Institutional Billing Instructions

Fee-for-service billing instructions for MMIS Provider Portal and UB-04 institutional claim formats for Oregon Medicaid providers

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Introduction

The *Institutional Claim Instructions* handbook is designed to help those who bill 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. You can find all provider guidelines at www.oregon.gov/OHA/HSD/OHP/pages/policies.aspx.

The institutional claim is also known as the UB-04. Throughout this handbook you will see the claim type referred to as an institutional 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 *Institutional Claim Instructions* are designed to assist the following providers:*

- Freestanding Kidney Dialysis Centers
- Home Health Agencies
- Hospice Services
- Hospitals
- Mental Health Institutions
- Nursing Facilities

*This list does not include all provider types that use the institutional 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.

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 go first to the ODHS/OHA Office of Imaging and Record Management Services (IRMS).

- The document is scanned through an Optical Character Recognition (OCR) machine and the claim is given an Internal Control Number (ICN).
- 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).

Web 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.

Once the data enters the MMIS, staff can immediately access submitted claim information by checking certain MMIS screens.

About the ICN

The ICN is an intelligent 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; ‘14’ (2014).
- 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.

Claim edits and review

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. There are two types of claim review: One type is a *suspense (suspended) claim*, and the other is a *financial hold.*

Remittance advice

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 dhs.edisupport@state.or.us for more information.

Before you bill OHA:

1. **Verify that the client is eligible on the date(s) of service for the services rendered.** Claims for services to clients enrolled with an OHP coordinated care organization (CCO) must be billed to the appropriate CCO.
    - In order for Skilled Nursing Facility (SNF) co-insurance claims to process successfully, the client’s benefit plan must be *BMD (OHP with Limited Drug), BMM (QMB + OHP with Limited Drug),* or *MED (QMB only)* for the dates of service you are billing.

- For Nursing Facility (NF) claims to process successfully, the client must also have the *NFC (Nursing Home)* benefit plan and an Oregon Medicaid Plan of Care (POC) for the dates of service you are billing.

2. **Medicaid is always the payer of last resort.** If the client has Medicare or third-party insurance, bill them first before billing Medicaid.

Institutional web claim instructions

When to submit a web claim

In order to use the web portal to submit claims, you must have received your Personal Identification Number (PIN) from OHA. If you do not know your PIN, contact Provider Services at 800-336-6016 for assistance.

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

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

- **Verify that you are signed on and are acting on behalf of the correct provider.** It is crucial to make sure you are logged on under the correct provider number because this is the provider OHA will pay.
- **You must complete and submit the claim in its entirety in order to save the data entered.** Partially completed claims data cannot be saved.
- **The session will end after 20 minutes of inactivity.** Any work or changes that have not been submitted will be lost.

- **Make sure you review all screens and enter all required and/or applicable data in each screen.** The institutional claim has 12 screens (see below). In some screens you simply move from field to field while in others you must indicate you wish to "Add" information by clicking the "Add" button.

  1. Institutional Claim Header
  2. Diagnosis
  3. Condition
  4. Payer
  5. Procedure
  6. Occurrence/Span
  7. Value
  8. Third-Party Liability (TPL)
  9. Medicare Information
  10. Detail Line Item
  11. Hard Copy Attachments
  12. Claims Status Information

How to submit an institutional web claim

Go to "Claims," then click on "Institutional." The following screen will appear:

Institutional Claim

Billing Information

ICN	
Provider ID	1811
Client ID*	[Search]
Last Name	
First Name, MI	
Date of Birth	
Patient Account #	
Medical Record #	
Attending Phys	[Search]
Taxonomy	
Zip+4	
Referring Phys	[Search]
Facility Number	[Search]
Taxonomy	
Zip+4	
Other Physician	[Search]
Taxonomy	
Zip+4	
Insurance Denied	

Mailbox and Filename

Mailbox #	
File Name	

Service Information

Claim Type*	
Type Of Bill*	[Search]
From Date*	
To Date*	
Patient Status	[Search]
Admit Source	[Search]
Admission Type	[Search]
Admission Date	
Admission Hour	
Discharge Time	

Charges

Total Charges	$0.00

Diagnosis Condition Payer Procedure Occurrence/Span Value

TPL

*** No rows found ***

Select row above to update.

Last Name		Plan Name	
First Name, MI		Plan ID	[Search]
Date of Birth		Adjustment Reason Code	[Search]
Relationship		Adjustment Group Code	
Policy Number		Adjustment Amount	

delete add

Medicare Information

	Medicare Paid Date	Coinsurance Amount	Deductible Amount	Medicare Paid Amount
A		$0.00	$0.00	$0.00

Medicare Paid Date		Coinsurance Amount	
Deductible Amount		Medicare Paid Amount	

Detail

	Item	Revenue Code	HCPCS/Rates	Units	Charges	Non Covered Charges	Status
A	1			0	$0.00	$0.00	

Type data below for new record.

Item	1	Modifiers	[Search] [Search] [Search] [Search]
From DOS*		Units Of Measurement	
To DOS*		Status	
Units*	0	Allowed Amount	$0.00
Charges*	$0.00	CoPay Amount	$0.00
Non Covered Charges	$0.00	Medicare Paid Date	
Adjustment Reason Code	[Search]	Deductible Amount	$0.00
		Coinsurance Amount	$0.00
Adjustment Amount		Medicare Paid Amount	$0.00
Revenue Code*	[Search]	TPL Amount	$0.00
HCPCS/Rates	[Search]	Plan Payment Amount	
NDC			
NDC UOM			
NDC Quantity	0		

delete add

Hard-Copy Attachments

*** No rows found ***

Select row above to update -or- click Add button below.

Control Number	
Transmission	
Report Type	
Description	

delete add

Claim Status Information

Claim Status	Not Submitted yet

Coversheet for supporting documentation

Outpatient APC

*** No rows found ***

submit cancel

NOTICE: This information may be sensitive and/or private, thus subject to HIPAA privacy and security regulations. This information is not to be shared or distributed to persons without a right or business need to know.

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Step 1: Enter header information

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

Institutional Claim

Billing Information

ICN

Provider ID 1811061708 NPI

Client ID* [Search]

Last Name

First Name, MI

Date of Birth

Patient Account #

Medical Record #

Attending Phys [Search]

Taxonomy

Zip+4

Referring Phys [Search]

Facility Number [Search]

Taxonomy

Zip+4

Other Physician [Search]

Taxonomy

Zip+4

Insurance Denied

Mailbox and Filename

Mailbox #

File Name

Service Information

Claim Type*

Type Of Bill* [Search]

From Date*

To Date*

Patient Status [Search]

Admit Source [Search]

Admission Type [Search]

Admission Date

Admission Hour

Discharge Time

Charges

Total Charges $0.00

Diagnosis Condition Payer Procedure Occurrence/Span Value

Clicking on the link directly below the Institutional Claim Header screen opens the Diagnosis, Condition, Payer, Procedure, Occurrence/Span, and Value code screens.

Institutional claim field descriptions

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

Field	Description
ICN	Internal control number of the claim. (Read-only)
Provider ID	National Provider Identifier (NPI) or Medicaid Provider ID number associated with this Provider Web Portal login. (Read-only)
Client ID*	Client identification number.
Last Name	Last name of the client.(Read-only)
First Name, MI	First name of the client. (Read-only)

Field	Description
Date of Birth	Client's date of birth. (Read-only)
Patient Account #	Identification for a client assigned by a provider.
Medical Record #	Medical record number.
Attending Physician	NPI of the attending physician, followed by NPI taxonomy and ZIP+4. The attending physician would be expected to certify and recertify the medical necessity of the services rendered and/or have primary responsibility for the client's medical care and treatment. • This field is required on all long-term care (LTC) and hospital claims. • For LTC and hospital claims, the attending physician's NPI must be a valid NPI on file with the National Plan and Provider Enumeration System (NPPES). • The attending physician must be enrolled with OHA. • When the attending physician is a resident at a teaching hospital, enter the supervising physician's information.
Referring Physician	NPI or Medicaid Provider ID number of the referring provider, followed by NPI taxonomy and ZIP+4. • The referring physician must be enrolled with OHA to comply with Affordable Care Act requirements.
Facility Number	NPI or Medicaid Provider ID number of the facility where services were rendered, followed by NPI taxonomy and ZIP+4.
Other Physician	NPI or Medicaid Provider ID number of the other physician who performed services, followed by NPI taxonomy and ZIP+4.
Insurance Denied	Indicates if other insurance was paid or denied.

