

**Health Services
Office of Medical Assistance Programs**

Allison Knight, Acting Manager
OMAP Program and Policy Section

Authorized Signature



Number: OMAP 05-195

Issue Date: 12/09/05

Topic: Medical Benefits

Subject: FCHQ/RHC Provider Announcement: Clarification of QMB-only billing policy

Applies to (check all that apply):

- | | |
|--|--|
| <input type="checkbox"/> All DHS employees | <input type="checkbox"/> County Mental Health Directors |
| <input type="checkbox"/> Area Agencies on Aging | <input type="checkbox"/> Health Services |
| <input type="checkbox"/> Children, Adults and Families | <input type="checkbox"/> Seniors and People with Disabilities |
| <input type="checkbox"/> County DD Program Managers | <input checked="" type="checkbox"/> Other (please specify): OMAP + Plans |

Message: OMAP will send the attached announcement to Federally Qualified Health Clinics and Rural Health Clinics to clarify OMAP billing policy for Qualified Medicare Beneficiaries (QMB)-only clients.

If you have any questions about this information, contact:

Contact(s):	Daneka Karma, FQHC/RHC Program Manager		
Phone:	(503) 945-6926		
E-mail:	daneka.karma@state.or.us		



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December 7, 2005

To: Federally Qualified Health Centers
(FQHC) and Rural Health Clinics (RHC)

From: Allison Knight, Manager
OMAP Program and Policy Section



Subject: Clarification for Billing Qualified Medicare Beneficiary—QMB-Only Clients

OMAP has identified a billing error that will cause your QMB claims to deny. Effective immediately:

When billing OMAP as secondary, FQHC/RHC providers must list the total Medicare-allowed amount minus any Medicare reductions—NOT your encounter rate—as total billed. If you list the encounter rate, the system will deny your claim.

See specific billing instructions and examples on the second page.

Clients identified on the OMAP Medical Care ID as “C ” (QMB-only) in Field 9b are Medicare beneficiaries. Therefore:

- They will all have a third party resource (TPR)—Medicare—that you need to bill first.
- OMAP pays ONLY their Medicare deductibles, premiums and coinsurance for the services Medicare covers, so providers must not charge the client for these three items.
- Providers may bill clients for health services that Medicare does not cover.

Refer to the Administrative Rules regarding this benefit package, OAR 410-120-1210 Medical Assistance Benefit Packages and Delivery Systems. OMAP posts the General Rules online: <http://www.dhs.state.or.us/policy/healthplan/guides/genrules/main.html>.

Questions?

If you have questions about this policy, please contact your OMAP Policy Analyst, Daneka Karma at (503) 945-6926 or by e-mail at daneka.karma@state.or.us.

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Billing instructions

If the service falls under the QMB client's deductible, and Medicare did not make any payment, you must list "UD" (under deductible) or "MU" (primary and secondary insurance under deductible) in field 9 of the CMS-1500 claim form.

Here are examples of correct Medicare Maximum Allowable minus reduction.

SAMPLE Medicare Remittance Advice Form

PERF	PROV	SERV DATE	POS	NOS	PROC	MODS	BILLED	ALLOWED	DEDUCT	COINS	GRP/RC-AMT	PROV PD
	NAME SMITH, JOHN				HIC XXXXXXXXXA		ACNT YYYYYYY		ICN ZZZZZZZZZZZZ		AAA B CCC DDDD EEEEE	
					I 90806		\$84.00	\$69.34	\$0.00	\$8.67 COB6	\$14.66	\$34.67
										PR-122	\$26.00	
PA RESP	\$34.67				CLAIM TOTALS		\$84.00	\$69.34	\$0.00	\$8.67	\$40.66	\$34.67

PR = Patient Responsibility
122 = Psychiatric Reduction

The Medicare maximum allowed amount that should be submitted to OMAP (Medicaid) will be \$43.34, Medicare's allowed amount \$69.34 reduced by PR-122 \$26.00.

To clarify, \$43.34 (Medicare max) - \$34.67 (Medicare paid) = \$8.67, the coinsurance amount listed on the Medicare RA.

Therefore, the amount OMAP pays to the provider cannot exceed \$8.67.

Example 2

PATIENT NAME	PATIENT CNTRL NUMBER	FRM DT	COST	REPTD CHGS	DRG NBR	OUTLIER AMT	REIMB RATE	ALLOW REIM	INTEREST
ICN NUMBER	HIC NUMBER	THR DT	DOVDV	NCVD/DENIE D	DRG AMOUNT	DEDUCTIBLE	MSP PRI PAY	PROC CD AMT	PAT REFUND
CLAIM #/CLM STATUS	MEDICAL REC NUMBER	PAT ST	NCVDV	CLAIM AKJS	DRG O-C	COINS AMT	PROF COMP	LINE ADJ AMT	PERDIEM AMT
NAME CHG-xx	HIC CHG=x TOB=xxx	CV LN	NCV L	COVD CHGS	NEW TECH	MSP LIAB MET	ESRD AMT	CONT ADJ AMT	NET. REIM
JONES A B	00000001	051201	0	88.96			70.750	42.06	0.00
1234567890	11111111A	051201	0	0.00	0.00	18.17	0.00	0.00	0.00
1 1	ABC12345		0	0.00	0.00	14.16	0.00	14.57	70.75
NAME CHG-OC	HIC CHG-HN TOB=711	0	0	88.96	0.00	0.00	0.00	0.00	42.06

The Medicare maximum allowed amount that should be submitted to OMAP (Medicaid) will be \$74.39, Medicare's "COVD CHGS" (covered charges) of \$88.96 reduced by the "LINE ADJ AMT" (line adjustment amount, or Medicare's reduction) of \$14.57.

To clarify, \$74.39 (Medicare max) - \$42.06 (Medicare paid) = \$32.33, the coinsurance (\$14.16) and deductible (\$18.17) amounts listed on the Medicare RA.

Therefore, the amount OMAP pays to the provider cannot exceed \$32.33.