An OMAP initiative designed to process claims timely and accurately on the first submission.

Impacting:

- *Unit processes and workflow*
- *Provider trainings and communications*
- *Reporting systems*

OMAP First Pass Touches Down!

Closing Report of the First Pass Initiative

10/1/04 – 10/1/05

DHS Oregon Department of Human Services

Oregon HEALTH PLAN

DMAP/CI/06-126

Dedication

We are dedicating the First Pass Closing Report to Rick Howard. During his time as Manager of the Health Financing Operations (HFO) Section, Rick provided a vision and quest for excellence that are embodied in the First Pass initiative.

Throughout First Pass, Rick encouraged his managers and staff to review and test current procedures and processes in search of enhancements and efficiencies which would further our Mission and Vision.

Thanks Rick, for letting us color outside the lines!

Alice LaBansky

Alice LaBansky, Manager
Health Financing Operations Section

HFO Mission

We excel at providing healthcare financing operations to ensure access to healthcare services for all qualifying Oregonians.

HFO Vision

To be a driving force in the healthcare financing industry by blending innovative people with advanced technology

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Background

The driving force behind the ***First Pass*** initiative was the need to change the perception in the provider community that OMAP was unwilling, or unable, to pay services in a timely and efficient manner. At the time ***First Pass*** was conceived, the Office of Medical Assistance Programs (OMAP) had a paper claims backlog of 59 days, as well as issues with claim failure, suspense, adjustment and refund rates. ***First Pass*** was an opportunity for OMAP to take a proactive approach and reclaim control over how we did business within our span of influence and controls. Part of the ***First Pass*** initiative was to:

- Establish performance metrics and standards to assess how our business operated in terms of claims processing and provider support
- Analyze key processes that influence provider claims and identify areas where efficiencies could be put into place
- Operationalize the identified process efficiencies.
- To continue following the new processes developed during ***First Pass*** and reviewing reports created during the initiative to monitor processes and identify improvements and enhancements.

Goal

The primary goal of ***First Pass*** was to:

- Reduce paper claims backlog, reprocessing rates (suspense, adjustment, incorrect denial and provider refunds), and
- Provide Medicaid providers with the tools and assistance to get their claims paid right the first time (on their first pass).

Participation

First Pass was a truly integrated project, with participation from various Office of Medical Assistance Programs (OMAP) Units and Sections, the Office of Forms and Documents, the Office of Mental Health and Addiction Services, DHS Audits, and Medicaid Management Information System (MMIS) staff.

> ***Note:*** While the Agency has recently undergone a reorganization, unit, section, and agency names referenced in this document reflect their 'pre-reorg.' names (i.e. Health Financing Operations [HFO], OMAP, Program and Policy Section [PPS]).

Steering Committee Roster

Rick Howard, OMAP HFO, Project Sponsor

Alice LaBansky, OMAP HFO, Project Manager

Cathy Holmes, Project Lead

Raeann Reese, Project Lead

Jesse Anderson, OMAP Policy Unit

Randy Canoy, MMIS Replacement Project

Conch Cirata, Office of Information Systems

Mary Greipp, OMAP Administration

Debra Herrli, MMIS Replacement Project

Joni Kilgore, OMAP HFO

Patricia Krewson, OMAP Technical Encounter Data Unit

Mike McCormick, DHS Audits, Director's Office

Kathy Mickenham, OMAP Communications

Anita Miller, DHS Office of Mental Health and Addiction Services

Terry Layman, OMAP Provider Services Unit

Wendy Woodard, DHS Office of Forms and Documents Management

First Pass Objectives

During the ***First Pass*** initiative, staff identified and met the following six objectives:

1. Access and analyze Operations Section processes and establish key performance indicators.

2. Identify process improvements in the areas influencing timely adjudication of claims.

3. Identify process improvements in the areas influencing the accuracy of claims processing.

4. Identification, definition and development of recurring reports and processes used for managing, monitoring and communicating Operations Section performance.

5. Improve provider communication, provider education and provider outreach efforts.

6. Electronic submission -- increase accuracy of claims and speed payment by expanding electronic claim submission and payment through Electronic Data Interchange (EDI) and Electronic Funds Transfer (EFT).

This closing report examines each objective, how it was met and the ongoing activities used to operationalize the objective, suggests logical “next steps” to continue the goals of the initiative, and illustrates one of the successes of the initiative in a short article about implementation of a new, centralized process for providers appealing claim denials.

Objective 1

Access and analyze HFO processes and establish key performance indicators.

Met through:

- Development of 12 new unique reports utilizing the Decision Support Surveillance and Utilization Review System (DSSURS) *(Attachment 1)*

Operationalized by:

- Review of the reports listed above on a routine basis.

Objective 2

Identify process improvements in the areas influencing timely adjudication of claims.