Field	Description
Mailbox and filename	For claims submitted via electronic data interchange (EDI), this indicates the mailbox and filename of the EDI submission. (Read-only)
Claim Type*	Code that specifies the type of claim record. • **For SNF claims, select A – Inpatient Crossover.** Technically, these are not crossover claims; this claim type is used to identify claims that are billed to both Medicare and Medicaid.
Type of Bill*	Code that indicates the specific Type of Bill (see Appendix for accepted Type of Bill codes).
From Date*	Date on which the statement period on the claim began. **Notes for nursing facilities:** • Medicare Part A and Part B claims should include the "From" and "Through" dates as indicated on the Medicare payment listing or EOB. • The Statement Covers Period must be a continuous period of time. A new claim must be submitted each time there is a break in service. See the "Breaks in service" section of the Appendix for how to bill for months with a break in service. • For LTC claims, when a resident is discharged, the "Through" date must be one day prior to the date of discharge. • For SNF claims, when a resident is discharged, the "Through" date must be the date of discharge.
To Date*	Date on which the statement period on the claim ended. • **For SNF claims,** see the "Breaks in service" section of the *Appendix* for how to bill for months with a break in service.

Field	Description
Patient Status	Code that indicates the discharge status of the client as of the ending service date of the period covered on an institutional claim. **For SNF claims:** • Use Status Code 30 (Still a Patient) when the resident is still a patient in your facility at the end of the statement period. • Use all other status codes to indicate the patient's status at the time they were discharged from your facility (*e.g.,* 02 – Discharged/Transferred to Another Short-Term General Hospital for Inpatient Care).
Admit Source	Code that indicates why the client was admitted.
Admission Type	Code that indicates the priority of the admission for inpatient or outpatient care.
Admission Date	Date that the provider admitted the client for inpatient care, outpatient care, or start of care.
Admission Hour	Hour during which the client was admitted for inpatient or outpatient care.
Discharge Time	The discharge time.
Covered Days	Number of days covered for the statement period of the claim.
Non Covered Days	Number of days not covered for the statement period of the claim.
Total Charges	Total amount charged for the claim. Sum of all charges are derived from the detail Line Item screen. (Read-only)

Step 2: Enter diagnosis information

Click on the "Diagnosis" link under the claim header; click "add" to add a diagnosis. Enter up to 10 diagnosis codes. Do not use decimals when entering diagnosis codes.

Diagnosis
*** No rows found ***
Select row above to update -or- click Add button below.
Sequence | Diagnosis | [Search]
Present on Admission | Description
ICD Version
delete | add

Field descriptions

Field	Description
Sequence	The sequence of the diagnosis. Used for the Diagnosis Code Pointer on the Institutional Claim-Detail screen.
Present on Admission	Required for inpatient claims; valid options are Y (Yes), N (No), U (Documentation insufficient) or W (Clinically undetermined).
Diagnosis	Code indicates the diagnosis. Use the “search” hyperlink next to this field to look up the diagnosis.
Description	Description of the diagnosis entered. (Read-only)
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.	Diagnosis displays.

Diagnosis search screen

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

Diagnosis [Close]
Search
Diagnosis | Description typhoid fever
ICD Version
search | clear

Search Results

Diagnosis	Description	ICD Version	Effective Date	End Date
0020	Typhoid fever	9	07/01/1981	09/30/2015
A010	Typhoid fever	10	10/01/2015	12/31/2299
A0100	Typhoid fever, unspecified	10	10/01/2015	12/31/2299
A0102	Typhoid fever with heart involvement	10	10/01/2015	12/31/2299
A0109	Typhoid fever with other complications	10	10/01/2015	12/31/2299

To look up a diagnosis via the search screen

You can only look up a diagnosis after you click the “add” button.

Step	Action	Response
1	Click the “search” hyperlink.	Diagnosis search screen displays.
2	Enter either a diagnosis code or a diagnosis description, then click search.	Search display diagnosis options.
3	Click on the line item that displays the most appropriate diagnosis.	Diagnosis code and description displays.

To delete a diagnosis

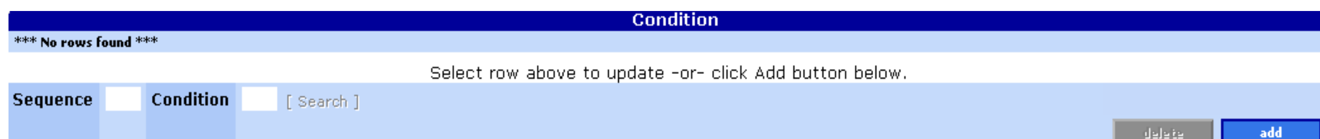
Step	Action	Response
1	Click on the line item to be deleted.	Data populates fields in the Diagnosis screen.
2	Click the Delete button. Note: The delete button deletes selected data on the current screen. It does not delete the claim.	Dialog displays to confirm deletion.
3	Click OK.	

To update a diagnosis

Step	Action	Response
1	Click on 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.

Step 3: Enter condition codes

Click the “Condition” link under the claim header; click “add” to add a condition.



Field descriptions

Field	Description
Sequence	Number that indicates the position of conditions listed on the claim.
Condition	Code used to identify conditions relating to an institutional claim that may affect payer processing. Use the “search” hyperlink next to this field to look up the code instead of typing it in.

To add a condition code

Step	Action	Response
1	Click the Add button.	Condition field is activated for data entry.
2	Enter the Sequence and Condition. Or, use the condition code search screen (click the “search” hyperlink” next to the Condition field).	Condition code displays.

Condition Search Screen

This screen allows you to verify or look up a condition code.

Condition [Close]
Search
Condition 31 Description
search clear
Search Results

Condition	Description
31	PATIENT IS STUDENT (FULL TIME DAY)

To look up a condition code

You can only look up a condition code after you have added a condition code line using the “Add” button.

Step	Action	Response
1	Click the “search” hyperlink.	Condition code search screen displays.
2	Enter either a condition code or a description. Then click search.	Search display condition options.
3	Click on the line item that displays the most appropriate condition code.	Condition code and description displays.

To delete a condition code

Step	Action	Response
1	Click on the line item to be deleted.	Data populates fields in the Condition Code 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 condition code

Step	Action	Response
1	Click on the line item to be updated.	Data populates detail fields.
2	Enter updated data in the Condition Code field.	Condition code will display.

Step 4: Add payer information

Click the “Payer” link under the claim header; click “add” to add a payer. This screen allows you to enter other payer organizations you have billed and the amounts paid, if any.

- **For Medicare-Medicaid claims:** Add Medicare as the primary payer.

Payer
*** No rows found ***
Select row above to update -or- click Add button below.
Sequence
Payer
Prior Payment
Estimated Amount Due
delete
add

Field descriptions

Field	Description
Sequence	Number indicating the order that a payer appears on the claim (1 for primary payer, 2 for secondary, etc.).
Payer	Indicates if the payer is Medicaid, Medicare, or other third party.
Prior Payment	Amount has been received from this payer.
Estimated Amount Due	Amount still due after the prior payment.

To add a payer

Step	Action	Response
1	Click the Add button.	Payer fields are activated for data entry.
2	Enter the sequence, payer, and estimated amount due. Enter prior amount, if applicable.	Payer line item displays.

