Professional Billing Instructions

Billing instructions for CMS-1500, OHP 505 and MMIS Provider Portal professional claim formats for Oregon Medicaid providers

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Introduction

The *Professional Claim Instructions* handbook is designed to help those who bill the Oregon Health Authority (OHA) for Medicaid services submit their claims correctly the first time. This will give you step-by-step instructions so that OHA can pay you, the provider, more quickly. Use this handbook with the General Rules and your provider guidelines (administrative rules and supplemental information), which contain information on policy and covered services specific to your provider type.

The professional claim is also known as the CMS-1500. Throughout this billing guide you will see the claim type being referred to as a professional claim.

This handbook lists the requirements for completion prior to sending your claim to OHA for payment processing, as well as helpful hints on how to avoid common billing errors.

The *Professional Claim Instructions* are designed to assist the following providers. This list does not include all provider types that use the professional claim format. If in doubt of which claim format to use, contact Provider Services at 800-336-6016 for assistance, or refer to your provider guidelines.

- Ambulatory Surgical Centers
- Certified Registered Nurse Anesthetists
- Chemical Dependency
- Chiropractors
- Doctors of Medicine
- Durable Medical Equipment
- Family Planning Clinics
- Federally Qualified Health Centers
- Home Enteral/Parenteral IV
- Independent Laboratories
- Medical Transportation
- Mental Health
- Naturopaths
- Nurse Practitioners
- Occupational Therapy
- Ophthalmologists

- Optometrists
- Physical Therapy
- Podiatrists
- Portable X-Ray Providers
- Psychologists
- Public Health Departments
- Rural Health Clinics
- School-Based Health Services

Claims processing

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

Paper claims

Paper claims submitted by mail are scanned through an Optical Character Recognition (OCR) machine.

- 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 is entered in the MMIS and images of the documents are stored on an Electronic Document Management System (EDMS).

Electronic claims

Data from web claims directly enter the MMIS if all information is entered correctly. Electronic data interchange (EDI, or electronic batch submission) claims are reviewed for compliance and translated from the HIPAA standard formats for MMIS processing.

Data processing

Once data enters MMIS, each claim is given an Internal Control Number (ICN). The ICN is a unique identifier.

- The first two digits indicate the type of format of the claim (e.g., “22” web claim, “10” paper claim, “20” electronic).
- The next two are the year; “24” (2024).
- The next three are the Julian date; “031” (January 31).
- The remaining digits are details of the claims regarding how they are ‘batched’ within the MMIS.

Staff can immediately access submitted claim information by checking certain MMIS screens.

The system performs daily edits for presence and validity of data as each claim is processed. 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.

If MMIS cannot make a payment decision based on the information submitted or if policy determines manual review is needed, the claim is routed to OHA staff for specific manual, medical or administrative review. This type of claim is a suspense (suspended) claim.

OHA does not return denied claims to providers in this process. Instead, OHA sends a listing of all claims paid and/or denied to the provider (with payment if appropriate). The listing is called a Remittance Advice (RA).

- The RA comes in paper and electronic formats. The paper format will list suspended claims while the electronic does not.
- If you aren’t already receiving the electronic RA, contact EDI Support at 888-690-9888 for more information.

Before you bill OHA:

1. Verify the client is eligible on the date of service for the services rendered. Services for clients enrolled in a coordinated care organization (CCO) must be billed to the appropriate CCO.
2. Medicaid is always the payer of last resort. If the client has Medicare or third-party insurance, bill them before billing Medicaid.

Professional web claim instructions

When not to submit a web claim

Do not submit a web claim when:

- **You need to submit hard-copy attachments (*e.g.,* consent forms or op reports).** If you submit a web claim for a procedure that requires attached documentation, the claim will suspend, then deny for missing documentation. Always bill on paper for claims that require attachments.
- **You need to bill for services more than a year after the date of service.** Claims past timely filing limits must be sent on paper.

Before you submit a web claim

To use the web portal for the first time, use the provider Personal Identification Number (PIN) from OHA. If you do not have your PIN, contact Provider Services at 800-336-6016 for assistance.

The following list will help you to better understand what needs to be done prior to submitting a web claim.

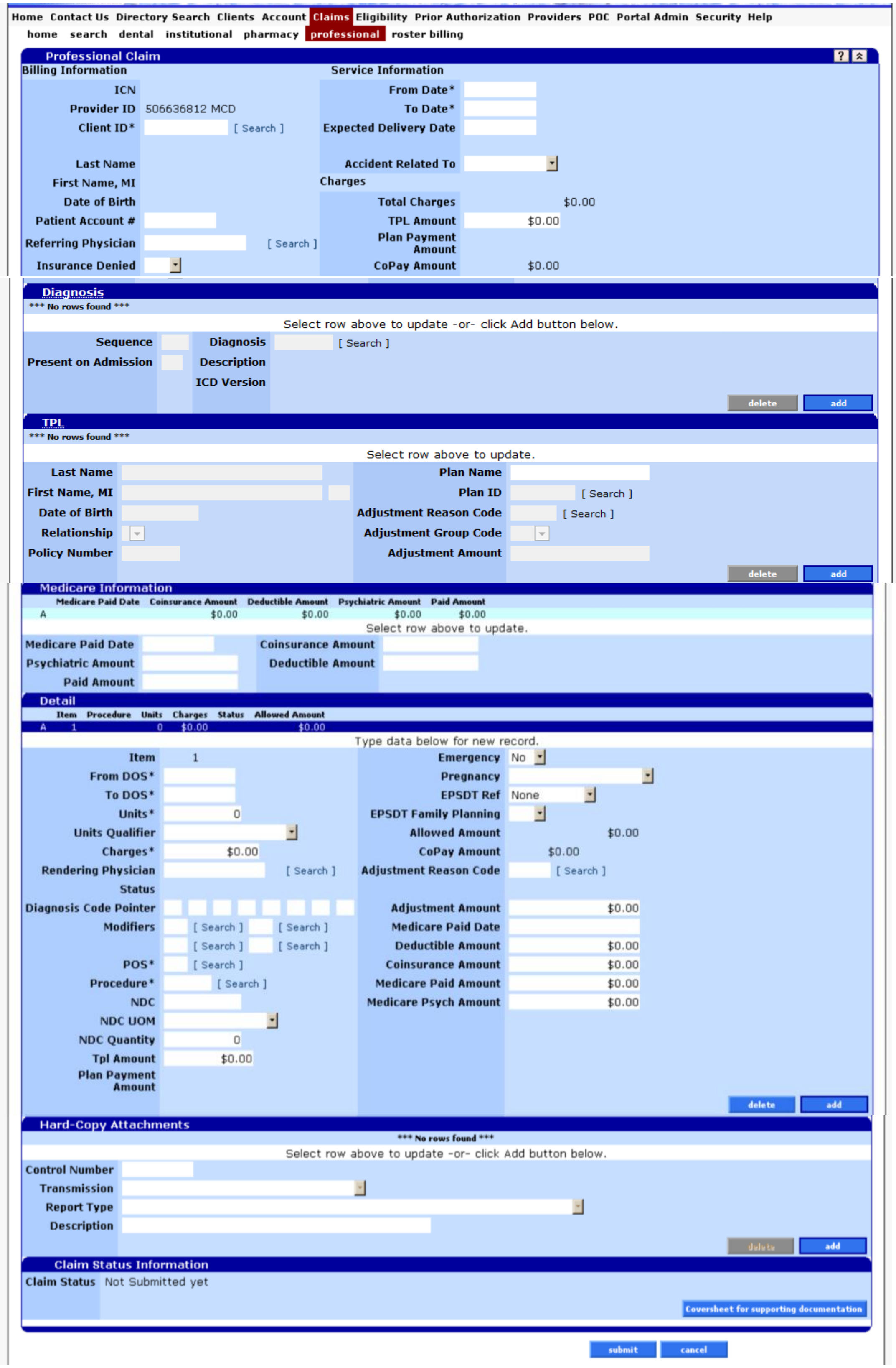
1. Verify that you are logged in as and acting on behalf of the correct provider. OHA will pay the provider you are logged in under.
2. You must complete and submit the claim in its entirety in order to save the data entered. Partially completed claims data cannot be saved.
3. The session will end after 20 minutes of inactivity. Any work or changes that have not been submitted will be lost.

4. The professional claim has 7 screens (listed below). In some screens you simply move from field to field while in others you must select the “Add” button to add information. Make sure you review all screens and enter all required and/or applicable data in each screen.