Met through:

- Decreasing paper claims backlog. Under ***First Pass***, we decreased the claims backlog from 69 days to its current status of one day. We accomplished this by identifying staffing and processing issues that contributed to the problem, and addressing those issues in the following ways:
  - ✓ The Office of Forms and Documents Management (OFDM) relocated all Medicaid paper claims processing from the failing data entry system to a newer Electronic Document Management System (EDMS), which is both stable and reliable.
  - ✓ OFDM began pre-screening CMS 1500 paper claims with six or fewer detail lines for completeness of 12 data fields that frequently contain critical errors from claims submitters and began returning incomplete claims to providers for correction. Problem fields were highlighted on each claim form before return. During the course of the ***First Pass*** initiative, additional claim forms were added to the pre-screening process.

Paper Claims Average Lag Time (Backlog)			
	10/04	**10/05**	**6/06**
Less than 30 days	27.61%	97.01%	93.38%
30 to 45 days	3.44%	1.79%	6.10%
More than 45 days	68.95%	1.20%	0.52%

During the time that the backlog issue was being resolved, OMAP regularly sent claim status updates with provider Remittance Advices (Attachment 2).

- Increase in accurate claims adjudication, exhibited by the increase in number of claims processed correctly on first submission, and a decrease in claims needing an adjustment.
- Decrease in the number of claims in suspense longer than 60 days

Percent of Claims adjudicated on first submission (clean or full pay)					
10/04	**10/05**	**6/06**	*Average*	**10/04 - 10/05**	**10/05 - 6/06**
56.53%	75.57%	74.35%		69.80%	73.75%
Percent of Claims Requiring an Adjustment (out of all claims)					
10/04	**10/05**	**6/06**	*Average*	**10/04 - 10/05**	**10/05 - 6/06**
1.98%	0.72%	0.66%		2.86%	1.09%
Percent of Claims Hitting Suspense					
10/04	**10/05**	**6/06**	*Average*	**10/04 - 10/05**	**10/05 - 6/06**
6.40%	6.60%	5.97%		7.65%	6.57%

Objective 3

Identify process improvements in the areas influencing the accuracy of claims processing.

Met through:

- Increased outreach and training efforts that focused on common claims errors *(Attachment 3)*. Trainings were operationalized by posting the training content on the following Web page:
  <http://www.oregon.gov/DHS/healthplan/first-pass/main.shtml#training>
- Implementation of a claims screening process by OFDM. Claims not meeting screening criteria were returned for correction/completion rather than being entered into the MMIS *(Attachment 4)*.
- New process of returning misdirected claims, with a letter stating the claim was mailed to the wrong address and giving the correct address *(Attachment 5)*.

Returned Claims During Screening				
Form Type	**7/05 - 12/05**	**Monthly Average**	**1/06 - 6/06**	**Monthly Average**
CMS1500	14,075	2,346	7,478	1,246
Dental 2000	137	23	190	32
Dental 2002	96	16	257	43
OMAP 505	1,551	259	1,502	250
UB 92	842	140	1,413	236
Totals	16,701	2,784	10,840	1,807

Objective 4

Identification, definition and development of recurring reports and processes used for managing, monitoring and communicating Operations' Section performance.

Met through:

- Implementation of performance reporting process, the Operations Performance Metrics Reporting System (OPMRS).
- Changing unit procedures to increase efficiency.

Operationalized by:

- Having Operations Units regularly enter data into OPMRS.
- Operations Section management is continuing to examine the capabilities of the OPMRS, analyze data and develop process improvements utilizing the new system.
- Implementing new Medical Unit procedures, including:
  - ✓ Development of a technical review process for Prior Authorizations (PAs) that have identified criteria not requiring an RN review for approval.
  - ✓ Use of the Groupwise Reminder Note feature by staff to enhance communication.
  - ✓ Transferred requests to approve Not Covered Services to the Provider Services Unit (PSU) utilizing support from the Medical Director's Unit.
  - ✓ Creation of an Excel Prioritized List resolution spreadsheet for liaison use.
  - ✓ Centralization of prior authorizations for certain services.

- Staffing needs identified and met:
  - ✓ Establishment of a trained Resource Pool position.
  - ✓ Creation of one unit administrative support position.
  - ✓ Identification of a Lead Worker.

Objective 5

Improve provider communications, provider education and provider outreach efforts.

Met through:

- An introduction letter from former OMAP Administrator, Barney Speight *(Attachment 6)*.
- Development of dedicated ***First Pass*** Web page.
- Creation of provider communications tools -- ***First Pass*** Connections newsletter *(Attachment 7)* and ***First Pass Flash*** bulletins *(Attachment 8)*.
- Decrease in the number of transferred provider inquiry calls.
- Development of a ***First Pass*** e-mail address for providers, staff and interested parties to send questions or suggestions. The e-mail account was closely monitored and action taken on all e-mails. The correspondent received an e-mail reply informing them of the action taken, or if the suggestion was beyond the scope of the project, where it was forwarded.
- Decrease in the number of provider complaints.
- Delivery of provider training -- Billing FUN-damentals.