To delete a payer

Step	Action	Response
1	Click on the line item to be deleted.	Data populates fields in the payer 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 payer

Step	Action	Response
1	Click on the line item to be updated.	Data populates detail fields in the payer screen.
2	Enter updated data in the payer fields.	New payer information will display.

Step 5: Enter principal procedure code (for hospital inpatient claims)

Click “Procedure” under the claim header; click “add” to add a procedure. This screen allows you to enter the ICD-10 procedure code. The principal procedure code is used to describe the procedure performed for definitive treatment rather than for diagnostic or exploratory purposes.

Field descriptions

Field	Description
Sequence	Number that indicates the position of the procedure on the claim.
ICD procedure	Code that identifies the service provided.
Date	The date the procedure was performed.

To add a procedure code

Step	Action	Response
1	Click the Add button.	Procedure Code field is activated for data entry.
2	Enter the Sequence, Procedure Code, and Date Procedure was performed.	Procedure code displays.

ICD Procedure Code Search

Field descriptions

Field	Description
ICD-PROC	ICD procedure code

Field	Description
Description	Text description of the procedure code
ICD Version	The ICD version (ICD-9 or ICD-10)

To look up a procedure code

You can only search for a procedure code after you have added a procedure code line using the "Add" button.

Step	Action	Response
1	Click the "search" hyperlink.	Procedure code search screen displays.
2	Choose the ICD Version you want to search. Enter either a procedure code or a description. Click "search."	Search displays procedure options.
3	Click on the line item that displays the most appropriate procedure code.	Procedure code and description displays.

To delete a procedure code

Step	Action	Response
1	Click on the line item to be deleted.	Data populates fields in the Procedure Code 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 procedure code

Step	Action	Response
1	Click on the line item to be updated.	Data populates detail fields in the Procedure code screen.
2	Enter updated data in the Procedure Code field.	New Procedure code will display.

Step 6: Enter occurrence code and dates

Click the "Occurrence/Span" link under the claim header; click "add" to add an occurrence. This screen allows you to enter the occurrence code and associated beginning and end dates used to define specific events relating to the billing period.

For Skilled Nursing Facility (SNF) services, use this screen to enter the client's qualifying hospital stay. This information is critical in order to receive payment for SNF coinsurance or for the 20-day Post-Hospital Extended Care (PHEC) benefit.

All SNF claims billed for the resident for the month must refer to the same qualifying hospital stay dates. See the *Appendix* for information about how to bill when there is a break in service.

Occurrence/Span
*** No rows found ***
Select row above to update -or- click Add button below.
Sequence
From Date
Occurrence Code
[Search]
To Date
delete
add

Field descriptions

Field	Description
Sequence	Number that indicates the position of the occurrence on the claim.
Occurrence Code	The code identifying a significant event relating to this bill that may affect payer processing. Use the "search" hyperlink next to this field to look up the code instead of typing it in. • **For SNF claims**, enter Occurrence Code 70.
From Date	Beginning date of the occurrence. • **For SNF claims**, all claims billed for the month for the patient must use the same "From" date.
To Date	End date of the occurrence. • **For SNF claims**, all claims billed for the month for the patient must use the same "To" date.

To add an occurrence code

Step	Action	Response
1	Click the Add button.	Occurrence/Span Code fields are activated for data entry.
2	Enter the sequence, occurrence/span code and related from and to dates. Or, use the search feature to look up the occurrence/span code.	Occurrence/Span Code line item displays.

Occurrence Code Search Screen

This screen allows you to look up an Occurrence Code.

Occurrence Code [Close]

Search

Occurrence | Description Auto Accident

search clear

Search Results

Occurrence	Description
**	Test
00	Patient involved - collison
01	AUTO ACCIDENT
02	NO FAULT INS INVOLVED - INCLUD AUTO ACCIDENT/OTHER
03	ACCIDENT/TORT LIABILITY
04	ACCIDENT/EMPLOYMENT RELATED
05	OTHER ACCIDENT
06	CRIME VICTIM
09	START OF INFERTILITY TREATMENT CYCLE
10	LAST MENSTRUAL PERIOD

1 2 3 4 5 6 7 8 Next >

To look up an occurrence code

You can only search for an occurrence code after you have added a line for the occurrence code using the “Add” button.

Step	Action	Response
1	Click the “search” hyperlink.	Occurrence code search screen displays.
2	Enter either an occurrence code or a description. Then click search.	Search display condition options.
3	Click the line item that displays the most appropriate occurrence code.	Occurrence code and description displays.

To delete an occurrence code

Step	Action	Response
1	Click on the line item to be deleted.	Data populates fields in the occurrence/span code screen.
2	Click the Delete button.	Dialog displays to confirm deletion.
3	Click OK.	

To update an occurrence code

Step	Action	Response
1	Click on the line item to be updated.	Data populates detail fields in the occurrence/span code screen.
2	Enter updated data in the occurrence/span code fields.	New occurrence/span code information will display.

Step 7: Enter value code

Click the “Value” link under the claim header; click “add” to add a value. This screen allows you to enter the value code and related dollar or unit amount(s) to identify data of a monetary nature.

For hospice services, use this screen to enter the Cost-Based Statistical Area (CBSA) code for your county as a dollar amount.

Field descriptions

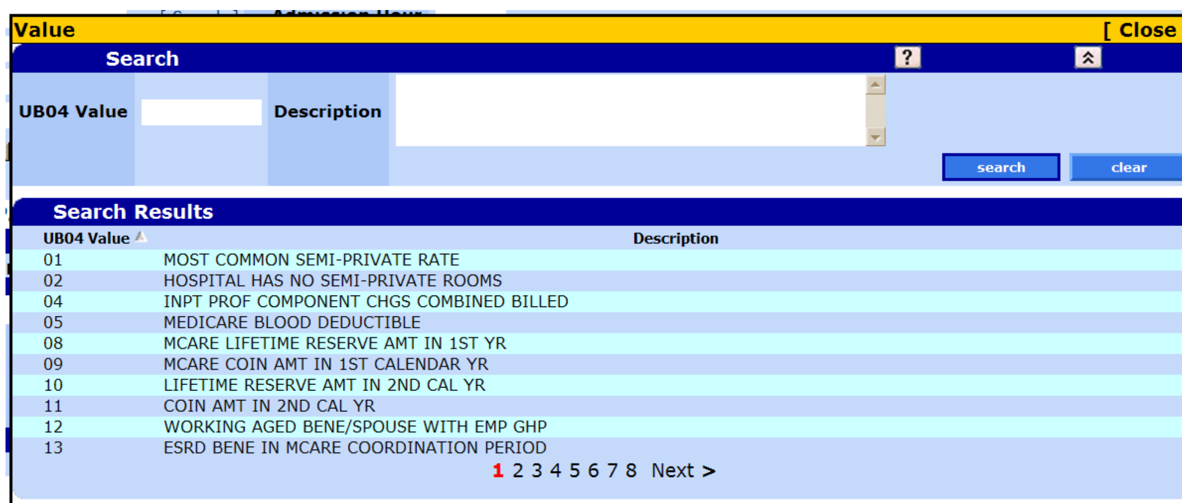
Field	Description
Sequence	Number that indicates the order of value codes appearing on the claim.
Value	Code used to relate values to identified data elements necessary to process an institutional claim. Use the “search” hyperlink next to this field to look up the code instead of typing it in.
Amount	Dollar amount of the corresponding value code.

To add a value code via the search screen

Step	Action	Response
1	Click the Add button.	Value Code field is activated for data entry.
2	Enter the sequence, value code and related dollar amount. Or, use the search feature to look up the value code.	Value Code line item displays.

Value Code Search Screen

This screen allows you to verify or look up a Value Code.



To look up a value code

You can only look up a value code after adding a value code line using the “Add” button.

