DHS
Oregon Department of Human Services

Common Fee-for-Service Billing Errors

The Division of Medical Assistance Programs (DMAP) processes medical claims that are submitted either by paper or electronically through a computerized system known as the Medicaid Management Information System (MMIS). The purpose of MMIS is to ensure accurate payment of claims within authorized amounts for covered services.

MMIS searches daily for presence and validity of data. Claims that fail edits are either automatically denied or suspended to a DMAP staff person who checks various information on the claim. When staff determines that the claim cannot be paid due to missing or invalid data, they deny the claim.

DMAP mails a Remittance Advice (RA) listing all claims paid and/or denied to the provider (with payment if appropriate). An explanation of benefits (EOB) appears on the RA with text that explains the resolution to a claim for your review and appropriate action. By reading the explanation and following the instructions listed in the EOB, you will be able to correct the error in a timely manner.

Read your provider rulebooks and supplemental information in order to bill DMAP correctly the first time. The following list indicates a few common fee-for-service billing errors with their resolutions.

Reminders

- ✓ Read your provider specific rulebooks and supplemental information and be sure you have the most current information that is in effect for the date of service being billed.
- ✓ Verify patient eligibility on the date the service is provided.
- ✓ If billing by paper, check your claim form for legibility so that we can read it.
- ✓ Read the explanation of benefit codes on your Remittance Advice. They will tell you what the error is.
- ✓ Contact DMAP Provider Services for assistance regarding any billing questions you may have. They can be reached at:

Toll free: 800-336-6016
Email: DMAP.providerservices@state.or.us

EOB 003

Message:
Our records show recipient is not eligible on date of service.

Resolution:
Recipient is not eligible on the date of service you are billing. Check the date of service on your claim for accuracy.

Eligibility information can be verified by looking at the DMAP Medical Care ID or by using the Automated Information System (AIS).

- AIS by phone: 800-522-2508
- AIS on the Internet: www.oregon.gov/DHS/healthplan/

Click on "Tools for Providers" and click on "Eligibility Verification" to register for Web-based access.

Refer to OAR 410-120-1140 Verification of Eligibility.

EOB 004

Message:
Provider was not enrolled on specified date of service or the date of service is not valid.

Resolution:
The six-digit DMAP "billing provider" number you are indicating on your claim is not enrolled on the date of service, and/or is missing on your claim form. Check your claim and the Remittance Advice to ensure the date of service was keyed correctly, and/or check your claim to see if your "billing provider" number is on the claim form.

If the date of service was keyed correctly, or you do not have a "billing provider" number, contact DMAP Provider Enrollment at:

- Toll free: 800-422-5047

Refer to OAR 410-120-1260 Provider Enrollment.

EOB 006

Message:
This service requires prior authorization (PA) unless performed as an emergency.

Resolution:
The service you are billing requires prior authorization and your claim form does not indicate the nine-digit prior authorization number that was provided by the approving authority.

Check your claim to determine if the prior authorization number is missing. This number will not appear on your Remittance Advice.

If the service you provided was an emergency and prior authorization was not obtained, the emergency indicator field on your claim should be checked.

Refer to OAR 410-120-1320 Authorization of Payment.

EOB 028

Message:
Recipient's name and number disagree and DMAP is unable to resolve it.

Resolution:
The name and the DMAP Medical Care ID number you are billing do not match. Use the name exactly as it appears on the DMAP Medical Care ID. Do not use nicknames. The DMAP Medical Care ID is always eight alpha-numeric characters.

Refer to OAR 410-120-1140 Verification of Eligibility.

EOB 044

Message:
Claim form inconsistent with provider type.

Resolution:
This message means that the wrong claim form was billed for your provider type. Use the correct billing form that is consistent with your provider type.

Refer to your provider specific rulebook and supplemental information to determine the form type you should use to bill DMAP.
Contact DMAP Provider Services for assistance if you have questions about which claim form to use. They can be reached at:

- Toll free: 800-336-6016
- Email: DMAP.providerservices@state.or.us

EOB 076

Message:
Claim is past the filing time limit.

Resolution:
The service you are billing cannot be processed because the date of service is past the 12-month filing limit.

A claim that was submitted within 12 months of the date of service, but may have been previously denied, may be resubmitted within 18 months of the date of service, with acceptable (proof of timely billing) documentation.

