment to prolong survival, arrest the growth or progression of disease. The person is willing to accept moderate side-effects and psychologically is fighting the disease. This person is not likely to be a client for hospice;

(b) Symptomatic: Is treatment for comfort, symptom control of the disease and improves the quality of life. The person is willing to accept minor side-effects and psychologically wants to live with the

disease in comfort. This person would have requested and been admitted to a hospice.

(24) "Period of Crisis": A period in which the individual requires continuous care to achieve palliation or management of acute medical symptoms.

(25) "Primary Caregiver": The person designated by the patient or representative. This person may be family, an individual who has personal significance to the patient but no blood or legal relationship (e.g., significant other), such as a neighbor, friend or other person. The primary caregiver assumes responsibility for care of the patient as needed. If the patient has no designated primary caregiver the hospice may, according to individual program policy, make an effort to designate a primary caregiver.

(26) "Prognosis": The amount of time set for the prediction of a probable outcome of a disease.

(27) "Representative": An individual who has been authorized under state law to terminate medical care or to elect or revoke the election of hospice care on behalf of a terminally ill individual who is mentally or physically incapacitated.

(28) "Terminal Illness": In hospice, a terminal illness is an illness or injury which is forecast to result in the death of the patient, for which treatment directed toward cure is no longer believed appropriate or effective.

(29) "Terminally Ill" means that the individual has a medical prognosis that his or her life expectancy is six months or less if the illness runs its normal course.

(30) "Volunteer": An individual who agrees to provide services to a hospice program without monetary compensation.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 409.010
10-1-00

410-142-0040 Eligibility for the Hospice Benefit

(1) OMAP clients with the Basic Health Care Benefit Package who have been certified as terminally ill in accordance with OAR 410-142-0060 are eligible for hospice benefits.

(2) Clients eligible for Part A of Medicare will be served by a Medicare certified hospice, if available in the area, according to Medicare regulations; Medicare will be billed for reimbursement. Medicare payment is to be considered as payment in full.

(3) Clients not eligible for Part A of Medicare, or with no Medicare certified hospice available, may be served by a hospice meeting the definition of Hospice as shown in OAR 410-142-0020.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065

410-142-0060 Certification of Terminal Illness

(1) The hospice must obtain written certification of terminal illness for each of the periods listed in OAR 410-142-0120, even if a single election continues in effect for two, three, or more periods.

(2) The hospice must obtain written certification that an individual is terminally ill at the beginning of the first period, within two days after hospice care begins. For all other periods the written certification must be on file before a claim is submitted.

(3) The certification must specify that the individual's prognosis is for a life expectancy of 6 months or less if the terminal illness runs its normal course, based on the physician's or medical director's clinical judgment regarding the normal course of the individual's illness.

(4) Signatures of the attending physician and medical director of the hospice or physician member of the hospice's interdisciplinary group are required to certify the terminal illness.

(5) Recertification for subsequent periods is by signature of one of the following:

(a) The medical director of the hospice; or

(b) Physician member of the hospice's interdisciplinary group.

(6) Hospice staff must make an appropriate entry in the patient's medical record as soon as they receive an oral certification; and file written certifications in the medical record.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
10-1-02

410-142-0080 Informed Consent

A hospice must demonstrate respect for an individual's rights by ensuring that an informed consent form has been obtained for every individual, either from the individual or representative as defined in OAR 410-142-0020. The form must specify the type of care and services that may be provided as hospice care during the course of the illness.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
2-1-03

410-142-0100 Election of Hospice Care

(1) An individual who meets the eligibility requirements of OAR 410-142-0040 may file an election statement with a particular hospice. If the individual is physically or mentally incapacitated, his or her representative may file the election statement.

(2) The election statement must include the following:

(a) Identification of the particular hospice that will provide care to the individual;

(b) The individual's or representative's acknowledgment that he or she has been given a full understanding of the palliative rather than curative nature of hospice care, as related to the individual's terminal illness;

(c) Acknowledgment that certain otherwise covered services are waived by the election. Election of a hospice benefit means that OMAP will only reimburse the hospice for those services included in the hospice benefit;

(d) The effective date of the election, which may be the first day of hospice care or a later date, but may be no earlier than the date of the election statement;

(e) The signature of the individual or representative.