Step	Action	Response
1	Click the Add button.	Search hyperlink is activated.
2	Click the “search” hyperlink.	Value code search screen displays.
3	Enter either a Value code or a description. Then click search.	Search display value code options.
4	Click the line item that displays the most appropriate value code.	Value code displays.

To delete a value code

Step	Action	Response
1	Click on the line item to be deleted.	Data populates fields in the Value Code 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 value code

Step	Action	Response
1	Click on the line item to be updated.	Data populates detail fields in the Value Code screen.
2	Enter updated data in the Value Code fields.	New Value Code information will display.

Step 8: 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. If applicable, TPL must be entered on each claim.

- Medicaid is the payer of last resort. If you report TPL in this part of the claim, this information should also be reflected in the Payer information.
- **Note**: Do not enter client liability (*e.g.,* copayments) on the claim.

TPL
*** No rows found ***
Select row above to update.
Last Name
First Name, MI
Date of Birth
Relationship
Policy Number
Plan Name
Plan ID [Search]
Adjustment Reason Code [Search]
Adjustment Group Code
Adjustment Amount
delete add

Field descriptions

Field	Description
Last Name	The TPL insured’s last name.
First Name/MI	The TPL insured’s first name and middle initial.

Field	Description
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.
Plan ID	The TPL insured's plan ID
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	This code identifies the general category of a payment adjustment.
Adjustment Amount	Monetary amount of the adjustment.

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	Click the Add button again.	Line item displays.

To delete a TPL

Step	Action	Response
1	Click on 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	Click on 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 9: Enter Medicare information

This section is only required for clients eligible for both Medicare and Medicaid services.

- Normally, when you submit your Medicare Part A (Hospital, hospital-related inpatient, and skilled nursing services) and 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 from Medicare, you must bill OHA separately and indicate what Medicare paid. Enter the Medicare information for the entire claim in the Medicare Information screen.

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.

Medicare Information

	Medicare Paid Date	Coinsurance Amount	Deductible Amount	Medicare Paid Amount
A		$0.00	$0.00	$0.00

Medicare Paid Date   Coinsurance Amount
Deductible Amount   Medicare Paid Amount

Field descriptions

Field	Description
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. Make sure the amount you enter in this field is for the deductible effective for the date of service billed.
Coinsurance Amount	Amount that represents the member's coinsurance payment (the amount that you are requesting from Medicaid).

Field	Description
	Note: If the amount you are requesting is zero (for example, an SNF claim for days 1-20 only), enter a zero in this field.
Medicare Paid Amount	The dollar amount paid by Medicare for the services. **Note:** This value may be more than what you originally billed Medicare. If so, be sure to enter the total Medicare/Plan-allowed amount in the “Charges” field on the Detail screen.

Step 10: 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. This date should be on or after the From date entered on the Header screen.
To DOS*	Ending date on which service was provided. This date should be on or before the To date entered on the Header screen.

Field	Description
Units*	Number of units billed for the service, for the From and To DOS dates entered. • When Patient Status is 30, include the units for the To Date of the range. • When Patient Status is any other code, do not include units for the To Date.
Charges*	Total dollar amount charged for the services. • **For Medicare-Medicaid claims,** enter the total allowed amount from your Medicare EOB. This may be more than the amount you originally billed Medicare.
Non Covered Charges	The non-covered charges.
Adjustment Reason Code	HIPAA Adjustment Reason Code (ARC) identifying the detailed reason the adjustment was made. On claims where Medicare is listed as payer, enter the appropriate ARC as found on the Medicare EOMB.
Adjustment Amount	The total dollar amount of the adjustment.
Revenue Code*	Code that identifies a specific accommodation, ancillary service or billing calculation. • **For SNF co-insurance claims,** enter code 0022. • **For Complex Medical Add-On (CMAO) services,** enter code 0229. • **For NF Basic Rate,** enter code 0100. • **For PHEC claims,** enter code 0101.
HCPCS/Rates	Code that identifies the service provided.

Field	Description
NDC	National Drug Code (NDC) that identifies the drug administered (for outpatient services only). • 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)
Modifiers	Code used to further define a procedure provided.
Units of Measurement	Code indicates measurement type.
Status	Claim status on the detail line. (Read-only)
Allowed Amount	Amount approved to pay for services provided to a client. (Read-only)
CoPay Amount	Amount paid by client for services performed. (Read-only)
The following information is required for Medicare-Medicaid claims only. Enter the following for each detail line. Amounts entered for all claim details should correspond to the total amount entered on the Medicare Information screen.	
Medicare Paid Date	The date Medicare pays 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 Medicare paid for the services.
TPL Amount	Dollar amount paid by third party liability for this detail line.

Field	Description
Plan Payment Amount	Dollar amount paid by OHP managed care plan for this detail line. Displays for managed care plan submissions only.

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, and Revenue code).	
3	Enter data in the remaining fields that are applicable or select the most appropriate data from the drop-down lists (Non-Covered Charges, TPL Amount, Adjustment Reason Code, HCPCS/Rates, Modifiers, and Units of Measurement).	

To delete a detail line item

Step	Action	Response
1	Click on 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.	

To update a detail line item

Step	Action	Response
1	Click on the line item to be updated.	Data populates detail fields in the Detail screen.

Step	Action	Response
2	Enter updated data in the From DOS, To DOS, Units, and Revenue code fields.	
3	Enter updated data in the remaining fields that are applicable or select the most appropriate data from the drop-down lists (Non Covered Charges, TPL Amount, Adjustment Reason Code, HCPCS/Rates, Modifiers, and Units of Measurement).	

Step 11: 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.** See Appendix for paper claim instructions.

Hard-Copy Attachments
Control Number Transmission Report Type Description
A
Type data below for new record.
Control Number*
Transmission*
Report Type*
Description
delete add

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	This tells OHA how you intend to provide access to the hardcopy attachment.
Report Type	Code describing the type of attachment /paperwork.
Description	Additional notes about the attachment /paperwork.

To add a hard copy attachment

Step	Action	Response
1	Click the Add button.	Hard Copy attachment activates.
2	Enter data in the Control Number and Description fields.	
3	Click the Transmission and Report Type drop-down arrows, and select an item from the list.	

To delete a hard copy attachment

Step	Action	Response
1	Click on the line item to be deleted.	Data populates fields in the hard copy Attachments 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 hard copy attachment

Step	Action	Response
1	Click on the line item.	Data populates detail fields.
2	Enter updated data in the Description field.	
3	Click the Transmission and Report Type drop-down arrows, and select an item from the list.	

Step 12: Submit claim and review claim status information

Before you click “Submit,” the following screen displays. Click the “Submit” button at the bottom of the screen to submit the claim.

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

Claim status information screen

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).

Claim Status Information

Claim Status	PAID
Claim ICN	2011182003344
Paid Date	07/01/2011
Allowed Amount	$8,669.19

Coversheet for supporting documentation

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.
Allowed Amount	The dollar amount allowed for the claim.
Coversheet for supporting documentation	Link to the coversheet used when submitting claim attachments This button allows you to print off an EDMS coversheet to attach to any supporting documentation you mail or fax in. The system will populate the ICN and mark the “Supporting documentation” checkbox for you. 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. See Appendix for paper claim instructions.

HIPAA Adjustment Reasons

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

HIPAA Adjustment Reasons

Detail Number	HIPAA Adjustment Reason Code	HIPAA Adjustment Reason Description
0	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).
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.
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.
3	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.
4	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.
5	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.
6	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.
7	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.
8	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.
9	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.
10	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.
11	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.
12	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.
13	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.

Field descriptions

Field	Description
Detail Number	The claim detail on which the EOB posted.
HIPAA Adjustment Reason Code	The ARC codes describing how OHA processed the claim.
Description	The description of the code.

Outpatient APC

If applicable, Ambulatory Payment Classification (APC) information shows on this screen.