You must resubmit the claim with acceptable proof of timely billing to DMAP Provider Services for special handling at:

DMAP – PRU
500 Summer Street NE. - E44
Salem, OR 97301-1079

Refer to OAR 410-120-1300 Timely Submission of Claims.

EOB 090

Message:
Service is covered by a managed care plan. Your claim must be billed to the appropriate managed care plan.

Resolution:

The procedure you are billing is covered by a managed care plan. Your claim must be billed to the appropriate managed care plan and not DMAP.

Make sure you verify that the recipient receiving medical services is eligible on the date of service and whether a managed care plan or DMAP is responsible for reimbursement.

Managed care information can be verified by looking at the DMAP Medical Care ID or by using the Automated Information System (AIS).

- AIS by phone: 800-522-2508
- AIS on the Internet: www.oregon.gov/DHS/healthplan/

Click on "Tools for Providers" and click on "Eligibility Verification" to register for Web-based access.

Refer to OAR 410-120-1140 Verification of Eligibility.

EOB 091

Message:
Non-covered service.

Resolution:
The service (CPT/HCPCS) you are billing is not covered. Check your procedure code on your claim against the Remittance Advice to verify the code was keyed correctly.

If the CPT/HCPCS was keyed correctly, the code you are billing is either an invalid code or is a non-covered service.

EOB 092

Message:
Our records show recipient has multiple insurance. Your claim must reflect a payment and/or a two-digit third party explanation denial code from all potential insurances.

Resolution:
This message indicates that the recipient has more than one insurance coverage in addition to DMAP coverage. Your claim does not reflect a payment or a two-digit third

party explanation code. When the recipient has more than one insurance carrier, the claim you are billing must have a two-digit third party explanation code.

Insurance coverage information can be found by looking at the DMAP Medical Care ID or by using the Automated Information System (AIS).

- AIS by phone: 800-522-2508
- AIS on the Internet: www.oregon.gov/DHS/healthplan/

Click on "Tools for Providers" and click on "Eligibility Verification" to register for Web-based access.

Refer to OAR 410-120-1280 Billing and Table 1280 for Third Party Explanation Codes. Use the multiple insurance coverage codes when the recipient has more than one insurance carrier.

EOB 145

Message:
The recipient number listed is not active or is not in our records.

Resolution:
The eight alpha-numeric DMAP Medical Care ID you are billing is not listed in our records. Use the correct identification number as it appears on the DMAP Medical Care ID. For assistance contact DMAP Provider Services at:

- Toll free: 800-336-6016

Refer to OAR 410-120-1140 Verification of Eligibility.

EOB 151

Message:
Referring physician number is required on your claim form.

Resolution:
The six-digit referring physician provider number is missing in the referral box on your claim form. Some services require a referral, such as independent lab, miscellaneous

medical, occupational therapist, ophthalmologist, dispensing optician, physical therapist, private duty nurse, audiologist-speech therapist and hearing aid services.

If the referring physician does not have a DMAP six-digit provider number, list the referring physician name and 999999 (six nines) in the referral box on your claim form.

Refer to your provider specific rulebook and supplemental information to determine if your service requires a referral.

EOB 314

Message:
Primary Care Manager (PCM) provider number is required in the referring provider field on your claim form.

Resolution:
The recipient is enrolled in managed care with a Primary Care Manager. The PCM's six-digit referring provider number is missing in the referral box on your claim form.

Refer to your provider specific rulebook and supplemental information to determine if your service requires a referral from the PCM.

Find PCM information by looking at the DMAP Medical Care ID or by using the Automated Information System (AIS).

- AIS by phone: 800-522-2508
- AIS on the Internet: www.oregon.gov/DHS/healthplan/

Click on "Tools for Providers" and click on "Eligibility Verification" to register for Web-based access.

Refer to OAR 410-141-0060 Oregon Health Plan Managed Care Enrollment Requirements and OAR 410-141-0410 Oregon Health Plan Primary Care Managers.

EOB 321

Message:
The combination of type-of-service and procedure code is not recognized by DMAP.

Resolution:
The type-of-service (TOS) code in conjunction with the procedure code is not recognized together. TOS codes will vary dependent on your provider type and the service you are providing.

Modifiers have replaced TOS codes. If you are using a modifier, make sure you are using the correct modifier for the service you are providing; they affect how you are paid.