Operationalized by:

- Posting training content on the following OMAP Web page"
  <http://www.oregon.gov/DHS/healthplan/first-pass/main.shtml#training>.
- Creation of a resource booklet for new providers "***Keys to Success***" which contains much of the information offered in the FUN-damentals training. The ***Keys to Success*** booklet is currently being field tested as part of the Delivery Service Unit's regional meetings.

Objective 6

Electronic submission -- increase accuracy of claims and speed payment by expanding electronic claim submission and payment through Electronic Data Interchange and Electronic Funds Transfer.

Met through:

- New payment standards -- 90% of clean electronic claims paid/denied within 15 days of receipt; all electronic claims paid/denied within 90 days of receipt.
- Hosting an EDI Vendor Fair *(Attachment 9)*.
- Increase in EDI submitters/submissions.

  Note: While OMAP recorded an average increase in EDI submitters during the ***First Pass*** initiative, in the months since the end of the project the number of electronic submissions has been reduced for some claim types. Factors beyond our control, such as problems with Medicare cross-over claims, are responsible for this reduction. We are continuously working to resolve these issues and increase the numbers of providers who submit claims electronically.
- Implementation of EFT.
- EDI Bulletins *(Attachment 10)*.

Percent of Electronic Submitters (Providers)					
10/04	**10/05**	**6/06**	***Average***	**10/04 - 10/05**	**10/05 - 6/06**
58.05%	61.05%	58.67%		56.90%	60.06%
Percent of Claims Submitted Electronically					
10/04	**10/05**	**6/06**	***Average***	**10/04 - 10/05**	**10/05 - 6/06**
58.05%	61.05%	58.67%		56.90%	60.06%

Lessons learned

"Just do it!"

Working within a system where many decisions are made based on budget constraints and directives from other entities (federal policies and state legislative decisions) it can sometimes seem like we have a limited ability to make meaningful changes to our own policies and processes. ***First Pass*** taught us to think outside the box, to examine and re-examine the way we do our jobs, and to act on those findings. To trust that we have the integrity, knowledge and skill to look for ways to become more efficient and to act on the things we've identified.

We learned that:

- **Providers need tools.** All of the provider trainings we held were filled to capacity and the dedicated ***First Pass*** Web page was the 18th most popular page on the entire DHS Web site.
- **Monitoring is critical.** Many of the reports developed through ***First Pass*** give us an accounting of claim volume, accuracy, and processing timeliness. While this information has always been available to us, it wasn't being reported on a regular basis, reviewed and compared in the way that it is now, with an eye toward trends and barriers that can be resolved early.
- **Not *every* swing is a hit.** While not all of our strategies resulted in the outcome we planned, the overall results of the project make it a success. *(Ty Cobb is baseball's all-time batting average leader with a batting average of .366.)*
- **Collaboration is key.** ***First Pass*** was successful, in large part, because of the effort of many people working together across our "vast" department on a common goal.

A *First Pass* Success Story

Prior to ***First Pass***, the provider appeals process was somewhat fragmented, with no common tracking system. Providers submitted appeals to one of several units which provided clinical or policy decisions. A review of the procedure made it clear that an important "up front" centralized processing piece was needed. As a result, a provider appeals database was designed, and the Provider Services Unit was designated as the manager of the process to package and route appeals to the appropriate reviewer. The database assures that all appeals, regardless of the type, are logged and tracked, making it easier for provider service staff to answer provider queries and for other units to access the information. Once a final determination is made, the appeal package is sent back to PSU for final action, including a letter to the provider of the findings. The decision is entered into the database and the appeal filed.

Having a centralized process and database for claim appeals provides:

- Easy access to information on current and past appeals. We can tell how many appeals of each type have been approved/denied in a specific time range, the total processing time (currently less than 15 days), and the location or status of any appeal when providers call.
- A tool to use to monitor trends. We can see the most common reason for appeals, the issues and their resolution.