Outpatient APC

Detail Number	Procedure Code	Payment APC	Procedure APC	APC Status Indicator
1	76805	00266	00266	S - Significant Procedure, Not Discounted when Multiple

Field descriptions

Field	Description
Detail Number	The claim detail that the APC information applies to.
Procedure Code	The procedure code that the APC information applies to.
Payment APC Procedure APC	The APC group that the procedure code belongs to. For a full list, see the Ambulatory Payment Classification codes on the Hospital Services page.
APC Status Indicator	Codes listed here explain whether the procedure paid at APC pricing, % billed or zero-paid. For a full list of indicators, see the APC indicators and actions list on the Hospital Services page.

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.

Claim Status Information

Claim Status	PAID
Claim ICN	2011182003344
Paid Date	07/01/2011
Allowed Amount	$8,669.19

Coversheet for supporting documentation

HIPAA Adjustment Reasons

Detail Number	HIPAA Adjustment Reason Code	HIPAA Adjustment Reason Description
0	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).
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.
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.
3	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.
4	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.
5	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.
6	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.
7	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.
8	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.
9	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.
10	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.
11	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.
12	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.
13	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.
14	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.
15	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.

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	1010246057001
Denied Date	09/08/2010
Allowed Amount	$0.00

HIPAA Adjustment Reasons

Detail Number	HIPAA Adjustment Reason Code	HIPAA Adjustment Reason Description
0	206	National Provider Identifier - missing.
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
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
1	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).
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
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
2	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).
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
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
3	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).
4	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
4	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
4	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).

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	9112094001006
Allowed Amount	$0.00

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.
0	206	National Provider Identifier - missing.
0	22	This care may be covered by another payer per coordination of benefits.
0	40	Charges do not meet qualifications for emergent/urgent care.
1	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).
2	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).
3	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).
4	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).
5	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).
6	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
6	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).
7	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).
8	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).
9	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).
10	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).
11	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).
12	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).
13	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).
14	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).
15	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	Correct all required and/or applicable fields. • Institutional Claim Header • Diagnosis • Condition • Payer • Procedure • Occurrence/Span • Value • TPL • Medicare Information • Detail • Hard Copy Attachments	

Step	Action	Response
2	Click the re-submit 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	Click on the copy button.	Duplicate claim displays with a claim status of “Not submitted yet.” Data fields are activated.
2	Update all required and/or applicable fields. • Institutional Claim Header • Diagnosis • Condition • Payer • Procedure • Occurrence/Span • Value • Third-Party Liability (TPL) • Medicare Information • Detail • Hard Copy Attachments	
3	Click the submit button.	The claim ICN and status is returned.

Appendix

Provider Portal resources

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

Quick reference: Submitting an institutional claim

Step	Action	Response
1	Go to the Claims menu.	The Claims menu options display.
2	Click Institutional.	The Institutional claim displays.
3	Enter data in all required and/or applicable fields. • Institutional Claim Header • Diagnosis • Condition • Payer • Procedure • Occurrence/Span • Value • Third-Party Liability (TPL) • Medicare Information • Detail • Hard Copy Attachments	
4	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	Click the Claims menu.	The Claims menu options display.
2	Click Institutional.	The Institutional claim displays.
3	Enter data in the client ID, patient account number, claim type, type of bill, from date, to date, and covered days field.	
4	Add a diagnosis, condition, payer, procedure, occurrence, and value code, if applicable.	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. Note: Report the total amount paid by Medicare for the entire claim. This information is found on the EOMB.	Medicare information displays.
7	Enter the detail line item information (from DOS, to DOS, units, charges, and revenue code). Report Medicare amounts and ARCs for each detail line, based on the EOMB.	Line item information displays.
8	Enter data in the remaining fields, if applicable. (Non-covered days, TPL amount, HCPCS/Rates, modifier, etc).	
9	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 hardcopy attachments, bill for claims over a year old, or as instructed by OHA for special handling.

Accepted forms

OHA only accepts commercially available, “red form” versions of the UB-04 claim form.

- We will return claims submitted in other formats, Turn-Around Documents (TAD) or Extended Care Invoices (DHS 1039) with a request to re-submit the claim on the correct form.
- OHA does not supply this form. This form is available through local business forms suppliers, or by calling the Standard Register Company, Forms Division at 800-755-6405.

Important notes about paper claim processing

OHA processes all hard-copy 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:

- 4 - Type of Bill
- 6 - Statement From and Through Dates
- 8b - Patient Name

If your forms are not to scale, or if the fields on your form are not correctly aligned, OHA will have problems processing your forms. OHA will have to 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.

Where to send claims

Mail	OHP Provider Services PO Box 14955 Salem, OR 97309
FedEx or drop-off	ODM 1430 Tandem Ave NE, Ste 100 Salem, OR 97301
Fax *(for nursing facilities only)* This method will delay processing since the claim will not be on a red-ink form.	503-378-4938 (Salem)

UB-04 claim form

The fields on the UB claim form are called Field Locators (FL). 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.

1
2
3a PAT. CNTL #
b. MED. REC. #
4
5 FED. TAX NO.
6 STATEMENT COVERS PERIOD FROM THROUGH
7
8 PATIENT NAME a
b 8b
9 PATIENT ADDRESS a b c d e
10 BIRTHDATE 11 SEX 12 ADMISSION 13 HR 14 TYPE 15 SRC 16 DHR 17 STAT
18 19 20 21 CONDITION CODES 22 23 24 25 26 27 28 29 ACDT STATE 30
31 OCCURRENCE CODE DATE 32 OCCURRENCE CODE DATE 33 OCCURRENCE CODE DATE 34 OCCURRENCE CODE DATE 35 OCCURRENCE SPAN CODE FROM THROUGH 36 OCCURRENCE SPAN CODE FROM THROUGH 37
38
39 VALUE CODES CODE AMOUNT 40 VALUE CODES CODE AMOUNT 41 VALUE CODES CODE AMOUNT
42 REV. CD. 43 DESCRIPTION 44 HCPCS / RATE / HIPPS CODE 45 SERV. DATE 46 SERV. UNITS 47 TOTAL CHARGES 48 NON-COVERED CHARGES 49
42 46 47
PAGE ____ OF ____ CREATION DATE
50 PAYER NAME 51 HEALTH PLAN ID 52 REL. INFO 53 ASG. BEN. 54 PRIOR PAYMENTS 55 EST. AMOUNT DUE 56 NPI
56
57 OTHER PRV ID
57
58 INSURED'S NAME 59 P. REL 60 INSURED'S UNIQUE ID 61 GROUP NAME 62 INSURANCE GROUP NO.
60
63 TREATMENT AUTHORIZATION CODES 64 DOCUMENT CONTROL NUMBER 65 EMPLOYER NAME
66 DX 67
68
69 ADMIT DX 70 PATIENT REASON DX 71 PPS CODE 72 ECI 73
74 PRINCIPAL PROCEDURE CODE DATE a. OTHER PROCEDURE CODE DATE b. OTHER PROCEDURE CODE DATE 75
c. OTHER PROCEDURE CODE DATE d. OTHER PROCEDURE CODE DATE e. OTHER PROCEDURE CODE DATE
76 ATTENDING NPI QUAL LAST FIRST
77 OPERATING NPI QUAL LAST FIRST
80 REMARKS 81CC
78 OTHER NPI QUAL LAST FIRST
79 OTHER NPI QUAL LAST FIRST
UB-04 CMS-1450 APPROVED OMB NO. NUBC LIC9213257 THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

Required Field Locators

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

- Make sure information is left-aligned and correctly placed in fields marked ***"Left-align."*** Misaligned information in these fields will delay processing.
- **When entering information in FLs 50-66, do not enter OHP (Medicaid) information on Lines A or B.** Line A is for Medicare information and Line B is for other payers, including Medicare supplemental plans and private health insurance.