If you are using a TOS code, make sure you are using the correct one. Check your claim form against your Remittance Advice to verify that the combination was keyed correctly.

EOB 349

Message:
Recipient has Medicare coverage. Medicare covered charges must be billed through the Medicare carrier.

Resolution:
This message indicates that the recipient has Medicare coverage and that you did not bill Medicare or you are billing on an incorrect claim form.

When the recipient has dual Medicare/Medicaid coverage, you must first submit your claim to Medicare. If DMAP has your Medicare provider number listed in our system, Medicare will be able to forward your claim to DMAP which is called a crossover.

If your claim form does not crossover, you will need to submit a claim to DMAP. Make sure your claim form reflects either a payment amount from Medicare or a two-digit third party explanation code.

For professional billing, you must submit your services on a proper claim form. Refer to your provider specific rulebook and supplemental information to determine the form type you should be billing DMAP with.

For institutional billing, you may be required to indicate XOVR in field 11 on the UB claim form. Refer to your provide specific rulebook and supplemental information to determine if XOVR is required for your claim type.

Medicare carrier information can be verified by looking at the DMAP Medical Care ID or by using the Automated Information System (AIS).

- AIS by phone: 800-522-2508
- AIS on the Internet: www.oregon.gov/DHS/healthplan/

Click on “Tools for Providers” and click on “Eligibility Verification” to register for Web-based access.

Refer to OAR 410-120-1280 Billing and Table 1280 for Third Party Explanation Codes. Use the single insurance coverage codes when the recipient has one insurance carrier or use the multiple insurance coverage codes when the recipient has more than one insurance carrier.

EOB 350

Message:
Rebill using a valid two-digit third party resource explanation code.

Resolution:
This message indicates that the recipient has one insurance policy in addition to DMAP coverage. Your claim does not reflect a payment or a two-digit third party explanation code.

Prior resource information can be found by looking at the DMAP Medical Care ID or by using the Automated Information System (AIS).

- AIS by phone: 800-522-2508
- AIS on the Internet: www.oregon.gov/DHS/healthplan/

Click on “Tools for Providers” and click on “Eligibility Verification” to register for Web-based access.

Refer to OAR 410-120-1280 Billing and Table 1280 for Third Party Explanation Codes. Use the single insurance coverage codes when the recipient has one insurance carrier.

EOB 368

Message:
Service is a duplicate of a service pending in our system.

Resolution:
The service you are billing is an exact duplicate of a service pending in our system. This means that there are more than one service/claim with the same date of service, same procedure code, same diagnosis, and same provider number for the same recipient in the system at the same time.

Wait for both services/claims to process before you proceed with further action.

EOB 456

Message:
MMIS is unable to process your claim.

Resolution:
MMIS searches presence and validity of data. Once the system recognizes that a claim has failed 15 edits, the claim is automatically denied due to too much missing or invalid information.

Contact DMAP Provider Services for assistance regarding any billing questions you may have. They can be reached at:

- Toll free: 800-336-6016
- Email: DMAP.providerservices@state.or.us

EOB 566

Message:
Diagnosis code is not covered by the basic health care package. The procedure billed is not diagnostic.

Resolution:
The diagnosis code you used to bill DMAP is excluded from the Health Services Commission's Prioritized List of Health Services and is not covered. The Prioritized List is the operational basis for the Oregon Health Plan, and is ranked by priority, from the most effective to the least effective condition and treatment pairs.

Diagnostic services are covered during the course of a diagnostic work-up until a diagnosis is established. Diagnostic services must be medically appropriate for the suspected condition(s) and must be for a known condition.

For questions concerning the Prioritized List of Health Services for fee-for-service treatment pairing, contact DMAP OHP Benefit RN Hotline at:

- Toll free: 800-393-9855
- Local: 503-945-5939
- Have the CPT/HCPCS and ICD-9 available

For more information about the Prioritized List of Health Services, log on to <http://www.oregon.gov/DHS/healthplan/tools_prov/main.shtml> and click on Prioritized List.

Refer to OAR 410-141-0500 Excluded Services and Limitations for Oregon Health Plan Clients and/or DMAP Members and OAR 410-141-0520 Prioritized List of Health Services.

EOB 581

Message:
The pairing of diagnosis and procedure is below the cutoff on the Health Services Commission list. The procedure code is not covered as it is not diagnostic.

