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Authorized Signature

Number: OMAP-IM-05-088

Issue Date: 06/28/2005

Topic: Medical Benefits

Subject: Provider Announcements - Screening Process for OMAP Claim Forms

Applies to:

DHS staff and others on the SPD, CAF, OMHAS and OMAP transmittal lists

Message:

OMAP will send the attached provider announcements this week.

1) The first announcement is to all providers who bill using the paper OMAP 505 claim form.

The announcement:

- defines the critical fields of the OMAP 505 claim form; and
- informs providers that OMAP now screens claims for these critical fields at receipting and returns incomplete claims to the provider for more information.

2) The second announcement is to all providers who bill using the paper UB-92 claim form.

The announcement:

- defines the critical fields of the UB-92 claim form; and
- informs providers that OMAP now screens claims for these critical fields at receipting and returns incomplete claims to the provider for more information.

If you have any questions about this information, contact:

Contact(s):	Terry Layman, Manager, OMAP Provider Relations		
Phone:	503-945-6501	Fax:	503-945-6873
E-mail:	terry.layman@state.or.us		



Inside

Provider
Announcement -
Billing Reminder to Complete
Critical OMAP 505 Fields

Need Help?

OMAP has developed several booklets and training materials to help you complete claims forms, including the *OMAP 505 Billing Instructions* handbook.

This and other materials can be found on our web page at:
http://www.oregon.gov/DHS/healthplan/tools_prov/tips/main.shtml

Questions?

If you have billing questions, call our Provider Relations



Unit at 1-800-336-6016.

OMAP CA - #05-023
OMAP 505 Claims

Important Billing Reminder to Complete OMAP 505 Critical Fields

We've recently changed our claim processing procedures to include a screening of certain critical fields on paper claims before entering them into our MMIS payment system.

This screening is only for certain fields, not all required fields. The screening allows us to identify incomplete claims and return them to you for completion. We will highlight your returned claim showing the incomplete field.

Reasons for Returning Claims

In the screening, our staff are checking to make sure the following fields (shaded in the sample at right) on the OMAP 505 are complete:

- 1 Patient's Name - enter the name as it appears on the OMAP Medical Care ID.
 - 6 Insured ID Number - enter the 8 alphanumeric characters found in field 11 of the client's OMAP Medical Care ID.
 - 23A Diagnosis or Nature of Injury - list up to four (4) diagnosis codes in priority order. DO NOT enter the decimal point.
- For each service provided, enter:
- 24A Date of Service - list numeric dates of service, i.e., 03/01/05.
 - 24B Place of Service - list the 1- or 2-character code.
 - 24C Procedures, Services or Supplies - list the five (5)-digit procedure code.
 - 24E Days or Units - enter the correct number of days or units for this procedure.
 - 24G Charges Billed Medicare - enter the total amount billed to Medicare.
 - 24H Medicare's Allowed Charges - enter the amount Medicare allowed.
 - 27* Total Charge - enter the total amount for all charges listed in field 24G.
 - 31* Balance Due - subtract the amounts in fields 28 and 30 from field 27 and enter the balance.
 - 34 I.D. Number - enter your 6-digit OMAP billing or performing provider number.

State of Oregon
Department of Human Services
Office of Medical Assistance Programs

**MEDICARE / MEDICAID BILLING INVOICE
FOR MEDICAL PRACTITIONER CLAIMS**

OMAP 505 (Rev. 11/99)