Box	FL	Description
3a	**Patient Control No.**	If a patient account number is provided in this box, OHA will print it on the Remittance Advice (RA).
4	**Type of Bill** ****Left-align***	**Enter the appropriate three (3)-digit code that identifies the type of service you are billing for.** See the “Type of Bill Codes” section of the *Appendix* for specific codes by provider type, or refer to the provider guidelines for your program.

Box	FL	Description
6	**Statement Covers Period** ****Left-align***	**Enter the beginning and ending dates of service covered by this claim.** Use MMDDYY numeric format (example: 102813). Total days in this field must correspond to the number of units in FL 46. • "From" date is the date services began. • "Through" date is the date services ended. **Notes for nursing facilities:** • Medicare Part A and Part B claims should include the "From" and "Through" dates as indicated on the Medicare payment listing or EOB. • The Statement Covers Period must be a continuous period of time. A new UB-04 must be submitted each time there is a Break in Service. • For LTC claims, when a resident is discharged, the "Through" date must be one day prior to the date of discharge. • For SNF claims, when a resident is discharged, the "Through" date must be the date of discharge.
7	**Crossover indicator**	**Enter "XOVR" for Medicare Part B claims.** • Nursing facilities: Leave this field blank for ICF claims.
8b	**Patient Name** ****Left-align***	**Enter the client name exactly as it is printed on the Oregon Health ID (formerly Medical Care ID).** DO NOT use "nicknames".
12	**Admission Date**	**Enter the actual admission date.** Use MMDDYYYY format.
13	**Admission Hour**	**For inpatient and outpatient hospital services, enter the hour of admission.** Use numbers from 00 to 24 (01 = 1 a.m., 10 = 10 a.m., 13 = 1 p.m. 23 = 11 p.m., etc.).

Box	FL	Description
14	**Type of Admission or Service**	**For inpatient hospital services, enter the one (1)-digit code to indicate type of service.** Use one of the following codes (see OAR 410-125-0401 for definitions): • 1 - Emergent • 2 – Urgent • 3 – Elective • 4 - Newborn
16	**Discharge Hour**	**For inpatient and outpatient hospital services, enter the hour of discharge.** Use numbers from 00 to 24 (01 = 1 a.m., 10 = 10 a.m., 13 = 1 p.m. 23 = 11 p.m., etc.). For nursing facilities, this field is only required if the resident discharged on the last day of the Statement Covers Period.
17	**Patient Status**	**For inpatient hospital and nursing facility services, enter the two (2)-digit code to indicate patient status on the last date of service listed on the claim.** See *Appendix* for a list of codes.
31-34	**Occurrence Date**	**For SNF and PHEC services, enter the two (2)-digit code to indicate the type of occurrence, followed by the date of the occurrence.** Use MMDDYYYY format. • 01 – Auto accident • 04 – Employment-related accident

<table>
<tr><th>Box</th><th>FL</th><th>Description</th></tr>
<tr><td>35-36</td><td>Occurrence Span</td><td>For SNF and PHEC services, enter the two (2)-digit code to indicate the type of occurrence, followed by the beginning and end dates of the occurrence. Use MMDDYYYY format.
70 – Qualifying Hospital Stay Dates for SNF (FL 35): Enter the date the resident was admitted to the hospital and the date the resident discharged from the hospital.
Note: Occurrence code 70 and qualifying dates must be entered in FL 35 or 36 in order to receive payment for skilled nursing facility coinsurance or for the 20-day post hospital extended care (PHEC) benefit.</td></tr>
<tr><td>39-41</td><td>Value Codes</td><td>For Medicare Part A and B claims, enter the appropriate value code(s) for Medicare Coinsurance and Deductible when Medicare is the primary payer. For more information about accepted value codes, refer to the CMS Web site or NUBC UB-04 Manual.
Enter the appropriate code(s), followed by the dollars and cents money amount being reported.
Make sure the Medicare deductible reported in FL 39-41 is for the correct date of service. For example, if billing for a 2016 date of service, do not report a 2017 deductible amount.
Failure to correctly report the Medicare deductible may result in incorrect payment, suspended claims, or denied claims.
For hospice services, enter code “61” and the Cost-Based Statistical Area (CBSA) code for your service/county as a dollar amount. Refer to the</td></tr>
</table>

Box	FL	Description
		"Hospice rates" table of the *Hospice Services Supplemental Information* guide for CBSA codes.
42	Revenue Codes	**Enter the four (4)-digit code that most accurately describes the service provided.** • Nursing facilities: See the Appendix for a complete list of revenue codes. • For other providers: Refer to the supplemental information for your program. **Enter "0001" in line 23 of this field** to indicate the claim's total charges (entered in FL 47).
43	Revenue Description	**When billing for physician-administered drugs, enter the drug information as follows:** N4 (Qualifier), 11-digit National Drug Code (NDC) in 5-4-2 format, Unit of Measure, NDC quantity (fractional units limited to 3 digits to the right of the decimal). Use the following codes to indicate Unit of Measure: • F2 – International Unit • GR – Gram • ML – Milliliter • UN – Unit Example for NDC reporting: 42 REV. CD.: 0636 / 43 DESCRIPTION: N412345678901UN1234.567 / 44 HCPCS / RATE / HIPPS CODE: J#### [Enter UD for 340B drugs] 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.

Box	FL	Description
44	HCPCS/Rates	**Enter the five (5)-digit code for each Revenue Center Code requiring CPT/HCPCS.** Refer to the "Revenue Code Table" or rate information in your program's Supplemental Information handbook for revenue codes requiring CPT/HCPCS. Inpatient hospital services do not require CPT/HCPCS. If billing for physician-administered drugs, also enter modifier "UD" if billing for drugs purchased through a 340B entity (see example above). **Nursing facilities should leave this field blank.** Entering the daily rate in this field may cause the claim to deny, suspend or pay at the incorrect amount.
45	Service Dates	**For all nursing facility claims, enter Creation Date on line 23 (MMDDYYYY)**: Enter the date the bill was created or prepared for submission. Report this date on all pages of the UB-04.
46	Service Units	**Enter total days or units of service for each Revenue Code listed.** • One visit equals one unit of service. • One supply item equals one unit of service. • For nursing facilities, one day equals one unit of service. Notes for nursing facilities: • The total number of units must not exceed the total number of days in the "Statement Covers Period" in FL 6.

Box	FL	Description
		• NOTE: Any time there is a Break in Service, you must submit a new UB-04. See the Appendix for examples and details.
47	**Total Charges**	**Enter the usual and customary charge for each Revenue Code listed.** Enter the sum of all charges in line 23 of this field.
50	**Payer Identification**	**Enter the name(s) of the payer organizations you are billing (up to three payers) in the following order.** Do not list OHA information on Lines A or B. • Line A – Only use for Medicare (if applicable). • Line B – Only use for other third-party payers (including Medicare supplement or replacement plans, or long-term care insurance). • Line C – Leave blank or use only for Medicaid.
54	**Prior Payments**	**Enter the actual amount of any payments you received from Third Party Resources (TPR) for the Statement Covers Period.** Use the line that corresponds with the payer entered in FL 50. • Line A – Enter the actual amount of any payments received from Medicare. • Line B - Enter the actual amount of any payments from other third party payers. • Line C – Always leave blank. Do not list write-offs, what Medicaid previously paid, or copayments.
56	**NPI**	**Enter your ten (10)-digit National Provider Identifier.**
57	**Other Provider ID**	**On Line C, enter your six (6)- or nine (9)-digit Oregon Medicaid provider number.** OHA will pay this provider. Do not enter other numbers (*e.g.*, Medicare).