1. Professional Claim Header
2. Diagnosis
3. Third-Party Liability (TPL)
4. Medicare Information (For Medicare-Medicaid claims)
5. Detail
6. Hard Copy Attachments
7. Claims Status Information

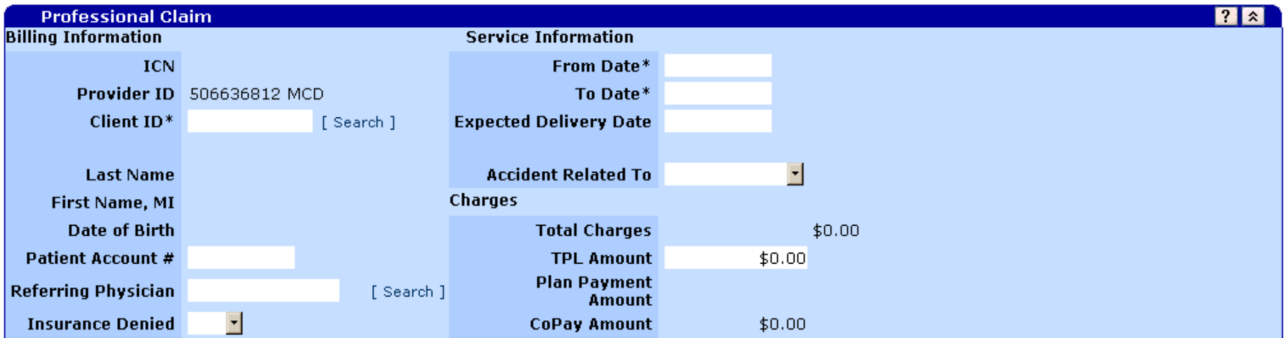
How to submit a professional web claim

“Claims” menu, click “Professional.”



Step 1: Enter claim header information

The professional claim header is the main screen including basic information for the entire claim.



Professional claim fields

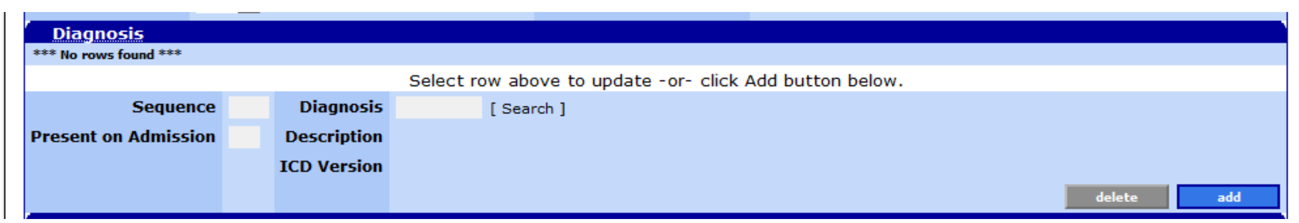
Shaded boxes are always mandatory. Non-shaded boxes are mandatory if applicable.

Field	Description
ICN	Claim's internal control number (ICN).
Provider ID	National Provider Identifier (NPI) or Billing Provider number.
Client ID*	Recipient identification number. Review the name fields under this field to make sure you have entered the correct ID number.
Last Name	Last name of the recipient. (This field will auto populate with the name associated with the client ID you entered.)
First Name, MI	First name and middle initial of the recipient. (This field will auto populate with the name associated with the client ID you entered.)
Date of Birth	The recipient's date of birth. (This field will auto populate with the DOB associated with the client ID you entered.)
Patient Account #	Identification for a recipient assigned by a provider. If a patient account number is provided in this field it will print on the Remittance Advice (RA).
Referring Physician	NPI or Medicaid Provider ID of the Referring Provider. The referring physician must be enrolled with DMAP to comply with Affordable Care Act requirements.
Insurance Denied	This is the field that indicates if the TPL was denied or not. Valid options are Yes or No.

Field	Description
From Date*	Beginning date on which service was provided. Must be before today’s date.
To Date*	Ending date on which service was provided. Must be after “from date” of service.
Expected Delivery Date	Pregnancy due date.
Accident Related To	Indicates whether service was performed as result of an accident.
Total Charges	Total dollar amount charged for the claim. Total charges are the sum of all charges and are derived from the detail Line Items. This field will not populate with total charges until the detailed line is completed.
TPL Amount	Dollar amount paid by any third-party resource (third-party liability, or TPL). This amount is the total payment received.
Plan Payment Amount	Dollar amount paid by recipient’s OHP managed care plan. Displays for managed care plan submissions only.
Co-Pay Amount	Amount recipient is to pay for services rendered. (This will auto populate based on the client’s benefit plan.)

Step 2: Enter diagnosis information

Click “add” to add a diagnosis. You may enter up to ten (10) ICD-10 diagnosis codes. Do not use decimals when entering diagnosis codes.



Field descriptions

Field	Description
Sequence	The sequence of the diagnosis (1 for primary, 2 for secondary, etc.). Used for the Diagnosis Code Pointer on the Professional Claim-Detail screen.

Field	Description
Diagnosis	Code indicates the diagnosis. Use the “search” hyperlink next to this field to look up the diagnosis.
Present on Admission	**This field does not apply to professional claims.**
Description	**This field does not apply to professional claims.**
ICD Version	Indicates whether the code selected is ICD-9 or ICD-10. (Read-only)

To add a diagnosis

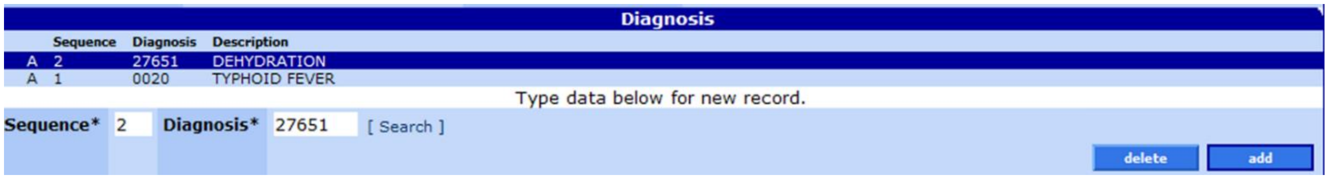
Step	Action	Response
1	Click the Add button.	Diagnosis field is activated for data entry.
2	Enter the Sequence and Diagnosis. Or, use the diagnosis search.	Diagnosis displays.

To delete a diagnosis

Step	Action	Response
1	Choose the line item to be deleted.	Data populates fields in the Diagnosis screen.
2	Click the Delete button. Note: The delete button deletes selected data on the current screen. It does not delete the claim.	Dialog displays to confirm deletion.
3	Click OK.	The system will indicate the deletion with a “D” on the line item. It will be removed from the claim once the claim is resubmitted or adjusted.

To update a diagnosis

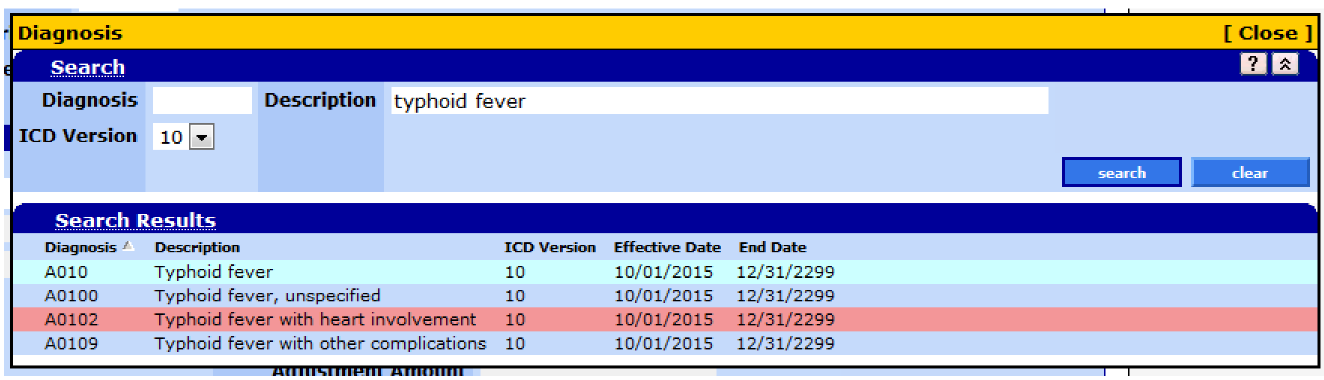
NOTE: To update the sequence, you will need to delete line items and re-add them in the correct order.



