Questions and answers from recent provider trainings,
OMAP Billing FUN-damentals.

Q1: Do you offer training for billing of special therapies?

A1: We are currently exploring all specialized training requests that we have recently received from our providers. Please contact Provider Relations at 1-800-336-6016 and talk to a representative to assist with your needs for now. We will explore specific provider training in the near future.

Q2: Can you only use OMAP's selected Electronic Eligibility Verification Service (EEVS) vendors for checking the eligibility of a client?

A2: You can choose to use either the contracted EEVS vendors or you can use the electronic 270/271-Eligibility Inquiry/Response transaction, or you can use the free Automated Information Service (AIS) through the WEB or by telephone. For more information, visit the following link:
http://www.oregon.gov/DHS/healthplan/tools_prov/electronverify.shtml#eevs

Q3: Please explain how we can check claim status on our electronically submitted claims?

A3: You can contact the Provider Relations Unit at 1-800-336-6016 to check on the status of up to 10 claims at a time or you can use the 276/277-Claim Status Inquiry/Response transaction. The 276/277 transactions allow you to either check on one claim at a time or you can send a batch inquiry. You can either purchase software or use a clearinghouse to help you with these transactions.

Q4: Since we bill electronically through a vendor service, will we still receive our remittance advices electronically?

A4: Your electronic remittance advice will be provided to whomever you designate to receive them. This can be your office, a billing service or a clearing house.

Q5: We receive requests for medical records from offices with instructions to bill OMAP. Is there an example of a proper CMS 1500 for medical records?

A5: Yes, use the Administrative Examination Rulebook that is available on the OMAP web site at the link below. It has valuable information on how to complete the claim form.
http://www.dhs.state.or.us/policy/healthplan/guides/adminexam/main.html

Q6: How do I get a Trading Partner Agreement?

A6: There are several options available. Please see the WEB address listed below, or you can call the EDI Registration Team at 1-800-527-5772 (in Oregon) or 1-503-947-5347 (outside Oregon).
http://www.oregon.gov/DHS/admin/hipaa/testing_reg.shtml

Q7: Is there a contact number or Web site where we can share suggestions?

A7: You may email both suggestions and questions to the OMAP First Pass team at firstpass.omap@state.or.us or you can contact the Provider Relations Unit at 1-800-336-6016.

Q8: When billing hospital out-patient claims for a PCO, do all charges get processed and paid by the PCO or only diagnostic charges?

A8: Outpatient hospital billings are processed and managed by the PCO. All inpatient services are processed by OMAP.

Q9: When OMAP goes live with the 270/271-Eligibility Inquiry/Response transactions, how will providers be able to verify eligibility past 1 year, if needed?

A9: The maximum eligibility the 270 (Eligibility Inquiry transaction) can verify is one year. If you need verification for more than one year, you will need to contact the Provider Relations Unit at 1-800-336-6016.

Q10: Instead of having a third party involved, why doesn't OMAP have electronic submissions of claim forms available through the WEB site?

A10: At this time OMAP does not have the ability to receive claims through a Web-based program. This functionality will be available with our new Medicaid Management Information System (MMIS) in the fall of 2007.

Q11: How can we identify when a patient and/or claim need to be billed with a Primary Care Manager (PCM) number?

A11: If a client has a PCM, it's listed on the Medical ID card in the Managed Care/TPR columns.

Q12: If we are required to get electronic Remittance Advice's (RA) after December 31, 2005, are we also required to get electronic funds transfer?

A12: No. Your payment will be transferred directly to the bank only if you sign an electronic funds transfer (EFT) authorization, otherwise you'll continue to get a paper check. Only providers billing via the 837 transactions may have EFT with OMAP.

Q13: Will electronic claims submission be mandatory?

A13: As of now, electronic claims submission is not mandatory for Oregon Medicaid.

Q14: OMAP is the only insurance that requires type of service (TOS) codes. Do you see this changing in the future?

A14: When you submit claims electronically in the 837 formats, a Type of Service (TOS) code is not required. Paper claims still require TOS. Refer to the CMS 1500 billing instructions at the following WEB address:
http://www.oregon.gov/DHS/healthplan/tools_prov/tips/main.shtml

Q15: I had some claims deny because I was told the Explanation of Benefits (EOB) was not attached, why?

A15: Usually we don't need the EOB from the primary insurance. When billing on paper, you do have to show either a payment or a Third Party Resource (TPR) code to indicate why the

primary insurance did not pay. If benefits are exhausted, you should attach a copy of the letter you have received and mail the claim to the Provider Relations Unit at 500 Summer Street, NE E44, Salem, Oregon 97301.
You can find the Third Party Resource 2 digit Insurance codes in your CMS billing instructions:
http://www.oregon.gov/DHS/healthplan/tools_prov/tips/main.shtml

Q16: Do all CPT code units need a quantity of one?

A16: No, some CPT codes are allowed a higher quantity than one. Please check the fee schedule for the quantity allowed for your code.
http://www.oregon.gov.DHS/healthplan/data_pubs/feeschedule/main.shtml

Q17: Where can I locate an OMAP 505 or other billing forms?

A17: Billing forms and instructions are available on the OMAP web site at the following address, or they can be found in your Program Supplemental Information booklet.
http://www.oregon.gov/DHS/healthplan/tools_prov/complete-claim-forms.shtml

Q18: If Medicare is crossing over claims, do we still need to bill?

A18: If your Medicare claims are crossing over and adjudicating correctly, then there is no need for you to re-bill.

Q19: I submit claims from our office for an entire week. Why are some claims paid right away and others paid later?

A19: Paper claims are usually processed within 20-30 days of receipt. Some claims may all be processed the same week and some may carry over to the next week. Also, if there are any problems with a claim it may suspend in our system and will need to be manually reviewed before it can be paid or denied.

Q20: When calling the Provider Relations Unit and transferred to second level OMAP representatives, I sometimes wait 10 minutes, then the phone hangs up. Why does this happen?

A20: The OMAP phone system currently allows providers to hold for 10 minutes for the next available representative before being transferred to our voice mail system. These calls are not disconnected. Calls are always taken in the order received, but there are occasionally more calls coming in than the representatives can handle within 10 minutes. If you leave your name and phone number, a representative will return your phone call.