Hospital Services Provider Guide

Use this guide as a supplement to the Hospital Services Oregon Administrative Rules (Chapter 410 Division 125). See current rules for official policies regarding billing.

Contents (last updated Dec. 22, 2025)

Client eligibility and enrollment

Refer to General Rules and OHP Rules for information about the service coverage according to OHP benefit plans and the Prioritized List of Health Services.

- The OHP eligibility verification page explains how to verify eligibility using the Provider Portal, Automated Voice Response or electronic data interchange (EDI) 270/271 transaction.

Prior authorization

Most non-emergent inpatient and outpatient services require prior authorization (PA), including:

- Durable medical equipment, prosthetics, orthotics and supplies (DMEPOS – Division 122)
- Home health services (Division 127)
- Home Enteral/Parenteral and IV services (Division 148)

- Hospital dentistry and certain dental services (Division 123)
- Physical and occupational therapy (Division 131)
- Private duty nursing (Division 132)
- Speech and hearing services (Division 129)
- Certain pharmaceutical, medical-surgical, vision, and hospital services

Refer to the program-specific administrative rules and supplemental information for specific details and required forms. Submit prior authorization (PA) requests to OHA using the Provider Portal or MSC 3971.

- For coordinated care organization (CCO) members, contact the CCO for PA instructions.
- For complete instructions on how to submit PA requests to OHA, see the Prior Authorization Handbook.

Products on the High-Cost Drug Carve-Out list

These drugs require prior authorization for all OHP members. Current and past High-Cost Drug Carve-Out (HCDCO) lists are at https://www.orpdl.org/.

The Oregon Medicaid Pharmacy program maintains the HCDCO list and provides quarterly updates for inclusion or exclusion of drugs.

- **For HCDCO prior authorization requirements,** see Oregon Medicaid PA criteria available on the Pharmaceutical Services Program page. You may also use the Searchable PDL to search for drugs by brand or generic name.
- **To request prior authorization,** please use the OHP 3978 form.

Billing for hospital services

Use the institutional claim format.

- **Billing instructions** are available on the OHP provider billing tips page.
- **For information about electronic billing,** go to the Electronic Business Practices page.

When to bill on paper

Bill on paper for claims that require attachments. Submit a cover letter and attachments for the following:

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

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

Medicare-Medicaid claims

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

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

When you submit claims to Medicare that you want to cross over to OHA:

- **For electronic claims:** Enter the client's Medicaid information on the third party payer screen.
- **For paper claims:** Enter Medicare as the primary payer, and "OHA" on line C of Field Locator (FL) 50. Enter "XOVR" in FL 7 when:
  - *For Inpatient Services:* The patient has Medicare Part A.
  - *For Outpatient Services:* The patient has Medicare Part B and the service is covered by Medicare.

Type of Bill

OHA accepts the following codes:

Inpatient Codes	Outpatient Codes
• 111 - For most inpatient services, including patients with Medicare Part A coverage only • 121 - For patients with Medicare Part B coverage only	• 131 - For most outpatient services • 141 - Referenced Diagnostic Services • 721 - Independent End Stage Renal Dialysis Facilities • 831 - Hospital-Based Ambulatory Surgery

Value Codes

Family Planning Percentage

When family planning services are part of the claim, enter Value Code "XO," followed by an estimate of the total charges related to family planning:

- Report the percentage in the cents area of the amount field.
- Round to the nearest whole percent (*e.g.,* 100% as 1.00, 45% as 0.45).

Medicare Coinsurance and Deductible

When Medicare is the primary payer, enter the appropriate Value Code(s), followed by the dollars and cents money amount being reported.

- A1 (Deductible Payer A) - For the Part A or Part B deductible amount.
- A2 (Coinsurance Payer A) - For Part A or Part B coinsurance amounts.
- B1 (Deductible Payer B) – For the Part A or Part B deductible amount.
- B2 (Coinsurance Payer B) – For the Part A or Part B coinsurance amounts.

Note: When Medicare coverage is present, it will normally be reported as "Payer A." However, in situations where Medicare is "Payer B", use Value Codes "B1" and "B2" to report Medicare coinsurance and deductible.

Failure to correctly report the Part A deductible may result in incorrect payment.

HCPCS/Rates

Enter the five-digit code. Do not enter a daily rate in this field; this will cause the claim to deny for an invalid procedure code.

- See the Revenue Codes List for codes requiring HCPCS.
- Attach explanation of unlisted HCPCS codes, so that OHA can price the claim.
- For physician-administered drugs: Enter HCPCS code; also enter modifier UD for drugs purchased for Medicaid clients through a 340B entity.

Units of Service

Enter total units of service or accommodation days.

For inpatient services:

A Leave of Absence day counts as an accommodation day.

- OHA does not count the day of discharge (through date) as a day.
- Always bill charges incurred on the day of discharge.

Example: Patient admitted on October 1and discharged on October 5, units of service would be four.

For outpatient services:

If you provide outpatient services over a period of time, you may bill for more than one service on a single claim form.

- List the units of service for each Revenue Code.
- For services which require prior authorization, the units of service should not exceed the number of services authorized for that time period.
- From and through dates must reflect the range of dates on which services were provided.

Diagnosis Codes

Enter up to four diagnosis codes for conditions that coexist at the time of admission or develop subsequently, that affect patient care. Enter the appropriate Present on Admission (POA) indicator in the shaded area for each code.

- Conditions that affect patient care are those that require clinical evaluation, therapeutic treatment, diagnostic procedures, increased length of stay, increased nursing care and/or monitoring. This may affect the DRG assignment on inpatient stays.
- Do not enter diagnoses that relate to an earlier episode which have no bearing on the current hospital stay.