Step	Action	Response
1	Choose the line item to be updated.	Data populates detail fields in the Diagnosis screen.
2	Enter updated data in the Diagnosis field.	Diagnosis will display.

Diagnosis→Search screen

This screen allows you to verify and look up a diagnosis code.



To look up a diagnosis via the search screen

Step	Action	Response
1	Click the Add button.	Search hyperlink is activated for selection.
2	Click the “search” hyperlink.	Diagnosis search screen displays.
3	Enter either a diagnosis code or a diagnosis description, then select ICD Version 9 or 10. Then click search.	Search display diagnosis options.
4	Click on the line item that displays the most appropriate diagnosis.	Diagnosis code and description displays.

Step 3: Enter third-party liability (TPL) information

This screen allows you to add third party liability (TPL, or third party resource) information. Click “add” to add TPL information. You can enter a line of TPL information for each payer other than OHA.

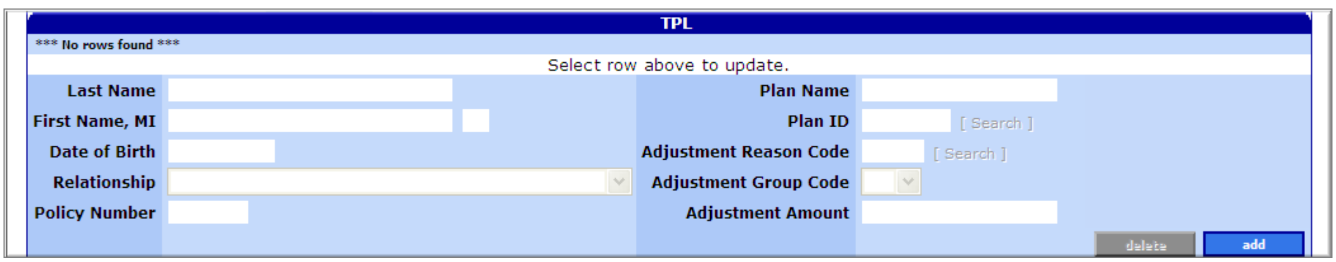
This includes Medicare supplement plans.

Do not enter Medicare as TPL; enter Medicare information in the Medicare information section of the web claim.

If applicable, TPL must be entered on each claim.

- If a third-party or other insurance did not make payment or made a partial payment, you must enter the appropriate HIPAA Adjustment Reason Code (ARC). This code identifies the detailed reason the other payer(s) did not make a payment.
- For a complete list of HIPAA ARCs, go to the Washington Publishing website at www.wpc-edi.com.

Note: Do not enter client liability (*e.g.*, copayments) on the claim.



Field descriptions

Field	Description
Last Name	The TPL insured’s last name.
First Name, MI	The TPL insured’s first name and middle initial
Date of Birth	The TPL insured’s date of birth.
Relationship	The TPL insured’s relationship.
Policy Number	The TPL insured’s policy number.
Plan Name	The TPL insured’s plan name.

Field	Description
Adjustment Reason Code*	HIPAA Adjustment Reason Code (ARC) identifying how TPL processed the claim. Use the “search” link to find the most appropriate ARC.
Adjustment Group Code	Review primary EOB for use of appropriate Adjustment Group Code.
Adjustment Amount	Amount adjusted off based on primary payment.

To add a TPL

Step	Action	Response
1	Click the Add button.	TPL fields are activated for data entry.
2	Enter the last name, first name, MI, DOB, Relationship, Policy number, and plan name.	The TPL data displays as a line item.
3	Select the Add button again (only when there is more than one TPL).	Line item displays.

To delete a TPL

Step	Action	Response
1	Choose the TPL line item to be deleted.	Data populates fields in the TPL screen.
2	Click the Delete button. Note: The delete button deletes selected data on the current screen. It does not delete the claim.	Dialog displays to confirm deletion.
3	Click OK.	

To update a TPL

Step	Action	Response
1	Choose the TPL line item to be updated.	Data populates fields in the TPL screen.
2	Type updated data in the TPL fields.	TPL information displays.

Step 4: Enter Medicare information

Medicare information is only required when you bill for a client who is eligible for both Medicare and Medicaid services.

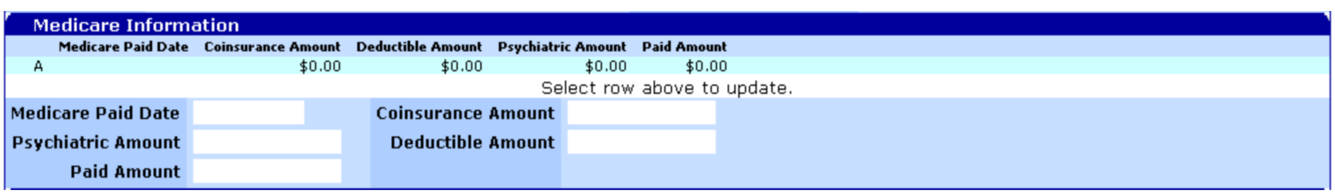
- Normally, when you submit your Medicare Part B (outpatient health care expense including provider fees) claim to Medicare, Medicare transmits the billing information to OHA electronically. This transmission is called a "crossover."
- If the claim does not automatically crossover, you must bill OHA separately and indicate what Medicare paid. Enter the Medicare information for the entire claim in the Medicare Information screen. This includes information on Medicare replacement plans.

You must complete this section when:

- Medicare transmits incorrect information to OHA; or
- OHA did not receive a crossover claim from Medicare; or
- You billed an out-of-state Medicare carrier or intermediary.

Medicare information screen

This screen is used to report the total amount paid by Medicare for the entire claim. This information can be found on the Medicare EOMB.



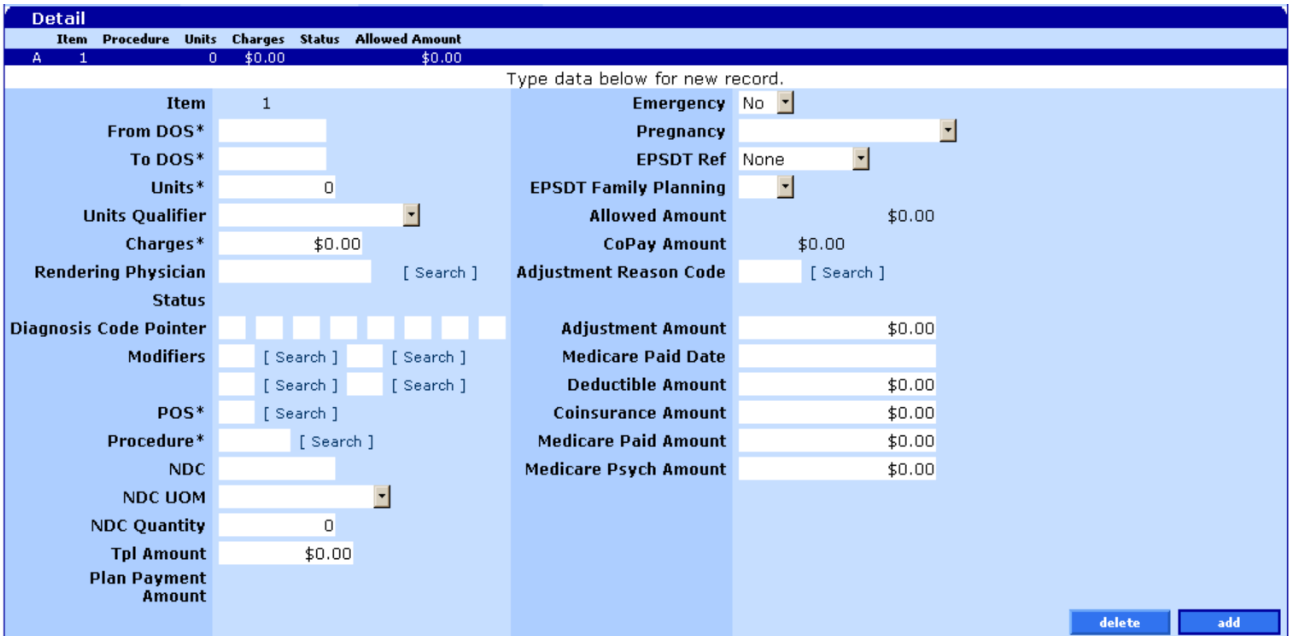
Field descriptions

Field	Description
Medicare Paid Date	The date Medicare paid for the services.
Psychiatric Amount	The Medicare psychiatric charge.
Paid Amount	The dollar amount paid by Medicare for the services.
Coinsurance Amount	Amount that represents the member's coinsurance payment.