Box	FL	Description
60	**Insured's Unique ID**	**On Line C, enter the client's 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 Web Portal at https://www.or-medicaid.gov.
63	**Treatment Authorization Codes**	**If the service was prior authorized, enter the ten (10)-digit Prior Authorization number issued for the service on line C**.
67	**Principal Diagnosis Code**	**Enter the primary diagnosis/condition of the client by entering the current ICD-10-CM code.** The diagnosis code must be the reason chiefly responsible for the service being provided as shown in the medical records. • Carry out code to its highest degree of specificity. • DO NOT enter the decimal point.
67A – 67Q	**Other Diagnosis Codes**	**Enter additional ICD-9- or ICD-10-CM codes, as appropriate. For each code, also enter the Present on Admission (POA) indicator in the shaded area.** You can enter additional diagnosis codes for conditions that: • Coexist at the time of admission. • Develop subsequently. • Affect treatment received and/or length of treatment.
69	**Admit Diagnosis**	**For nursing facility and inpatient hospital services, enter the ICD-9 or ICD-10 code for the admitting diagnosis/condition.**
74	**Principal Procedure**	**For hospital inpatient claims, enter the ICD-9- or ICD-10-PCS code which best identifies the procedure completed.** The principal procedure is performed for definitive treatment rather than for diagnostic or exploratory purposes, or to treat a complication, or the procedure most related to the principal diagnosis.

Box	FL	Description
74A – 74B	**Other Procedure Codes and Dates**	**For hospital inpatient claims, when applicable:** Enter ICD-9- or ICD-10-PCS codes (up to two) for other procedures performed and the date on which the principal procedure was performed. Coding is not required for diagnostic and therapeutic procedures such as CT scans, physical, occupational, or respiratory therapy, or radiological studies.
76	**Attending Physician ID**	**For nursing facility and hospital claims**, enter the ten (10)-digit NPI for the attending physician (primary care physician). • The Attending Physician's NPI is required on all long-term care claims. Effective 10/1/2015, it is also required on all hospital claims. • The NPI must be a valid NPI registered with NPPES; the attending physician must be enrolled with OHA. • When the attending physician is a resident at a teaching hospital, enter the supervising physician's information.
78	**Other Physician ID**	Enter the referring physician's ten (10)-digit NPI, followed by the six (6) or nine (9)-digit Oregon Medicaid provider number. • For **Primary Care Manager (PCM) clients**, enter the PCM's provider numbers. • The referring physician must be enrolled with OHA to comply with Affordable Care Act requirements.
80	**Remarks**	**If the client has other medical coverage, enter the appropriate two (2)-digit third party resource (TPR) explanation code.** See *Appendix* for TPR explanation codes.

Helpful tips before billing OHA

Additional information is available on the OHP website at **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. Click on "OHP policies" in the left-hand menu of the Web page," then select the policy program you want to view.
- Nursing facilities can view Aging and People with Disabilities (APD) provider guidelines on the APD Provider Tools page.
- If you do not have Internet access, you may contact OHA at 800-527-5772 and ask to have OHP provider guidelines mailed to you.

OBTAIN PRIOR AUTHORIZATION (PA) when applicable. Refer to your provider guidelines for the specific services that require PA.

Nursing facilities must obtain prior authorization from the local APD/AAA office before providing nursing facility services to Medicaid-eligible individuals.

VERIFY client eligibility and enrollment on the date of service. Use one of the services listed on the OHP Eligibility Verification web 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 UB-04 claim form must match the name and number shown on the client's Oregon Health ID. The General Rules supplemental information book shows an example of an Oregon Health ID. The Oregon Health ID is always 8 characters.

MAKE SURE that you billed prior resources (*e.g.*, Medicare, private insurance, long-term care insurance) and reported the correct dollar amount in Lines A (for Medicare) or B (for other payers) of FL 54.

DO NOT attach prior resource EOBs.

DO NOT enter OHA information on Lines A or B of FLs 55-63. If you need to enter OHA information, enter it on Line C.

ALWAYS USE the correct 2-digit third-party resource (TPR) explanation code in the Remarks field (FL 80) when the client has TPR. If the client has TPR, you must enter the appropriate code even when the TPR made no payment. Always enter a code if the client has more than one TPR available.

USE commercially available "red form" versions of the UB-04 (not black and white copies). OHA will return claims submitted on black and white forms with a request to submit on "red form" or electronic format.

USE only one prior authorization number on Line C of FL 63.

ALWAYS ENTER the 6- to 9-digit Oregon Medicaid provider number you want OHA to send payment to on Line C of FL 57, and your National Provider Identifier (NPI) in FL 56. 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.

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 22 lines per claim, and poorly handwritten claim forms. Complete only the required boxes. Handwritten claims must be written in blue or black ink.

EACH UB-04 is a complete billing document. DO NOT carry over totals from one claim form to the other.

If there is not enough space available on the UB claim 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 your claim electronically.

For nursing facilities: If there is a break in service (*e.g.,* resident leaves facility due to hospitalization or other leave of absence), break in benefit package date ranges or change in level of care, use a separate UB-04 to bill for the time period following the break.

READ the explanation of benefit (EOB) codes on your Remittance Advice. They will tell you what the error is, and if you should re-bill or adjust the claim. For help reading the RA, go to http://www.oregon.gov/oha/HSD/OHP/Pages/Remittance-Advice.aspx.

CONTACT Provider Services at 800-336-6016 for questions regarding an institutional claim.

Type of Bill codes

Use in Field Locator (FL) 4 of the UB-04. OHA accepts the following codes:

Home Health Services

Code	Description
321	**Admit through Discharge Claim:** Encompasses an entire home health span of service for which the agency expects reimbursement.
322	**First Claim:** Use for the first of an expected series of payment claims for the same home health start of care.
323	**Interim-Continuing Claim:** Use when one or more claims for the same home health start of care have already been submitted, and further claims are expected to be submitted at a later date.
324	**Interim-Last Claim:** Use for a claim which is the last of a series for a home health start of care. The “through” date of this claim (FL 6) is the discharge date or date of death for this service span.

Hospice Services

Codes beginning in “81” indicate non-hospital based hospice services; codes beginning in “82” indicate hospital-based hospice services.

Code	Code	Description
811	**821**	**Admit through Discharge Claim:** Encompasses an entire course of hospice treatment. Use when no further bills will be submitted for this client (*i.e.*, client revokes or expires within the first billing period).
812	**822**	**First Claim:** Use this code for the first of an expected series of payment bills for course of treatment.
813	**823**	**Interim-Continuing Claim:** Use when a bill has been submitted and further bills area expected to be submitted.
814	**824**	**Last Claim:** Use for a bill which is the last of a series for a hospice course of treatment. The through date of this bill (FL 6) is the discharge date or date of death.

Hospital Services – Inpatient

Code	Description
111	Use for most inpatient billings, including clients with Medicare Part A coverage only.
121	Use for clients with Medicare Part B coverage only.

Hospital Services – Outpatient

Code	Description
131	Use for most outpatient billings.
141	Referenced diagnostic services
831	Hospital-based ambulatory surgery

Kidney Dialysis Services

Code	Description
721	Independent End Stage Renal Dialysis Facilities

Nursing facilities

Intermediate Care Facility (ICF) - The codes in this column are to be used when a facility has provided Medicaid long-term care to a resident in a nursing facility.

Skilled Nursing Facility (SNF) - The codes in this column are to be used when the facility has provided short-term skilled nursing facility services to a resident. This includes Medicare Part A (or Medicare Managed Care) stays only.

Swing-Beds (Swing) - The codes in this column are to be used by hospitals that have a Medicaid contract to provide swing bed services to Medicaid clients.

ICF	SNF	Swing	Description
651	**211**	**181**	**Admit through Discharge Claim:** Encompasses an entire span of service (admission through discharge) for which the facility expects reimbursement.
652	**212**	**182**	**First Claim:** Use this code when the resident is admitted to the facility and this is the first of an expected series of claims.
653	**213**	**183**	**Continuing Claim:** Use when one or more claims for the span of service have already been submitted, and further claims are expected to be submitted at a later date.
654	**214**	**184**	**Last Claim:** Use this code when the resident is discharged from the facility and this is the last in a series of claims. The “through” date of this claim (FL 6) is the discharge date or date of death for this service span.