You must enter POA indicators and codes to indicate hospital acquired conditions (HAC) and other provider preventable conditions (OPPC).

- For HAC codes, see the CMS website and our ICD-10 code list.
- For OPPC codes, see our searchable list of these codes.
- Some codes do not require a POA indicator. See our searchable list of these codes.

Remarks field

- Itemization of services provided under Revenue Code 512
- Description of “unlisted” lab or radiology HCPCS codes for manual pricing

Coding guidelines for specific services

Maternity Case Management

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

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

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

- **Technical component:** Use Revenue Codes 300-359, 400-409, 610-619, 923 and 925.
- **Professional component:** Use Revenue Codes 970 to 974. Bill the professional component for CT scans and MRIs under Revenue Code 972.

Do not fragment or unbundle lab services. Refer to the Medical-Surgical rules (OAR 410 Division 130) for additional information.

You can bill OHA for the collection of blood through venipuncture or capillary puncture, or the collection of a urine sample by catheterization. However, OHA will not reimburse these services more than one time per day.

Therapeutic services, durable medical equipment & supplies

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

For services requiring prior authorization, use code Z51.89 in FL 67.

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

30-day readmission claims processing – See 410-125-0410

OHA applies 30-day readmission criteria for inpatient claims that:

- List the same hospital/facility provider ID and recipient ID as an inpatient claim submitted within the past 30 days, and
- Do not contain any diagnosis codes exempt from 30-day readmission policy. Lists of exempt codes are available in a searchable list.

MMIS will compare all diagnosis codes listed on the claim to the list of codes exempt from the 30-day readmission policy. If the claim does not contain codes on the exemption list, OHA will combine the first and second claims when:

- Both claims use the same primary diagnosis code; or
- Related diagnosis: The first three digits of any diagnosis code on the first claim matches the first three digits of the primary diagnosis code on the second claim.

Present on Admission (POA) Indicators

Indicator	Description
Y	Diagnosis was present at time of inpatient admission.
N	Diagnosis was not present at time of inpatient admission.
U	Documentation insufficient to determine if condition was present at the time of inpatient admission.
W	Clinically undetermined. Provider unable to clinically determine whether the condition was present at the time of inpatient admission.

Billing for products on the High-Cost Drug Carve-Out list

Drugs on the HCDCO are carved out of CCO benefits and reimbursed directly by OHA on a fee-for-service (FFS) basis. For CCO members:

- Bill OHA for the drug only; all other services associated with the drug will be billed to the CCO.
- For more CCO billing requirements, see OAR 410-141-3855.

Inpatient hospital billing:

Inpatient hospital services related to the HCDCO are reimbursed using the hospital's current inpatient payment methodology.

- Bill HCDCO drugs to OHA on a separate outpatient claim with the appropriate HCPCS and NDC.
- Attach an invoice to show the actual acquisition cost.

Recommended coding requirements for drugs on the HCDCO list

For drugs with a specific procedure code, utilize normal billing guidance.

Drugs with a non-specific procedure codes must include:

- Revenue code 636 (Drugs requiring detail coding).

- Modifier KZ (New coverage not implemented by managed care).
- Primary diagnosis code that is consistent with the FDA-approved indication.

Cell and gene therapy (CGT) products on the HCDCO list

According to terms set by the Centers for Medicaid and Medicare Services (CMS) for Oregon's participation in the CGT Access Model:

- Claims for CGT for sickle cell disease must be submitted to OHA within 3 months of the actual administration date.
- Only OHA-approved qualified treatment centers may bill for CGT to treat sickle cell disease.

To receive reimbursement, qualified treatment centers must:

- Be a member of the CMS-designated patient registry for the Access Model.
- Participate in the Center for International Blood & Marrow Transplant Research (CIBMTR) CMS-specified study.
- Acquire the CGT products outside of the 340B program.

OHA will provide qualified treatment centers a list of primary and secondary contacts for each CCO to facilitate care coordination.

Hospital reimbursement:

Outpatient reimbursement for HCDCO will be acquisition cost according to invoice up to wholesale acquisition cost (WAC).

Claim status and adjustments

For information about the paper remittance advice and other ways to get claim status information via the Provider Web Portal, AVR or EDI 835 (Electronic Remittance Advice), go to the OHP remittance advice page.

- For information about how to adjust a claim, refer to the Claim Adjustment Handbook.

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

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

The completed form provides necessary information that OHA uses to determine final fee for service (FFS) and coordinated care organization (CCO) Medicaid cost settlements for the period. Since the form calculates an estimated amount for the cost settlement period, the hospital may want to budget accordingly for the expected revenue or expense that will be due upon final cost settlement.

OHA will send the 42 to complete when it is needed.

Hospital Presumptive Eligibility process

Hospitals enrolled with Oregon Medicaid may qualify to act as Hospital Presumptive Eligibility (HPE) determination sites. These sites will:

- Identify individuals who may be eligible for Medicaid/CHIP coverage and who could benefit from immediate temporary medical assistance;
- Make immediate temporary eligibility determinations for these individuals;
- Educate individuals about their responsibility to complete the full Medicaid/CHIP application (OHP 7210) within required timeframes;
- Provide the OHP 7210; and
- Assist the individual with completing the OHP 7210 or provide information on resources to help individuals complete the application within required timeframes.

To learn more about the HPE process, visit the HPE page.

To learn more about HPE eligibility criteria, see OAR 410-200-0105 in Medical Eligibility Program rules.

You can get this document in other languages, large print, braille or a format you prefer free of charge. Contact medicaid.programs@odhsoha.oregon.gov.

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