

Hospital Services Provider Guide

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

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Client eligibility and enrollment

Refer to [General Rules](#) and [OHP Rules](#) for information about 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 Web 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. For complete instructions on how to submit PA requests to DMAP, see the [Prior Authorization Handbook](#). For OHP coordinated care organization (CCO) or managed care plan members, contact the CCO/plan for PA instructions.

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 Web 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 DMAP Medical Management 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 DMAP 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 DMAP:

- **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 "DMAP" 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

DMAP accepts the following codes:

Inpatient Codes	Outpatient Codes
<ul style="list-style-type: none">■ 111 - For most inpatient services, including patients with Medicare Part A coverage only■ 121 - For patients with Medicare Part B coverage only	<ul style="list-style-type: none">■ 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 DMAP 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.

- DMAP 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 1 and 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

Use ICD-9-CM codes for dates of discharge on or before 9/30/2015, and ICD-10-CM codes for dates of discharge on or after 10/1/2015.

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 [ICD-9](#) and [ICD-10](#) code lists.
- Some codes do not require a POA indicator. See our [ICD-9](#) and [ICD-10](#) lists 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 DMAP for the collection of blood through venipuncture or capillary puncture, or the collection of a urine sample by catheterization. However, DMAP 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 one of the following codes in FL 67:

Type of service	ICD-9 code	ICD-10 code
Physical therapy	V57.1	Z51.89
Occupational therapy	V57.21	
Speech-language therapy	V57.3	
Audiology	V57.89	
Durable medical equipment	V58.9	

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.

Diagnosis codes exempt from 30-day readmissions policy – See 410-125-0410

Lists of exempt codes are available in [ICD-9](#) and [ICD-10](#).

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.

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](#).

Hospital Hold Request (OHP 3261)

When hospitals admit individuals for inpatient stays with no OHP coverage, they can submit the individual's information on the [OHP 3261 form](#). The individual's OHP application request will then be dated the hospital admission date. If the individual qualifies for OHP coverage, the effective date of coverage will be the hospital admission date.

Please list all admissions for the day on a single OHP 3261. Email the completed form to OHP Customer Service at application.requests@state.or.us. Requests must be submitted within 24 hours of the admission time.

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

The DMAP form 42 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.

Submitting your completed DMAP form 42 to DMAP provides necessary information that is used by DMAP to determine final Fee For Service (FFS) and Managed Care Organization (MCO) Medicaid cost settlements for the period. Since the DMAP form 42 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.

DMAP will send hospital providers the DMAP 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 [DMAP's HPE page](#).

To learn more about HPE eligibility criteria, see OAR 410-200-0105 in [the Office of Client and Community Services Medical Program rules](#).