Patient Status codes

This information is required for inpatient hospital and nursing facility claims only. Use in FL 17 of the UB-04.

Code	Description
01	Discharged to home or self-care (routine discharge)
02	Discharged or transferred to another acute care hospital
03	Discharged or transferred to skilled nursing facility (SNF)
04	Discharged or transferred to an intermediate care facility (ICF)
05	Discharged or transferred to another type of institution (not another acute care hospital)
06	Discharged or transferred to home under care of home health service organization
07	Left against medical advice

Code	Description
08	Discharged to home under care of Home Enteral/Parenteral Provider
20	Expired
30	Still a resident
50	Discharged or transferred to Hospice care
65	Discharged or transferred to a psychiatric hospital

NOTE: Nursing facilities are paid for the day a resident is admitted, but not the day they are discharged. The Patient Status Code is used during claims processing to determine whether or not to pay for the last date of service identified in FL 6 (Statement Covers Period) on the UB-04 claim form.

Nursing facilities can bill on a monthly basis for a resident who has not been discharged from the facility. **If the resident is not discharged or transferred on the last day of the Statement Covers Period, you must use Patient Status code 30 in order to get paid for the last day of the Statement Covers Period.** If you use any other Patient Status Code, the last day will be considered the day of discharge and you will not get paid for that day.

Revenue codes for nursing facilities

Use in FL 42 of the UB-04 form. The level of care (LOC) codes in this table are provided for reference only. **Do not use LOC codes when billing for NF services.** However, you may need to review with the resident's APD/AAA worker the appropriate LOC if you feel you are being overpaid or underpaid for the level of care you provide.

Type of care	Revenue code	Level of care	Description
ICF/LTC	100	01	Basic
		02	Pediatric
		04	Enhanced Care
		05	Outlier
		06	Out of State Nursing Facility
		10	Enhanced Care
	229	03	Complex Medical Add-On
Swing-Bed	101	N/A	Hospital Swing-Bed (Short Stay Only)

<table>
<tr><th>Type of care</th><th>Revenue code</th><th>Level of care</th><th>Description</th></tr>
<tr><td>20-day PHEC</td><td>101</td><td>N/A</td><td>Post Hospital Extended Care</td></tr>
<tr><td rowspan="2">SNF</td><td rowspan="2">022</td><td>N/A</td><td>Medicare (no co-insurance days)</td></tr>
<tr><td>N/A</td><td>Medicare (w/co-insurance days)</td></tr>
</table>

Additional information for nursing facilities

Billing cycles

Monthly claims

Nursing facilities will bill on a monthly basis for residents who are identified in FL 17 as “Still a patient” (Patient Status Code 30).

- Claims can be submitted on a monthly basis for services provided in the previous month(s).
- All claims must be submitted on or after the 1st day of the month following the month in which services have been provided. Facilities will be allowed to bill for services up to 12 months after the date the service was provided.
- Facilities cannot bill for future dates of service.

Partial month claims

Facilities can bill for a partial month if the resident is discharged or if the resident expires before the end of the month.

Denied claims

If a claim is denied you can re-submit the claim at any time, up to 18 months after the date the service was provided.

Suspended claims

If a claim is suspended for OHA review you must wait for OHA to complete the review and the claim is in a finalized adjudicated status of paid, partially paid or denied before resubmission.

Financial hold

If a claim is in a Financial Hold for OHA review you must wait for OHA to complete the review and the claim is in a finalized adjudicated status of paid, partially paid or denied before resubmission.

Paid claims

If determined after a review of a Paid claim that OHA did not pay the appropriate amount you can submit an individual adjustment request indicating the needed change (see the Claim Adjustment Handbook for web and paper adjustment instructions).

Breaks in service

Any time a resident is out of the facility past midnight and is expected to return, it is considered a *break in service*. A break in service includes, but is not limited to, a hospitalization and/or a leave of absence (*i.e.*, overnight or extended stay with family or friends).

Each time there is a break in service you must submit an additional UB-04 for each Statement Covers Period.

Example:

<table>
<tr><th>Date</th><th>Activity</th><th>How to bill</th></tr>
<tr><td>12/01/16</td><td>Resident is admitted to the nursing facility</td><td rowspan="2">Bill 12/1 through 12/5 on one claim</td></tr>
<tr><td>12/05/16</td><td>Resident goes to the hospital and is expected to return</td></tr>
<tr><td>12/06/16</td><td>Resident returns from the hospital and remains at the facility through the end of the month</td><td>Bill 12/6 through 12/31 on a separate claim</td></tr>
</table>

NOTE: Any time there is a break in service, you must notify the local APD/AAA office so the resident's Plan of Care can be updated. If the dates of service in the authorized Plan of Care do not match the dates of service on the claim(s), the claim(s) may be suspended or be denied.

Client (resident) liability

Do not enter client liability on the claim. Client liability is automatically deducted from the total billed amount indicated in FL 47 (Total Charges), Line 23.

- If you enter the client liability, this will deduct the client liability twice.
- To adjust this, you would need to submit an adjustment request (see the Claim Adjustment Handbook for web and paper adjustment instructions).

The amount of client liability deducted for a specific Statement Covers Period will be reported back to the nursing facility on the remittance advice (RA).

- If the liability amount is different than what you were expecting, you will need to contact the local APD/AAA office to verify the amount.
- If the liability amount needs to be adjusted, you will need to submit an adjustment request along with a copy of the Financial Planning form (SDS 0458A) for the dates of service on the claim.

Level of care (LOC)

Do not include the resident's level of care on the claim. APD sets the resident's level of care, which determines the maximum daily amount OHA will pay on the claim. If you bill more than this daily amount, you will still only be paid the maximum daily amount set by APD.

- If a resident's level of care needs to be adjusted, you must notify the local or central APD office. After receiving verification that APD has assigned a new level of care for the resident, you can bill according to the new daily limit.
- If you need to bill the higher level of care for days you have already billed, you will need to submit an adjustment request.

Change in LOC

If the LOC changes in the middle of a billing (*i.e.,* middle of the month), you will need to submit an additional claim each time the LOC changes. Example:

Date	Activity	How to bill
10/01/16	Resident admitted at the Basic LOC	Bill all of October on one claim

Date	Activity	How to bill
		Bill all of November on one claim
12/15/16	Resident approved for Complex Medical Add-On LOC	Bill 12/1 through 12/14 on one claim Bill 12/15 through 12/21 on a second claim Bill 12/22 through 12/31 on a third claim
12/22/16	Resident goes back to Basic LOC	

Skilled nursing facility (SNF) billing

For eligible residents, OHA will pay the Medicare Part A coinsurance rate for care rendered from the 21st day through the 100th day of care in a Medicare-certified nursing facility.

Note: Before billing OHA for coinsurance, the facility must bill the primary payer (Medicare or the managed care plan) responsible for the Medicare Part A benefit.

Submitting an SNF coinsurance claim

In order for OHA to identify and track days 1 through 20 (which Medicaid does not pay) and days 21 through 100 (which Medicaid does pay), your claim must include all days the resident is in your facility in a month for a continuous stay. OHA will calculate which days are covered by Medicaid and pay each claim accordingly. For example:

Date	Activity	How to bill	How claim will process *(assuming no breaks in service)*
1/20/2017	Resident admitted to facility	Bill 1/20 through 1/31	Claim will zero-pay.
2/28/2017	Resident is still at facility	Bill 2/1 through 2/28.	Claim will zero pay the first 8 days (2/1 through 2/8) and pay for the rest of the month (2/9 through 2/28).

OHA will continue to calculate up to day 100 as subsequent claims are submitted. When there are breaks in service, OHA will calculate the number of days as described above based on each claim submitted. However, you must submit one claim for each statement period, including statement periods that fall within days 1 through 20.

You can get this document in other languages, large print, braille or a format you prefer free of charge. Contact dmap.providerservices@oha.oregon.gov or call 800-336-6016. We accept all relay calls.

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