Field	Description
Deductible Amount	The amount a Medicare client with no Medicaid benefits would have to pay before Medicare pays anything.

Step 5: Enter detail lines

This screen allows you to enter multiple detail lines. Enter information for the first detail line. Click the “add” button for each additional detail line.



Field descriptions

Shaded boxes are always mandatory. Non-shaded boxes are mandatory if applicable.

Field	Description
Item	The number of the detail line. *Read-only*
From DOS*	Beginning date on which service was provided.
To DOS*	Ending date on which service was provided
Units*	Number of units billed for the service For anesthesia codes (00100-011996), bill time in minutes when appropriate. OHA will convert minutes to units.
Charges*	Total dollar amount charged for the services.

Field	Description
Rendering Physician *(required for claims submitted by clinic, group or OHA-approved facilities for services rendered by enrolled OHA providers)*	NPI or Medicaid Provider ID of the rendering provider. This field is required when you need to indicate who in the clinic, group or OHA-approved mental health or chemical dependency facility actually performed/rendered the service. • When the rendering provider is under direct supervision (*e.g.,* resident at a teaching hospital), enter the supervising physician's information. • For medical claims, the rendering provider must be enrolled with OHA and have their ID number reported in this field to ensure appropriate claim processing. • For chemical dependency or mental health claims, only rendering providers who meet OHA's certification or enrollment criteria are required to enroll with OHA and have their ID numbers reported in this field.
Status	Claim status on the detail line. *Read-only*
Diagnosis Code Pointer	Indicates the sequence number(s) of diagnosis (referring to the Claim-Diagnosis screen) for which services were provided.
Modifiers	Code used to further define a procedure provided. You can use the [search] link next to this field to search for a modifier by code or description.
POS*	2-digit place of service code (POS) is used for the location where service was rendered. You can use the [search] link next to this field to search for a POS code by code or description.
Procedure*	Code that identifies the service provided. You can use the [search] link next to this field to search for procedure codes by code or description.

Field	Description
NDC	National Drug Code (NDC) that identifies the drug administered (for outpatient services only). You can use the Drug Search screen to find a drug by NDC or name. • The “N4” qualifier is not required on web portal claims. • Enter NDC in 5-4-2 format (add leading zeroes as needed), without dashes. • OHA only pays for drugs that are rebateable (*i.e.,* part of the federal Medicaid Drug Rebate Program). To verify that an NDC is rebateable, search for it in the CMS rebate drug product data file on the CMS Medicaid Drug Rebate Program Data page. If the NDC is on file, it is rebateable.
NDC UOM	Code that identifies the NDC Unit of Measure.
NDC Quantity	Number that identifies NDC quantity (fractional units limited to 3 digits after the decimal)
TPL amount	Enter the amount paid by third party for the individual procedure codes.
Emergency	Indicates whether service was provided as result of emergency situation. Valid values: Yes, No.
Pregnancy	Indicates whether service is related to condition of being pregnant.
EPSDT Ref	Not used
EPSDT Family Planning	Indicates whether the service is Family Planning (FP) and/or Early and Periodic Screening, Diagnostic and Treatment (EPSDT) or not applicable (optional field)
Allowed Amount	Amount approved to pay for services provided. *Read-only*
Copay Amount	Amount paid by recipient for services performed. *Read-only*

Field	Description
Adjustment Reason Code (only when Medicare is the primary payer)	Enter ARC to describe why Medicare did not make payment. • ARC codes are used in place of the unique 2-digit code on paper claims. A complete list of ARC codes can be found by using the web claims search feature or at www.wpc-edi.com. • If entering an ARC for multiple payers, select the code that is most appropriate.
Adjustment Amount	Amount adjusted for the reason code entered above.
The following information is required for Medicare-Medicaid claims only. Amounts entered for the claim details should correspond to the total amount entered on the Medicare Information screen.	
Medicare Paid Date	The date Medicare paid for the services.
Deductible Amount	The amount a Medicare client with no Medicaid benefits would have to pay before Medicare pays anything.
Coinsurance Amount	Amount that represents the member's coinsurance payment.
Medicare Paid Amount	The dollar amount paid by Medicare for the services.
Medicare Psych Amount	The Medicare psychiatric charge.

To add a detail line item

Step	Action	Response
1	Click the Add button.	Detail screen activates fields for data entry.
2	Enter data in the required fields (From DOS, To DOS, Units, Charges, Rendering Physician, POS, and Procedure).	
3	Enter data in the remaining fields that are applicable (Diagnosis Code Pointer, Modifier, Emergency, Pregnancy)	

Step	Action	Response
4	Enter information in EPSDT Family Planning field if applicable	‘1’ for Family Planning (FP) ‘2’ for Family Planning and EPSDT (FP/ EPSDT) ‘3’ for EPSDT (EPSDT) ‘ ‘ a blank entry that allows for this field to be optional

To delete a detail line item

Step	Action	Response
1	Choose the line item to be deleted.	Data populates fields in the Detail screen.
2	Click the Delete button. Note: The delete button deletes selected data on the current screen. It does not delete the claim.	Dialog displays to confirm deletion.
3	Click OK.	(The system will indicate the deletion with a “D” on the line item. It will be removed when the claim is resubmitted or adjusted.)

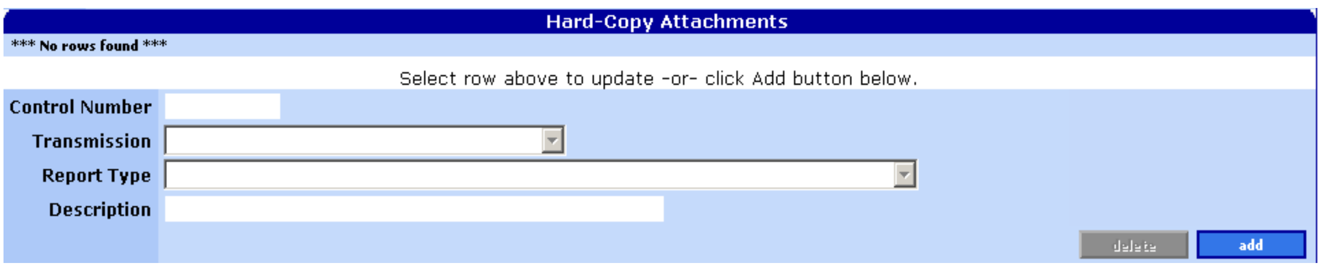
To update a detail line item

Step	Action	Response
1	Choose the line item to be updated.	Data populates detail fields in the Detail screen.
2	Enter updated data in the From DOS, To DOS, Units, Charges, Rendering Physician, POS, and Procedure fields.	

Step	Action	Response
3	Enter updated data in the remaining fields that are applicable or select the most appropriate data from the drop-down lists (Diagnosis Code Pointer, Modifier, Emergency, Pregnancy, EPSDT Family Planning).	

Step 6: Enter notes about hard copy attachments

This screen is not currently used by Medicaid. If you need to send hard copy attachments (*e.g.,* sterilization consent form) for a claim**, submit the claim on paper with the attached documentation, or** use the EDMS Coversheet to fax the documentation to OHA**.** See Appendix for paper claim instructions.



Field descriptions

Field	Description
Control Number	Attachment/Paperwork Identifier selected by the user to identify a document that they intend to send in. This identifier is not used by the system. Attachments are associated to a claim through the EDMS coversheet by the claim ICN.
Transmission	Code defining timing, transmission method or format of attachment/paperwork.
Report Type	Code describing the type of attachment /paperwork.
Description	Additional notes about the attachment /paperwork.

Step 7: Submit claim and review claim status information

Before you click "Submit," claim status information displays as follows:

Click the “Submit” button at the bottom of the screen to submit the claim. If the claim encounters an error (i.e. missing information), a message will display at the top of the claim.