(3) Re-election of hospice benefits. If an election has been revoked in accordance with OAR 410-142-0160, the individual (or his or her representative if the individual is mentally or physically incapacitated) may at any time file an election, in accordance with this section, for any other election period that is still available to the individual.

(4) File the election statement in the medical record.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
2-1-03

410-142-0120 Duration of Hospice Care

(1) An eligible individual may elect to receive hospice care during one or more of the following election periods:

(a) An initial 90-day period;

(b) A subsequent 90-day period;

(c) An unlimited number of subsequent 60-day periods.

(2) An election to receive hospice care will be considered to continue through the initial election period and through the subsequent election periods without a break in care as long as the individual:

(a) Remains in the care of a hospice; and

(b) Does not revoke the election under the provisions of OAR 410-142-0160.

(3) For the duration of an election of hospice care, an individual waives all rights to OMAP payments for the following services:

(a) Hospice care provided by a hospice other than the hospice designated by the individual, unless provided under arrangements made by the designated hospice;

(b) Any covered services related to the treatment of the terminal condition for which hospice care was elected or a related condition, or services equivalent to hospice care.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
1-1-98

410-142-0140 Changing the Designated Hospice

(1) An individual or representative may change, once in each election period, the designation of the particular hospice from which hospice care will be received.

(2) The change of the designated hospice is not a revocation of the election for the period in which it is made.

(3) To change the designation of hospice programs, the individual or representative must file, with the hospice from which care has been received and with the newly designated hospice, a statement that includes the following:

(a) The name of the hospice from which the individual has received care and the name of the hospice from which he or she plans to receive care;

(b) The date the change is to be effective.

(4) The statement shall be kept on file in the medical record.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
8-1-95

410-142-0160 Revoking the Election of Hospice Care

(1) An individual or representative may revoke the individual's election of hospice care at any time during an election period.

(2) Revocation Procedure: To revoke the election of hospice care, the individual or representative must file with the Hospice a statement to be placed in the medical record that includes the following information:

(a) A signed statement that the individual or representative revokes the individual's election for coverage of hospice care for the remainder of that election period;

(b) The date that the revocation is to be effective. (An individual or representative may not designate an effective date earlier than the date that the revocation is made.)

(3) An individual, upon revocation of the election of coverage of hospice care for a particular election period:

(a) Is no longer covered for hospice care;

(b) Resumes eligibility for all covered services as before the election to hospice; and

(c) May at any time elect to receive hospice coverage for any other hospice election periods he or she is eligible to receive, in accordance with OAR 410-142-0120.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
10-1-00

10-142-0180 Plan of Care

A written plan of care must be established and maintained for each individual admitted to a hospice program, and the care provided to an individual must be in accordance with the plan:

(1) Establishment of Plan. The plan is established by the attending physician, the medical director or physician designee and interdisciplinary group prior to providing care.

(2) Content of Plan. The plan must include an assessment of the individual's needs and identification of the services including the management of discomfort and symptom relief. It must state in detail the scope and frequency of services needed to meet the patient's and family's needs.

(3) Review of Plan. The plan must be reviewed and updated, at intervals specified in the plan, by the attending physician, the medical director or physician designee and interdisciplinary group. These reviews must be documented.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
2-1-94

410-142-0200 Interdisciplinary Group

The hospice must designate an interdisciplinary group or groups composed of individuals who provide or supervise the care and services offered by the hospice:

(1) Composition of Group. The hospice must have an interdisciplinary group or groups composed of or including at least the following individuals who are employees of the hospice, or, in the case of a doctor, be under contract with the hospice:

(a) A doctor of medicine or osteopathy;

(b) A registered nurse;

(c) A social worker;

(d) A pastoral or other counselor.

(2) Role of Interdisciplinary Group. Members of the group interact on a regular basis and have a working knowledge of the assessment and care of the patient/family unit by each member of the group. The interdisciplinary group is responsible for:

(a) Participation in the establishment of the plan of care;

(b) Provision or supervision of hospice care and services;

(c) Periodic review and updating of the plan of care for each individual receiving hospice care; and

(d) Establishment of policies governing the day-to-day provision of hospice care and services.