PATIENT AND INSURED (SUBSCRIBER) INFORMATION										
1. PATIENT'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL)			2. PATIENT'S DATE OF BIRTH			3. INSURED'S NAME (Last Name, first name, middle initial)				
4. PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE)			5. PATIENT'S SEX MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>			6. INSURED'S I.D. NO. (Include all letters & Numbers)				
7. PATIENT'S RELATIONSHIP TO INSURED SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER <input type="checkbox"/>			8. INSURED'S GROUP NO. (Or Group Name)			9. OTHER HEALTH INSURANCE COVERAGE: Enter Name of Policyholder and Plan Name and Address and Policy or Medical Assistance Number				
10. WAS CONDITION RELATED TO: A. PATIENT'S EMPLOYMENT YES <input type="checkbox"/> NO <input type="checkbox"/> B. ACCIDENT AUTO <input type="checkbox"/> OTHER <input type="checkbox"/>			11. INSURED'S ADDRESS (Street, city, state, ZIP code)			12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (Read back before signing) <i>I authorize the Release of any Medical Information Necessary to Process this Claim and Request Payment of MEDICARE Benefits Either to Myself or to the Party Who Accepts Assignment Below.</i>				
SIGNED _____ DATE _____			SIGNED (Insured or Authorized Person) _____			13. AUTHORITY PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW				
PHYSICIAN OR SUPPLIER INFORMATION										
14. DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)			15. DATE FIRST CONSULTED YOU FOR THIS CONDITION			16. IF PATIENT HAS HAD SAME OR SIMILAR SYMPTOMS? YES <input type="checkbox"/> NO <input type="checkbox"/>		16A. IF EMERGENCY CHECK HERE <input type="checkbox"/>		
17. DATE PATIENT ABLE TO RETURN TO WORK			18. DATES OF TOTAL DISABILITY FROM _____ THROUGH _____			19. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE (e.g., PUBLIC HEALTH AGENCY)		20. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED _____ DISCHARGED _____		
21. NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE)			22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? YES <input type="checkbox"/> NO <input type="checkbox"/>			23. A. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY; RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE 1, 2, 3, ETC. OR DX CODE		23B. EPSTD <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> FAMILY PLANNING <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>		
24. DATE OF SERVICE			24B. PLACE OF SERVICE			24C. FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN (IDENTIFY PROCEDURE CODE)			24E. DAYS OR UNITS	
24A			24B			24C			24G. CHARGES BILLED MEDICARE	
									24H. MEDICARE'S ALLOWED CHARGES	
									27. TOTAL CHARGE	
									28. MEDICARE TOTAL PAYMENT	
									30. INSURANCE OTHER THAN MEDICARE/MEDICAID	
									31. BALANCE DUE	
25. SIGNATURE OF PHYSICIAN OR SUPPLIER (INCLUDING DEGREE(S) OR CREDENTIALS) (I CERTIFY THAT THE STATEMENTS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART THEREOF)			26. ACCEPT ASSIGNMENT (GOVERNMENT CLAIMS ONLY) YES <input type="checkbox"/> NO <input type="checkbox"/>			29. YOUR SOCIAL SECURITY NO.			34. I.D. NO.	
SIGNED _____ DATE _____			32. YOUR PATIENT'S ACCOUNT NO. REMARKS:			33. YOUR EMPLOYER I.D. NO.			34. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE & PHONE NO.	

Help us make sure your payment is correct and prompt -- check your claims for accuracy and completeness before you submit them to us. *Many claims suspend because of math errors in fields 27 through 31.

Important Billing Reminder to Complete UB-92 Critical Fields

We've recently changed our claim processing procedures to include a screening of certain critical fields on paper claims before entering them into our MMIS payment system. The screening allows us to identify incomplete claims and return them to you for completion. We will highlight your returned claim showing the incomplete field.

Reasons for Returning Claims

In the screening, our staff are checking to make sure the following fields (shaded in the sample at right) on the UB-92 are complete:

- 4 Type of Bill - enter the appropriate 3-digit code.
- 6 Statement Covers Period - enter dates using MMDDYY format (example: 072805).
- 12 Patient's Name - enter the name as it appears on the OMAP Medical Care ID.
- 17 Admission Date - enter the date using MMDDYY format.
- 42 Revenue Codes - enter the appropriate 3-digit code.
- 51 Provider Number - enter your 6-digit OMAP provider number on the line that corresponds to the line you entered OMAP's payer information in field 50.
- 60 Cert-SSN-HIC-ID No. - enter the 8 alpha/numeric characters found in field 11 of the client's OMAP Medical Care ID
- 67 Principal Diagnosis Code - enter the ICD-9-CM code that best describes the principal diagnosis.