Claim status information

Claim processing is real-time, and you can immediately view the status of the claim:

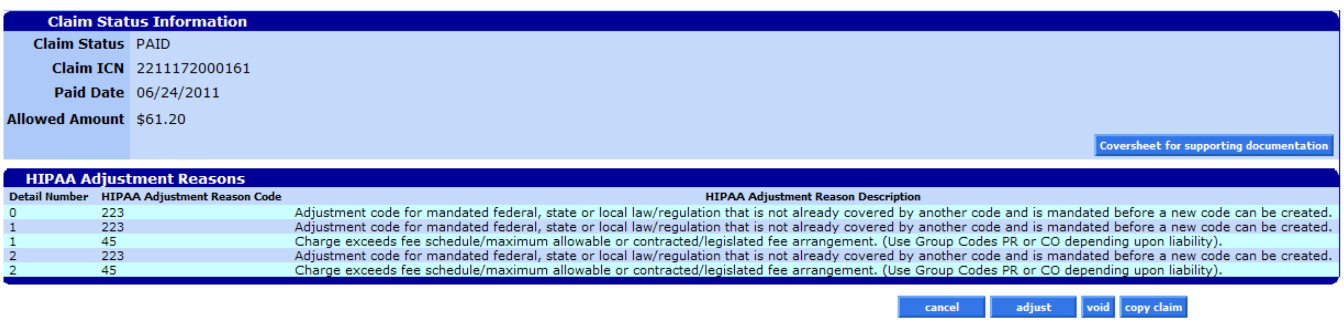
The Claim Status Information screen displays information regarding the claim status after the claim has been processed. For example, the claim status may show that the claim has been 1) paid, 2) denied, or 3) suspended (pending).

“Cover Sheet for Supporting Documentation” button

If you need to send hard copy attachments (*e.g.,* sterilization consent form) for a claim, this button allows you to print off an EDMS coversheet use as the coversheet for the supporting documentation you mail or fax in. The system will populate the ICN and mark the “Supporting documentation” checkbox for you.

HIPAA Adjustment Reasons

If there are Adjustment Reason Codes, they will also display on this screen.



Field descriptions

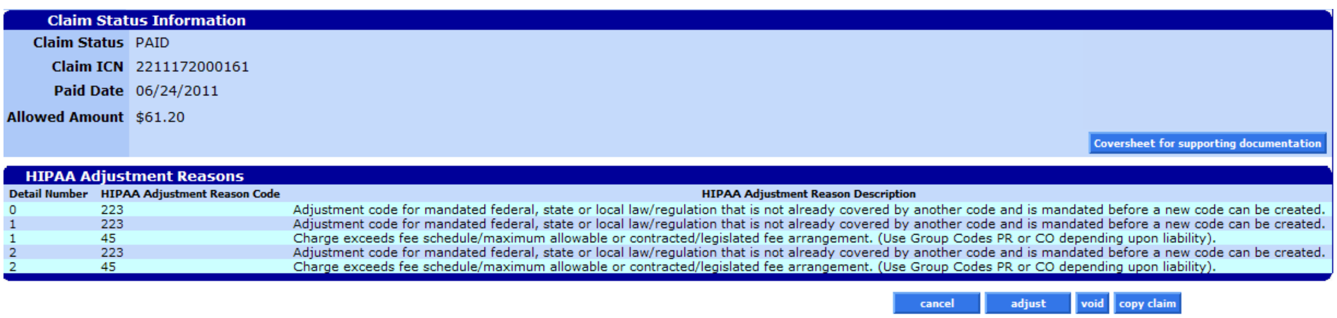
Field	Description
Claim Status	The detailed description of the status of the claim.
Claim ICN	Internal control number that uniquely identifies a claim.
Paid Date	The date that the claim was paid.

Field	Description
Allowed Amount	The dollar amount allowed for the claim.
Coversheet for supporting documentation	Link to the coversheet used when submitting claim attachments
Detail Number	The claim detail on which the EOB posted.
Code	The Explanation of Benefit code.
Description	The description of the EOB code.

Paid claim

The claim status, ICN, paid date, allowed amount, and HIPAA Adjustment Reason Codes (ARCs) display on all paid claims. The “cancel,” “adjust,” “void,” and “copy claim” buttons at the bottom of the claim will activate. See the *Claim Adjustment Handbook* for more information about adjust and void.

The claim will not show the amount paid, only OHA’s allowed amount. You will need to refer to the Remittance Advice for the paid amount.


Claim Status Information

Claim Status PAID
Claim ICN 2211172000161
Paid Date 06/24/2011
Allowed Amount $61.20

Coversheet for supporting documentation

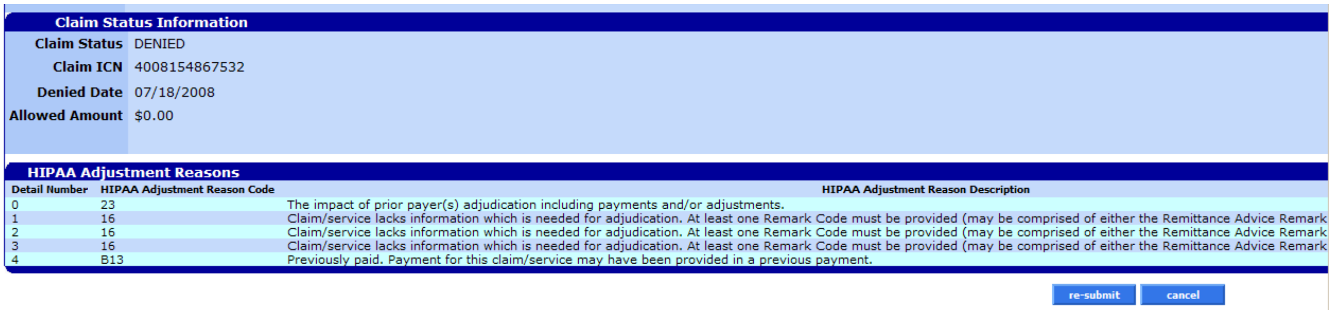
HIPAA Adjustment Reasons

Detail Number	HIPAA Adjustment Reason Code	HIPAA Adjustment Reason Description
0	223	Adjustment code for mandated federal, state or local law/regulation that is not already covered by another code and is mandated before a new code can be created.
1	223	Adjustment code for mandated federal, state or local law/regulation that is not already covered by another code and is mandated before a new code can be created.
1	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).
2	223	Adjustment code for mandated federal, state or local law/regulation that is not already covered by another code and is mandated before a new code can be created.
2	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).

cancel adjust void copy claim

Denied claim

The claim status, ICN, denied date, allowed amount and HIPAA Adjustment Reason Codes (ARCs) display on all denied claims. The “re-submit” button at the bottom of the claim will activate. “Re-submit” allows you to correct the denied claim and re-submit it as an original, new claim.



Claim Status Information

Claim Status	DENIED
Claim ICN	4008154867532
Denied Date	07/18/2008
Allowed Amount	$0.00

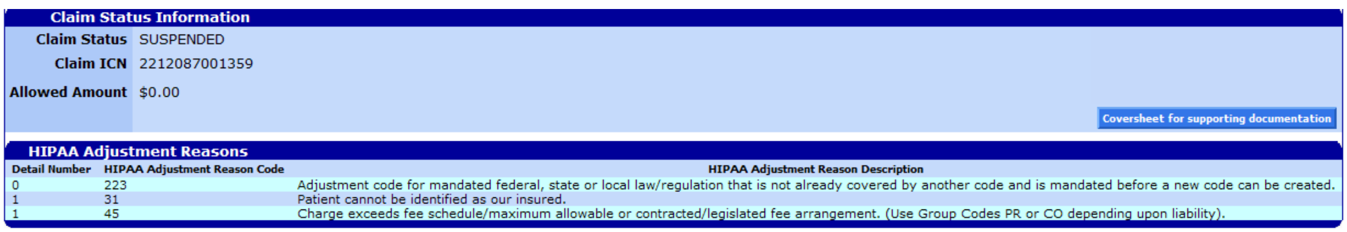
HIPAA Adjustment Reasons

Detail Number	HIPAA Adjustment Reason Code	HIPAA Adjustment Reason Description
0	23	The impact of prior payer(s) adjudication including payments and/or adjustments.
1	16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark
2	16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark
3	16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark
4	B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.

re-submit cancel

Suspended claim

Suspended means the claim is still in process. The claim status, ICN and allowed amount display on suspended claims. Suspended claims can ONLY be viewed. No action buttons display at the bottom of the claim until after the claim is processed (paid or denied) by an OHA Adjustment Analyst.



Claim Status Information

Claim Status	SUSPENDED
Claim ICN	2212087001359
Allowed Amount	$0.00

Coversheet for supporting documentation

HIPAA Adjustment Reasons

Detail Number	HIPAA Adjustment Reason Code	HIPAA Adjustment Reason Description
0	223	Adjustment code for mandated federal, state or local law/regulation that is not already covered by another code and is mandated before a new code can be created.
1	31	Patient cannot be identified as our insured.
1	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).

How to resubmit a denied claim

After a claim has denied, two (2) buttons will be displayed at the bottom of the screen: 1) Re-submit and 2) Cancel.