Resolution:
The diagnosis code you used to bill DMAP is excluded from the Health Services Commission's Prioritized List of Health Services and is not covered. The Prioritized List is the operational basis for the Oregon Health Plan, and is ranked by priority, from the most effective to the least effective condition and treatment pairs.

Examples of non-pairing are:

- ✓ Diagnosis is below the funded line; procedure code is above/below the funded line; both pair below the funded line; the procedure code is not diagnostic.
- ✓ Diagnosis is below the funded line; procedure code is below the funded line; both pair below the funded line; the procedure code is not diagnostic.
- ✓ Diagnosis is above/below the funded line; procedure code is below the funded line; both pair below the funded line; the procedure code is not diagnostic.
- ✓ Diagnosis is above/below the funded line; procedure code is above/below the funded line; both pair below the funded line; the procedure code is not diagnostic.

For questions concerning the Prioritized List of Health Services for fee-for-service treatment pairing, contact DMAP OHP Benefit RN Hotline at:

- Toll free: 800-393-9855
- Local: 503-945-5939
- Have the CPT/HCPCS and ICD-9 available

For more information about the Prioritized List of Health Services, log on to <http://www.oregon.gov/DHS/healthplan/tools_prov/main.shtml> and click on Prioritized List.

Refer to OAR 410-141-0500 Excluded Services and Limitations for Oregon Health Plan Clients and/or DMAP Members and OAR 410-141-0520 Prioritized List of Health Services.

EOB 594

Message:
Medicare's allowed amount on your claim is zero. DMAP only pays for Medicare allowed services under the qualified Medicare program.

Resolution:
This message indicates that the recipient is enrolled under the Qualified Medicare Beneficiary (QMB) benefit package. DMAP pays for services if it is an allowable service that Medicare covers.

Check the Medicare allowed amount field on your claim form for accuracy.

Find benefit package information by looking at the DMAP Medical Care ID or by using the Automated Information System (AIS).

- AIS by phone: 800-522-2508
- AIS on the Internet: www.oregon.gov/DHS/healthplan/

Click on "Tools for Providers", and click on "Eligibility Verification" to register for Web-based access.

Refer to OAR 410-120-1140 Verification of Eligibility and OAR 410-120-1210 Medical Assistance Benefit Packages and Delivery System.

EOB 624

Message:
Coverage is limited to emergency medical services.

Resolution:
The recipient you are billing for is eligible only for the Citizen/Alien Waived Emergency Medical (CAWEM) benefit package. This limited benefit package helps aliens who are not eligible for other Medicaid programs.

Find benefit package information by looking at the DMAP Medical Care ID or by using the Automated Information System (AIS).

- AIS by phone: 800-522-2508
- AIS on the Internet: www.oregon.gov/DHS/healthplan/

Click on "Tools for Providers" and click on "Eligibility Verification" to register for Web-based access.

Refer to OAR 410-120-1210 Medical Assistance Benefit Packages and Delivery System.

EOB 626

Message:
Diagnosis and procedure codes do not pair on the Health Services Commission list and is not covered by the basic health care package.

Resolution:
The diagnosis code you used to bill DMAP is excluded from the Health Services Commission's Prioritized List of Health Services and is not covered. The Prioritized List is the operational basis for the Oregon Health Plan, and is ranked by priority, from the most effective to the least effective condition and treatment pairs.

Examples of non-pairing are:

- ✓ Diagnosis above the funded line; procedure code above the funded line; but not paired.
- ✓ Diagnosis above the funded line; procedure code above/below the funded line; but not paired.

- ✓ Diagnosis above/below the funded line; procedure code above the funded line; but not paired.
- ✓ Diagnosis above/below the funded line; procedure code above/below the funded line; but not paired.

For questions concerning the Prioritized List of Health Services for fee-for-service treatment pairing, contact DMAP OHP Benefit RN Hotline at:

- Toll free: 800-393-9855
- Local: 503-945-5939
- Have the CPT/HCPCS and ICD-9 available

For more information about the Prioritized List of Health Services, log on to: <http://www.oregon.gov/DHS/healthplan/tools_prov/main.shtml> and click on Prioritized List.

Refer to OAR 410-141-0500 Excluded Services and Limitations for Oregon Health Plan Clients and/or DMAP Members and OAR 410-141-0520 Prioritized List of Health Services.