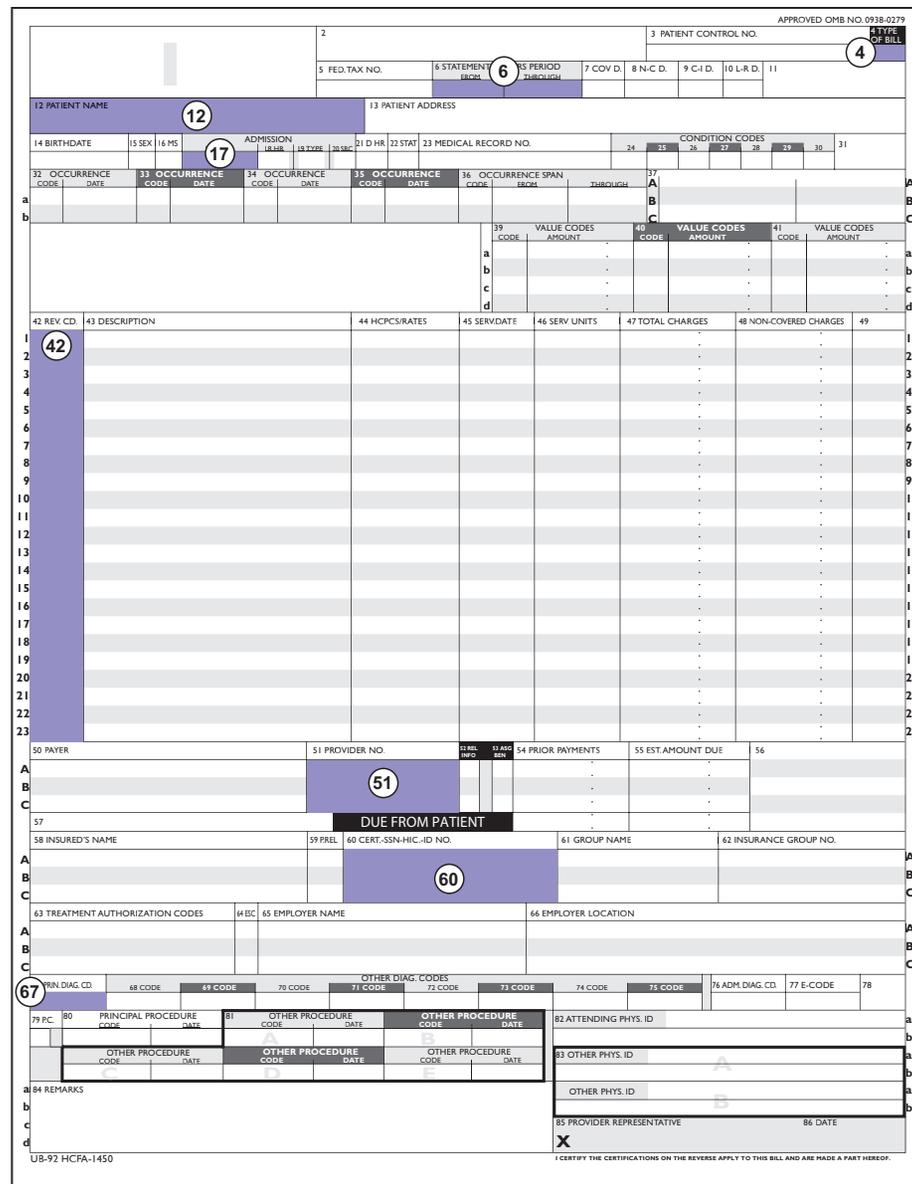
Help us make sure your payment is correct and prompt -- check your claims for accuracy and completeness before you submit them to us.

Need Help?

This screening process is only for certain fields, not all required fields. We have developed several booklets and training materials to help you complete claim forms and identify all required fields on a claim form.

These materials can be found on our web page at: http://www.oregon.gov/DHS/healthplan/tools_prov/tips/main.shtml

Call our Provider Relations Unit, if you have billing questions, at 1-800-336-6016.



The image shows a sample UB-92 form with several critical fields highlighted in purple and numbered. The highlighted fields are: 4 (Type of Bill), 6 (Statement Covers Period), 12 (Patient Name), 17 (Admission Date), 42 (Revenue Codes), 51 (Provider Number), 60 (Cert-SSN-HIC-ID No.), and 67 (Principal Diagnosis Code). The form includes various sections for patient information, admission details, occurrence codes, value codes, and charges. The bottom section includes remarks and provider information.