Step	Action	Response
1	Enter data in all required and/or applicable fields. • Professional Claim Header • Diagnosis • Third-Party Liability (TPL) • Medicare Information • Detail • Hard Copy Attachments	

Step	Action	Response
2	Click the resubmit button.	New claim status information displays with new ICN, status, and EOB Information.

How to copy a paid claim

The copy button allows you to make an exact duplicate of an existing claim. Once copied, you can update the claim data and submit the copied claim as a new claim.

This feature saves time because you do not have to enter all new data, but you must make sure to update all relevant data. Once the new claim is processed, a new ICN will display.

Step	Action	Response
1	Select the copy button.	The screen will refresh and display an exact copy of the claim. Data fields are activated to update pertinent information. You will now see “submit” and “cancel” in the lower right of the claim.
2	Update all required and/or applicable fields. Professional Claim Header Diagnosis Third-Party Liability (TPL) Medicare Information Detail Hard Copy Attachments	
3	Click the submit button.	The claim ICN, status, and/or error code is returned.

Appendix

Provider Portal resources

Self-study guides and quick reference

Go to the Provider Portal page at www.oregon.gov/OHA/HSD/OHP/pages/webportal.aspx.

Video training

View the “Oregon Health Plan” provider training videos on the OHA YouTube channel at www.youtube.com/playlist?list=PL7mua_4kMbMqaLy0gARbaM-WWn7P-Z7-S.

Quick reference: Submitting a professional claim

Step	Action	Response
1	Click the Claims menu.	The Claims menu options display.
2	Click Professional.	The Professional claim displays.
3	Enter data in the recipient ID, patient account number, from date, and to date fields.	
4	Add a diagnosis code.	Diagnosis displays.
5	Add TPL, if applicable.	TPL displays, if applicable.
6	Enter the detail line item information (from DOS, to DOS, units, charges, POS, and procedure code).	Line item information displays.
7	Enter data in the remaining fields, if applicable (rendering provider, diagnosis code pointer, modifier, emergency, pregnancy).	
8	Enter information in EPSDT Family Planning field if applicable	‘1’ for Family Planning (FP) ‘2’ for Family Planning and EPSDT (FP/ EPSDT) ‘3’ for EPSDT (EPSDT) ‘ ‘ a blank entry that allows for this field to be optional

Step	Action	Response
9	Enter the HIPAA ARC code that identifies the detailed reason the claim adjustment was made.	
10	Click the submit button.	The claim ICN, status, and/or error code is returned.

Quick reference: How to submit a Medicare-Medicaid claim

Step	Action	Response
1	Go to the Claims menu.	The Claims menu options display.
2	Click Professional.	The Professional claim displays.
3	Enter data in the client ID, from date, and to date fields.	
4	Add a diagnosis code.	Diagnosis displays.
5	Add TPL, if applicable.	TPL displays, if applicable.
6	On the Medicare Information screen, enter the Medicare paid date, **total** amount for allowed amount, and coinsurance/deductible amounts.	Medicare information displays.
7	Enter the detail line item information (from DOS, to DOS, units, charges, POS, procedure code).	Line item information displays.
8	Enter data in the remaining fields, if applicable (rendering provider, diagnosis code pointer, modifier, emergency, pregnancy).	
9	Enter information in EPSDT Family Planning field, if applicable	‘1’ for Family Planning (FP) ‘2’ for Family Planning and EPSDT (FP/ EPSDT) ‘3’ for EPSDT (EPSDT) ‘ ‘ a blank entry that allows for this field to be optional
10	Enter the HIPAA ARC code that identifies the detailed reason the claim adjustment was made.	

Step	Action	Response
	• If Medicare made no payment or partial payments, use an ARC to explain why.	
11	Enter Medicare paid date, enter total amount for allowed amount, paid amount, and coinsurance/ deductible amounts. Note: Report individual detailed line item amounts paid by Medicare for each service. This information is found on the Medicare EOMB.	
12	Click the submit button.	The claim ICN, status, and/or error code is returned.

Paper billing instructions

You only need to bill on paper when you need to submit hard-copy attachments, bill for claims over a year old, or as instructed by OHA for special handling.

CMS-1500

OHA only accepts commercially-available versions of the 2/12 CMS-1500 claim form.

- OHA will return invoices and claims submitted in any other formats with a request to re-submit the claim on the correct form.
- OHA 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 202-512-1800.

OHP 505

The OHP 505 claim form is unique. It is specifically used for clients who receive both Medicare and Medicaid services. When you submit your CMS-1500 claim form to Medicare, Medicare electronically transmits the billing information to OHA. This transmission is called a *crossover*.

- You must use the OHP 505 form if:
- Medicare transmits incorrect information to OHA, and OHA denied payment; or
- You billed an out-of-state Medicare carrier or intermediary.

Starting January 1, 2016, OHA will only accept versions of the OHP 505 form revised 8/15 or later.

We will return claims submitted on previous versions with a request to resubmit them on the correct form.

This form is available on the OHP Forms page at www.oregon.gov/OHA/HSD/OHP/Pages/forms.aspx.

Where to mail claims

Death with Dignity claims
OHP Clinical Review
PO Box 992
Salem, OR 97308-0992

Claims less than a year old
OHP Provider Services
PO Box 14955
Salem, OR 97309

Claims more than a year old
Provider Services Unit
500 Summer St NE, E44
Salem, OR 97301-1079

Important notes about paper claim processing

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 Portal. Do not “carry over” totals from one claim to another.

OHA processes all hardcopy claims using Optical Character Recognition (OCR) scanning. To avoid processing delays, use red-ink claim forms (not black and white copies) and make sure information is left-aligned in the following fields:

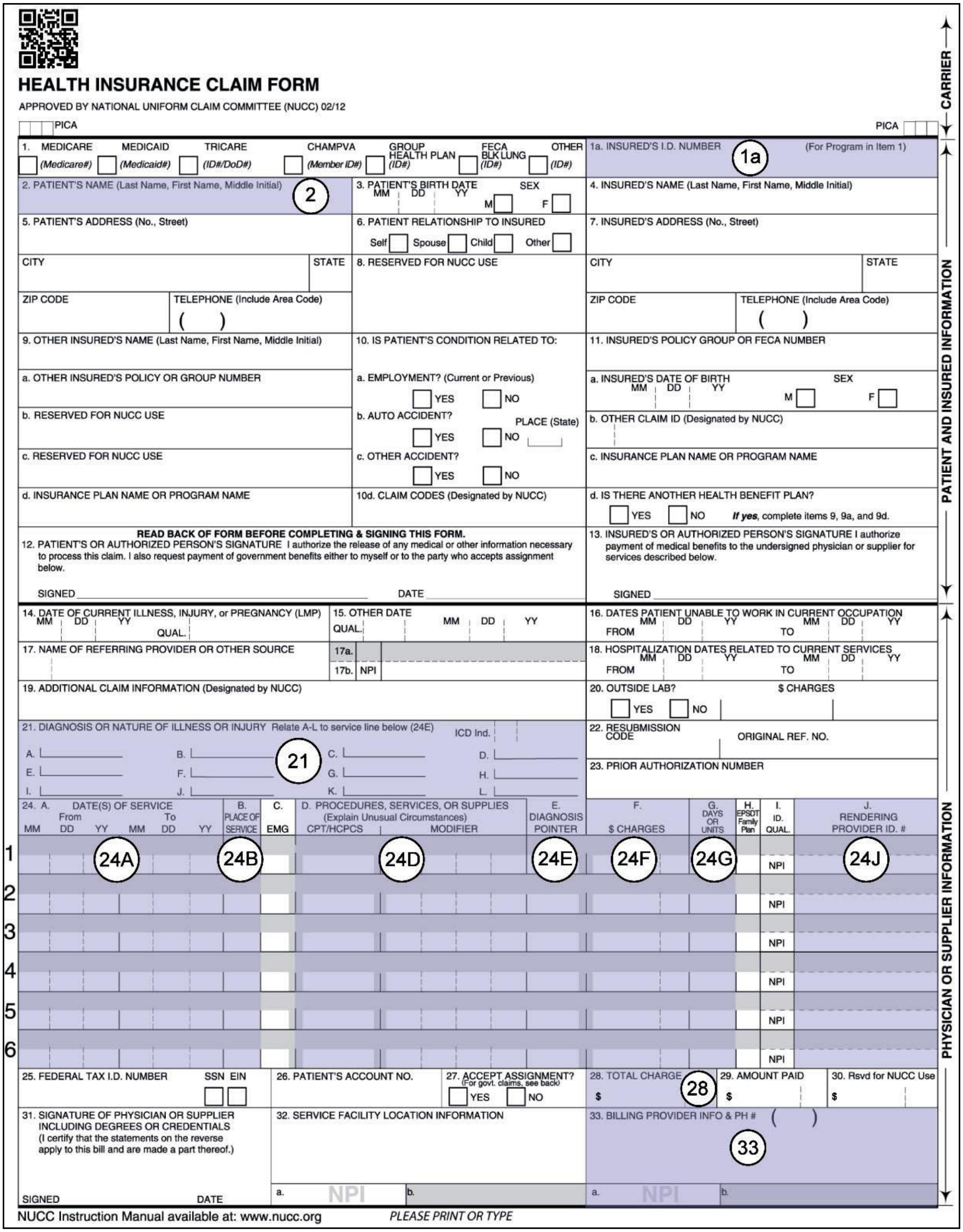
Field	Box number	
	CMS-1500	**OHP 505**
Client ID	1a	3
Patient Name	2	1
Dates of service - For detail line 1 only	24A	22A