(3) If a hospice has more than one interdisciplinary group, it must document in advance the group it chooses to execute the functions described in Paragraph (1) of this section;

(4) Coordinator. The hospice must designate a registered nurse to coordinate the implementation of the plan of care for each patient.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
2-1-03

410-142-0220 Requirements for Coverage

To be covered, hospice services must meet the following requirements:

(1) They must be reasonable and necessary for the palliation or management of the terminal illness as well as related conditions.

(2) The individual must elect hospice care in accordance with OAR 410-142-0100 and a plan of care must be established as set forth in OAR 410-142-0180 before services are provided.

(3) The services must be consistent with the plan of care.

(4) A certification that the individual is terminally ill must be completed as set forth in OAR 410-142-0060.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
2-1-94

410-142-0240 Hospice Core Services

The following services are covered hospice services when consistent with the plan of care and must be provided in accordance with recognized standards of practice:

(1) Nursing Services. The hospice must provide nursing care and services by or under the supervision of a registered nurse:

(a) Nursing services must be directed and staffed to assure that the nursing needs of the patient are met;

(b) Patient care responsibilities of nursing personnel must be specified;

(c) Services must be provided in accordance with recognized standards of practice.

(2) Medical Social Services. Medical social services must be provided by a qualified social worker, under the direction of a physician;

(3) Physician Services. In addition to palliative and management of terminal illness and related conditions, physician employees of the hospice, including the physician member(s), of the interdisciplinary group, must also meet the general medical needs of the patient to the extent these needs are not met by the attending physician:

(a) Reimbursement for physician supervisory and interdisciplinary group services for those physicians employed by the hospice agency is included in the rate paid to the agency;

(b) Reimbursement of attending physician services for those physicians not employed by the hospice agency is according to the OMAP fee schedule. These physicians must bill OMAP for their services;

(c) Reimbursement of attending physician services (not including supervisory and interdisciplinary group services) for those physicians

employed by the hospice agency is according to the OMAP fee schedule. These physicians must bill OMAP for their services;

(d) Reimbursement of the hospice for consulting physician services furnished by hospice employees or by other physicians under arrangements by the hospice is included in the rate paid to the agency.

(4) Counseling Services. Counseling services must be available to both the patient and the family. Counseling includes bereavement counseling provided after the patient's death as well as dietary, spiritual and any other counseling services for the patient and family provided while the individual is enrolled in the hospice;

(5) Short-Term Inpatient Care. Inpatient care must be available for pain control, symptom management and respite purposes;

(6) Medical Appliances and Supplies:

(a) Includes drugs and biologicals as needed for the palliation and management of the terminal illness and related conditions;

(b) Drugs prescribed for conditions other than for the palliation and management of the terminal illness are not covered under the hospice program.

(7) Home Health Aide and Homemaker Services;

(8) Physical Therapy, Occupational Therapy, and Speech-Language Pathology Services;

(9) Other services. Other services specified in the plan of care that are covered by OHP.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
2-1-03

410-142-0260 Hospice Level of Care

(1) Each day of hospice care is classified into one of five levels of care. The level of care determines the payment for each day of hospice benefit:

(a) Routine Home Care. A routine home care day is a day on which a patient who has elected to receive hospice care is in a place of residence and is not receiving continuous home care;

(b) Continuous Home Care. A continuous home care day is a day on which a patient who has elected to receive hospice care is not in an inpatient facility and receives hospice care consisting predominantly of nursing care on a continuous basis at home. Home health aid or homemaker services or both may also be provided on a continuous basis. Continuous home care is only furnished during brief periods of crisis as necessary to maintain the terminally ill individual at home. Nursing care must be provided by a registered nurse or a licensed practical nurse and a nurse must be providing care for more than half of the period of care. A minimum of eight hours of care must be provided during a 24-hour day, which begins and ends at midnight. When fewer than 8 hours of nursing care are required, the services are covered as routine home care rather than continuous home care;