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

If any claim information is handwritten, write clearly and in the appropriate box. Client identification numbers are alpha numeric so it can be difficult to distinguish between the number zero (“0”) and the letter “O”, the number one (“1”) and the letter “I”, or the number five (“5”) and the letter “S”. These errors can cause a claim to deny.

CMS-1500 Health Insurance Claim Form (revised 2/12)

Shaded boxes are fields OHA uses to process your claim; your claim may suspend or deny if information in this box is missing or incomplete. Non-required fields will be ignored.



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA | PICA

CARRIER

1. MEDICARE (Medicare#) | MEDICAID (Medicaid#) | TRICARE (ID#/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1) — 1a

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) — 2

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, complete items 9, 9a, and 9d.

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

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. 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. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. — 21

A. B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

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 NPI
3 NPI
4 NPI
5 NPI
6 NPI

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $ — 28

29. AMOUNT PAID $

30. Rsvd for NUCC Use $

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.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

OHP 505 form (revised 7/16)

Shaded boxes are fields OHA uses to process your claim; your claim may suspend or deny if information in this box is missing or incomplete.

Medicare/Medicaid Billing Invoice for Medical Practitioner Claims

1. Patient's Name (Last, First, MI) 1	2. Patient's birthdate/sex MM DD YY M ☐ F ☐	3. Oregon Medicaid ID (include all l 3 numbers)
4. Patient's address (number, street)	5. Patient's relation to insured Self ☐ Spouse ☐ Child ☐ Other ☐	6. Insured's Name (Last, First, MI)
City / State	7. Was condition related to: a. Patient's employment Y ☐ N ☐	8. Insured's address (number, street)
ZIP code / Phone (Area Code)	b. Accident Auto ☐ Other ☐	City / State
9. Other insured's name (Last, First, MI)	a. Other insured's plan name	ZIP code / Phone (Area Code)
Other insured's plan address (number, street)	b. Other insured's policy number	10. Insured's group # (or group name)
City / State	ZIP code / Phone (Area Code)	12. I authorize payment of medical benefits to undersigned physician or supplier for services described below.
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 11. 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*		*Signed (insured or authorized person)*
13. Date of current: MM DD YY ◀ Illness (first symptom) or Injury (accident) or Pregnancy (LMP)	14. If emergency, check here ☐	15. First date patient had same or similar illness MM DD YY
16. Name of referring provider or other source	16a. / 16b. NPI	17. Dates patient unable to work in current occupation From MM DD YY To MM DD YY
18. Outside lab? Yes ☐ No ☐ $ Charges	19. Prior authorization number	20. Hospitalization dates related to current services From MM DD YY To MM DD YY

21. Diagnosis or nature of illness or injury: Relate items A-L to service line below (22D) 21

A. B. C. D. E. F.
G. H. I. J. K. L.

22. A. Date(s) of service From MM DD YY To MM DD YY	B. Place of service	C. Procedures, services or supplies (explain unusual circumstances) CPT/HCPCS Modifier	D. Diagnosis pointer	E. Days or units	F. EPSDT Family Plan	G. Charges billed Medicare	H. Medicare's allowed charges	I. Rendering provider number
22A	22B	22C	22D	22E		22G	22H	OHA ID: NPI:
								OHA ID: NPI:
								OHA ID: NPI:
								OHA ID: NPI:
								OHA ID: NPI:
								OHA ID: NPI:

23. Federal Tax ID #	SSN ☐ EIN ☐	24. Total charge 24	25. Total Medicare paym 25
26. Patient's account #	27. Accept assignment? Y ☐ N ☐	28. Ins (not Medicaid/Medicare)	29. Reserved 29
30. Service facility location information NPI #: OHA #:	31. Billing provider information and phone number 31 NPI #: OHA #:		32. Provider certification By completing this form and entering my provider identification, I certify that the statements on the reverse apply to this bill and are made a part thereof.

OHP 505 (Rev. 07/16)

Required CMS-1500/OHP 505 fields

Shaded boxes are always mandatory. Non-shaded boxes are mandatory if applicable. Non-required fields will be ignored.

Make sure information is left-aligned and correctly placed in fields marked ***"Left-align."*** Misaligned information in these fields will delay processing.

Box			
CMS-1500	**OHP 505**	**Field**	**Description**
1 a	**3**	**Insured ID Number *Left-align**	**Use the eight (8)-digit Client ID Number.** The number is printed on the Oregon Health ID (formerly the Medical Care ID). It can also be obtained through the Automated Voice Response (AVR) at 866-692-3864, or the Provider Portal at https://www.or-medicaid.gov.
2	**1**	**Patient's Name *Left-align**	**Enter the client's name exactly as it is printed on the Medical Care ID.** DO NOT use "nicknames".
9	**9**	**Other Insured's Name**	**If the client has other medical coverage, enter the appropriate two (2)-digit explanation code for third-party liability (TPL).** This code explains both insurance actions.
10	**7**	**Is Patient's Condition Related To:**	Check the appropriate box when an injury is involved.
17	**16**	**Name of Referring Physician or Other Resource**	**Enter the name of the referring provider.**

<table>
<tr><th colspan="2">Box</th><th rowspan="2">Field</th><th rowspan="2">Description</th></tr>
<tr><th>CMS-1500</th><th>OHP 505</th></tr>
<tr><td>17 a</td><td>16a</td><td>ID Number of Referring Physician</td><td>Enter the six (6)- or nine (9)-digit Oregon Medicaid provider number of the referring provider.
The referring provider must be enrolled with OHA to comply with Affordable Care Act requirements.</td></tr>
<tr><td>17 b</td><td>16b</td><td>NPI of Referring Physician</td><td>Enter the referring physician’s 10-digit National Provider Identifier (NPI).</td></tr>
<tr><td>21</td><td>21</td><td>Diagnosis or Nature of Injury</td><td>Enter the primary diagnosis/condition of the client by entering current ICD-9- or ICD-10-CM codes. The diagnosis code must be the reason chiefly responsible for the service being provided as shown in the medical records.
Use ICD-9 codes for services on or before 9/30/2015.
Use ICD-10 codes for services on or after 10/1/2015.
Enter up to twelve (12) codes in priority order.
Carry out codes to their highest degree of specificity.
DO NOT enter the decimal point.
Exceptions: Transportation providers and Lifeline providers do not need to provide diagnosis information.</td></tr>
<tr><td>23</td><td>19</td><td>Prior Authorization Number</td><td>If the service was prior authorized, enter the ten (10)-digit Prior Authorization number issued for the service.</td></tr>
</table>

<table>
<tr><th colspan="2">Box</th><th rowspan="2">Field</th><th rowspan="2">Description</th></tr>
<tr><th>CMS-1500</th><th>OHP 505</th></tr>
<tr><td>24</td><td>22</td><td>Supplemental information</td><td>In the shaded area above each detail line, enter supplemental information (e.g., NDC codes, vendor numbers, anesthesia units) about the service rendered. Enter the appropriate qualifier(s), followed by the information.
• 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.
• See Appendix for more information about entering supplemental information.</td></tr>
<tr><td>24 A</td><td>22A</td><td>Dates of Service *Left-align for line item 1</td><td>This box must list 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:
• Correct: 05-01-16 thru 05-05-16 (5 units)
• Incorrect: 05-01-16 thru 05-06-16 (5 units)</td></tr>
</table>

Box		Field	Description
CMS-1500	**OHP 505**		
24 B	**22B**	**Place of Service**	**List the two (2)-digit Place of Service (POS) code for where the service was provided.** Use the standard CMS codes available in your CPT or HCPCS book or the CMS website at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/Website-POS-database.pdf.
24C	**14**	**Emergency Flag**	If the service was provided in an emergency situation, flag as follows: • CMS-1500: Enter a “Y” in this box. • OHP 505: Check this box.
24 D	**22C**	**Procedures, Services, or Supplies**	**List the five (5)-digit procedure code for the service provided.** Use only CPT or HCPCS codes. Add up to two (2) national modifiers.
24 E	**22D**	**Diagnosis Pointer**	**Only list one (1) letter that cross-references the diagnosis as listed in Box 21.** DO NOT enter the actual diagnosis code here. *Exceptions:* Transportation providers and Lifeline providers **do not** need to provide diagnosis information.
24 F	**N/A**	**$ Charges**	**Enter the total usual and customary charge for each line item.** OHA will not calculate your charge if billing for more than 1 item (unit).

Box		Field	Description
CMS-1500	**OHP 505**		
24 G	**22E**	**Days or Units**	**This number must match the number of days being provided as indicated in the Dates of Service field.** • As example: Procedure code 97110 (therapeutic exercise), 1 unit = 15 minutes, you treated the patient for 45 minutes, the number of units you must record is 3, not 1. • The units must match the number of consecutive days. For anesthesia codes (00100-011996), bill time in minutes when appropriate. OHA will convert minutes to units.
N/A	**22 G**	**Charges Billed Medicare**	Enter the amount you billed Medicare for each service provided.
N/A	**22 H**	**Medicare's Allowed Charges**	Enter the amount Medicare allowed for each service provided.
24 H	**22F**	**EPSDT Family Planning**	Enter '1' for Family Planning; '2' for Family Planning and EPSDT and '3' for EPSDT. Leave blank if not applicable

Box		Field	Description
CMS-1500	OHP 505		
24 J	**22I**	**Rendering Provider ID (required for claims submitted by clinic, group, or OHA-approved facilities for services rendered by enrolled Oregon Medicaid providers)**	**List the six (6)- or nine (9)-digit Oregon Medicaid rendering provider number in the shaded half of the field, and the NPI registered with the Oregon Medicaid ID in the non-shaded half of the field.** When clinics, group practices, or OHA-approved mental health and chemical dependency facilities bill OHA using their specific billing provider number in Box 33, they must complete this field to indicate who performed the service being billed. • When the rendering provider is under direct supervision (*e.g.,* resident at a teaching hospital), enter the supervising physician's information. • For medical claims, rendering providers must be enrolled with OHA and have their ID numbers reported in this field to ensure appropriate claim processing. • For chemical dependency or mental health claims, only rendering providers who meet OHA's certification or enrollment criteria are required to enroll with OHA and have their ID numbers reported in this field.

Box		Field	Description
CMS-1500	**OHP 505**		
26	**26**	**Patient’s Account No.**	If a patient account number is provided in this box, OHA will print it on the Remittance Advice (RA).
28	**24**	**Total Charge**	**Enter the total amount for all charges listed in Box 24F.** All lines listed under Box 24F should add up to the total amount billed.
N/A	**25**	**Total Medicare Payment**	**Enter the total amount paid by Medicare.** DO NOT enter the amount of write-offs.
29	**28**	**Amount Paid**	**Enter the total amount paid by any prior resource(s).** These DO NOT include: • Medicare payments. • OHP copayments. • Previous payment amounts made by OHA. • Contract write-offs required by other payers.
30	**29**	**Reserved (Balance Due)**	**Enter the total balance due.** • CMS-1500: This field is not required. • OHP 505: Box 24 minus the total of Boxes 25 and 28 equals Box 29, “balance due”.

Box			
CMS-1500	**OHP 505**	**Field**	**Description**
33	**31**	**Billing Provider's NPI and Oregon Medicaid ID**	**If you have an NPI, you must enter the ten (10)-digit number in part "a" of this field. In part "b" of this field, you must enter your six (6)- or nine (9)-digit Oregon Medicaid billing or performing provider number.** OHA will pay this provider. If you leave part "b" blank, OHA will use the NPI in part "a" to process your claim, which may result in OHA processing the claim under the wrong provider number.

Helpful tips

Additional information is available on the OHP website **OHP.Oregon.gov/Providers**. Click "Submit claims."

READ your provider guidelines! Pay special attention to the billing instructions. Be sure you have the most current rulebook and supplemental information that are in effect for the date of service you are billing for.

Provider guidelines are available on the OHP website at **OHP.Oregon.gov/Providers**. Click "Provider guides" for a list of current guideline pages.

If you do not have internet access, you may contact us at 800-527-5772 and ask to have provider guidelines mailed to you.

VERIFY client eligibility on the date of service.

Use one of the services listed on the OHP Eligibility Verification page at www.oregon.gov/OHA/HSD/OHP/Pages/Eligibility-Verification.aspx.

- Provider Portal: Go to https://www.or-medicaid.gov;
- Automated Voice Response (AVR): Call 866-692-3864;

- 270/271 EDI transaction: Available to approved Electronic Data Interchange (EDI) providers. Go to www.oregon.gov/OHA/HSD/OHP/Pages/edi.aspx for more EDI information.

The client name and number on the claim needs to match the name and number on the Oregon Health ID. A Client ID number is always eight characters and is listed on the front of the Oregon Health ID. The General Rules supplemental information book shows an example of an Oregon Health ID.

BEFORE billing OHA…

- **MAKE SURE** that you billed prior resources and reported the correct dollar amount.
- **DO NOT** attach prior resource EOBs unless specifically requested.
- **ALWAYS USE** the correct 2-digit explanation code (for paper claims) or ARC (for electronic claims) when the client has TPL. If the client has TPL, you must enter the appropriate code even when the TPL made no payment. Always enter a code if the client has more than one TPL available.

USE commercially available "red form" versions of the CMS-1500 (not black and white copies).

USE only one prior authorization number.

ALWAYS ENTER the Oregon Medicaid 6- or 9-digit provider number you want OHA to send payment to in the Billing Provider field. It is crucial that you list this information. An invalid or missing provider number could delay your payment, make payment to a wrong provider or deny your payment.

- If the rendering provider is different from the billing provider, enter the rendering provider number in the Rendering Provider field.
- A rendering provider is the individual who provided the service; a "billing" provider bills on behalf of the rendering provider.

CHECK your claim form for legibility so that we can clearly read it. Avoid tiny print, print that overlaps onto a line, entering more than 6 lines per claim, and poorly hand written claim forms. Complete only the required boxes.

EACH CMS-1500 and OHP 505 is a complete billing document. If there is not enough space available on the form to bill all procedures provided **on the same date of service**, complete a new billing form for the rest of the procedures or submit the claim electronically.

READ the explanation of benefit (EOB) codes on your Remittance Advice. EOBs tell you what the error is, and if you should re-bill or submit an adjustment request.

CONTACT Provider Services at 800-336-6016 for assistance in completing your CMS-1500 or OHP 505, or other questions regarding a medical claim.

Supplemental information

Above each detail line on the CMS-1500 claim form and OHP 505 form, you can enter supplemental information about the service(s) rendered.

- 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: N4 qualifier, NDC (in 5-4-2 format), 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.

OHA 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: • F2 – International Unit • GR – Gram • ML – Milliliter

Qualifier	Information Type
	• 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

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 or claims.

Anesthesia Services – Payment based on minutes as units

24. A. DATE(S) OF SERVICE From MM	From DD	From YY	To MM	To DD	To 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. #
7Begin 1245 End 1415															123456
06	01	14	06	01	14	1		00770	MJ	1	### ##	90		NPI	1234567890

Unspecified Code

24. A. DATE(S) OF SERVICE From MM	From DD	From YY	To MM	To DD	To 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. #
ZZ Kaye Walker															123456
06	01	14	06	01	14	4		E1399		1	### ##	1		NPI	1234567890

NDC

24. A. DATE(S) OF SERVICE From MM	From DD	From YY	To MM	To DD	To 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. #
N412345678901 UN20															123456789
MM	DD	YY	MM	DD	YY	1		J####	UD [for 340B drugs]	1	### ##	20		NPI	1234567890

Vendor Product Number

24. A. DATE(S) OF SERVICE From MM	From DD	From YY	To MM	To DD	To 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. #
VPA122BIC5D6E7G															123456
06	01	14	06	01	14	1		A6410		1	##	##		NPI	1234567890

Global Trade Item Number

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. #
OZ00301134678906															123456
06	01	14	06	01	14	1		A6410		1	## ##	1		NPI	1234567890

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