(c) In-Home Respite Care. An in-home respite care day is a day on which short-term in-home care is provided to the patient only when necessary to relieve the family members or other persons caring for the patient at home. Respite care may be provided only on an occasional basis and may not be reimbursed for more than five consecutive days at a time. In-home respite care will be provided at the level necessary to meet the patient's need, with a minimum of eight hours of care provided in a 24-hour day, which begins and ends at midnight. Home health aide/CNA or homemaker services or both may be utilized for providing in-home respite care;

(d) Inpatient Respite Care. An inpatient respite care day is a day on which short-term inpatient care is provided to the patient only when necessary to relieve the family members or other persons caring for the patient at home. Respite care may be provided only on an

occasional basis and may not be reimbursed for more than five consecutive days at a time. Payment for the sixth, and any subsequent days, is to be made at the routine home care rate. Respite care may not be provided when the hospice patient is a nursing home resident;

(e) General Inpatient Care. A general inpatient care day is a day on which a hospice patient receives care in an inpatient facility for pain control, acute or chronic symptom management, or other procedures which cannot be managed or provided in any other setting.

(2) Inpatient care must be provided by a facility that has an agreement with the hospice:

(a) A hospice capable of providing inpatient care;

(b) A hospital; or

(c) A nursing facility.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
10-1-02

410-142-0280 Recipient Benefits

An individual who has elected to receive hospice care remains entitled to receive other services not included in the hospice benefit. These services are subject to the same rules as for non-hospice clients. Typical services used that are not covered by the hospice benefit include:

(1) Attending physician care (e.g. office visits, hospital visits, etc.);

(2) Medical transportation;

(3) Optometric services;

(4) Any services, drugs or supplies for a condition other than the recipient's terminal illness or a related condition (e.g. broken leg, pre-existing diabetes).

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
1-1-98

410-142-0300 Billing and Rate Information

(1) Hospice care is defined as a group of services and is therefore paid on a per diem basis dependent upon the level of care being provided. If the client is enrolled in a prepaid health plan, the hospice must contact the plan and bill according to their instructions.

(2) When the client has the "OHP Standard or OHP Plus" benefit package but is not enrolled in a prepaid health plan, bill with the appropriate Revenue Codes using the instructions on how to complete the UB-92.

(3) If the client is enrolled in Medicare Part A, do not bill OMAP unless no Medicare certified Hospice is available.

(4) If the client is enrolled in Medicare Part B, enter NC or MC in Form Locator 84.

(5) If the client is enrolled in Medicare Part A and you are not a Medicare-certified hospice, and there is no Medicare-certified hospice available in the area, enter NC or MC in Form Locator 84.

(6) Submit your claim to OMAP on a hard copy UB-92 or electronically:

(a) Send paper UB-92 claims to: Office of Medical Assistance Programs (OMAP);

(b) For information about electronic billing (EMC), contact OMAP. Electronic billing (EMC) information is also available at OMAP's website, www.dhs.state.or.us.

(7) When billing for hospice services, the provider must bill the usual charge or the rate based upon the geographic location in which the care is furnished, whichever is lower. See Table 142-0300: (Hospice Rate Chart -- Revised 10/01/ 04. Rates were calculated per CMS State Agency Letter, dated August 11, 2004.) Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

10-1-04

Table 142-0300

Hospice Rates – Effective 10/01/2004 Follow CMS guidelines						
Area (per Federal Register)	MSA Code (Federal Register)	Routine Home Care (Rev 651, T2042); per diem	Continuous Home Care (Rev 652, T2043); per hour	Inpatient Respite Care (Rev 655, T2044); per diem	General Inpatient Care (Rev 656, T2045); per diem	In-Home Respite Care (Rev 659); per diem
Corvallis	1890	$141.22	$34.31	$149.17	$621.59	$147.40
Eugene / Springfield	2400	$140.69	$34.18	$148.71	$619.37	$146.86
Medford / Ashland	4890	$134.57	$32.69	$143.47	$594.05	$140.46
Portland Metro						
Clackamas	6440	$138.51	$33.65	$146.85	$610.37	$144.59
Columbia	6440	$138.51	$33.65	$146.85	$610.37	$144.59
Multnomah	6440	$138.51	$33.65	$146.85	$610.37	$144.59
Washington	6440	$138.51	$33.65	$146.85	$610.37	$144.59
Yamhill	6440	$138.51	$33.65	$146.85	$610.37	$144.59
Salem Metro						
Marion	7080	$131.98	$32.06	$141.25	$583.32	$137.76
Polk	7080	$131.98	$32.06	$141.25	$583.32	$137.76
All Other Areas	9938	$127.61	$31.00	$137.51	$565.25	$133.20

3

410-142-0320 Instructions for Completing the UB-92

Required items:

(1) Provider Identification: Enter provider name, mailing address and zip code if billing paper claim;

(2) Type of Bill: Enter the appropriate three-digit numeric code to identify the type of claim:

(a) Enter an "8" as the first digit;

(b) Enter a "1" as the second digit if the Hospice is non-hospital based, and a "2" if it is a hospital-based Hospice;

(c) The third digit identifies Frequency/ Definition:

(A) 1 -- Admission through discharge claim: Encompasses an entire course of hospice treatment and no further bills will be submitted for this client (i.e. client revokes or expires within the first billing period);

(B) 2 -- First Claim: Use this code for the first of an expected series of payment bills for course of treatment;

(C) 3 -- Interim-Continuing Claim: Use when a bill has been submitted and further bills are expected to be submitted;

(D) 4 -- Last Billing: Use for a bill which is the last of series for a hospice course of treatment. The through date of this bill (Form Locator 6) is the discharge date or the date of death.

(3) Statement Covers Period: Enter the beginning and ending dates of service covered by this claim as MMDDYY;

(4) Patient's Name: Enter the client's last name, first name and middle initial as it appears on the Medical Care Identification;

(5) Condition Codes: Enter A1 if EPSDT (Medicheck);

(6) Revenue Codes: Enter the Revenue Code which most accurately describes the service provided:

(a) 651 -- Routine Home Care;

(b) 652 -- Continuous Home Care (billed in hours, not days);

(c) 655 -- Inpatient Respite Care;

(d) 656 -- General Inpatient Care;

(e) 659 -- Other Hospice -- use for in-home respite care.

(7) Service Units: Enter total units of service (days or hours) for each type of service.

(8) Total Charges: Enter the total charges pertaining to the related code. At the bottom of Form Locator 42, enter Revenue Code 001. At the bottom of Form Locator 47, enter the total charge;

(9) Payer Identification (optional): Enter the names of up to three payer organizations in order:

(a) Primary payer;

(b) Secondary payer;

(c) Tertiary payer: If Medicaid is primary enter "Medicaid" on line A. If Medicaid is secondary or tertiary payer, enter the primary payer on line A and Medicaid on line B or C as appropriate.

(10) Provider Number: Enter your six-digit OMAP provider number on the line (A, B or C) which corresponds to the line you used to identify OMAP in Form Locator 50. Your OMAP provider number is required. OMAP does not require that you report your provider number for other payers listed in Form Locator 50;

(11) Prior Payments: Enter the amount of payments received from a third party resource on the same letter line listed in Form Locator 50;

(12) Cert-SSN-HIC-ID No.: Enter the patient's Medicaid Identification number on the same letter line (A, B or C) that corresponds to the line on which Medicaid payer information is shown in Form Locator 50;

(13) Principal Diagnosis Code: Enter the ICD-9-CM code describing the principal diagnosis (i.e., the condition for which the plan of treatment was established and the patient taken into service). The ICD-9-CM must be carried out to its highest degree of specificity -- see General Rules for specific details. Do not enter decimal points or unnecessary characters.

(14) Attending Physician I.D.: Enter the attending physician's six-digit OMAP provider number or UPIN.

(15) Remarks: Use this space for Third Party Resource (TPR) explanation codes.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
2-1-03

410-142-0380 Death With Dignity

(1) All death with dignity services must be billed directly to OMAP, even if the client is in a Fully Capitated Health Plan (FCHP).

(2) Death with dignity services are defined in the Medical-Surgical Services and Pharmaceutical Services Guide rules and must not be included in the hospice care per diem payment.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
10-1-00