Appendices

Attachment 1

Summary of New Reports

Weekly Reports

MMIS Claims Payment Report – All Provider Types and Claim Types

MMIS Claims Payment Report – Unique provider counts

MMIS Claims Payment Report – Media type expenditures

MMIS Claims Payment Report – By Medical Benefit Package

MMIS Claims Payment Report – Top 25 expenditures and Claim Volume by Provider Type

Claims Payment Lag – Clean Paper Claims Avg. Payment in Days, Most Recent Weeks

Claims Adjustment Rates – Most Recent 53 Weeks

Claims Adjustment Rates – Most Recent 53 Weeks (batch)

Claims Edit Counts Report – Fee-for-Service Top 25 Report Errors

Claims Edit Counts Report – Fee-for-Service Top 25 Suspend Errors

Monthly Reports

MMIS Claims Payment Report – Title XIX and XXI Expenditures by Health Account, Year-to-Date

MMIS Claims Payment Report – Top 25 Expenditures and Claim Volume by Provider Type

MMIS Transactions Report – Total Transactions – Adjudication Statistics

MMIS Provider Report – Monthly Provider Statistics (MMIS Provider File)

MMIS Claims Payment Report – Capitation Expenditures by Rate Group

Ad-Hoc Reports

Claim Type Payment (Payment Date and Provider Type)

Provider Type Payment Report (Payment Date and Claim Type)

Claims Edit Counts Reports (series)

MMIS Claims Payment Report (Expenditures by Claim Type)

MMIS Claims Processing Exceptions Report

Claims Edit Counts Report: Pharmacy Fee-for-Service (Top 25 Report Errors)

Claims Edit Counts Report: Original Claims Paper Media (Top 25 Report Errors)

Claims Edit Counts Report: Encounter (Top 25 Report Errors)

Claims Edit Could Report: Pharmacy Encounter (Top 25 Report Errors)

Attachment 2 - Letter to Providers announcing backlog resolution

Oregon

Theodore R. Kulongoski, Governor

Department of Human Services
Health Services
Office of Medical Assistance Programs
500 Summer Street NE, E-35
Salem, OR 97301-1077
Voice (503) 945-5772
FAX (503) 373-7689
TTY (503) 378-6791

December 30, 2004

To: OMAP Providers

From: Wendy Woodard, Administrator
Office of Forms and Document Management (OFDM)

Subject: Paper Claims Backlog Resolution

The Department of Human Services (DHS) is experiencing a backlog in the data entry of paper, or hardcopy, Medicaid claims. I understand this backlog has caused many providers an unacceptable delay in payment and for that I apologize.

In the past month, the OFDM has reduced this backlog from 77 days to 64 days for CMS 1500 claims with six or fewer detail lines. Since these claim types comprise 80% of our workload, I am confident that OFDM will achieve a goal of 30 days for the data entry of all paper claims by March 15, 2005.

There are several reasons for the backlog. OFDM relies on an obsolete data entry system that has experienced frequent down time; we have encountered a shortage of experienced data entry staff; and there is an increase in paper claims since HIPAA went into effect.

To resolve this situation, DHS has recently taken action in four areas:

1. OFDM will relocate all Medicaid paper claims processing from the failing data entry system to a newer Electronic Document Management System (EDMS), which is both stable and reliable.

2. In November 2004, OFDM began pre-screening CMS 1500 paper claims with six or fewer detail lines for completeness of 12 data fields that frequently contain critical errors from claims submitters. Instead of allowing problem claims to process and deny, OFDM screeners now return incomplete claims to providers for correction. Problem fields are highlighted on each claim form before return. If you need help completing your CMS 1500 forms, please contact the Provider Relations Unit at 1-800-336-6016

CN 04-262

"Assisting People to Become Independent, Healthy and Safe"
An Equal Opportunity Employer

Attachment 2a - sample backlog update

Claims backlog resolution update

Claim Type	12/31/04	1/12/05
CMS 1500 six or fewer line items	63 days out	65 days out
CMS 1500 seven + line items	99 days out	105 days out
UB 92	99 days out	105 days out
UC 5.1	07 days out	0 days out
ADA	99 days out	105 days out
SPD 595	0 days out	0 days out
TAD	0 days out	0 days out

Attachment 3 - Billing FUN-damentals Announcement

Register now for OMAP's new provider training

OHP Billing *FUN*-damentals

May 18, 2005 **Employment Building, Salem**

Billing *FUN*-damentals is a free training for OMAP fee-for-service providers that will cover:

- ✓ billing issues
- ✓ information on eligibility verification
- ✓ electronic billing information
- ✓ available resources—where to find provider tips, billing instructions and other printed information, contacts
- ✓ basic requirements for requesting payment authorization

To register, fax, call, or email the information requested below to:

- Fax—(503) 947-5221, or
- Phone—(503) 945-6549, or
- Email—omap.training@state.or.us

Seating is limited so register today!

Date: May 18, 2005
Time: 8:30 - 12:00 ***or*** 1:00 - 4:30

Place: Employment Building - Auditorium
875 Union St NE
Salem, OR 97301

Company/Organization Name:	
Contact Name and Phone Number:	
Provider Number:	
Phone Number:	
Attending (check one): ❑ **8:30 - 12:00** ❑ **1:00 - 4:30**	**Number Attending:**

- Auxiliary aids for individuals with disabilities are available upon request
- Your confirmation will include directions and parking information

Attachment 3a - Billing FUN-damentals Evaluations

Training Dates	5/17/05 am	5/18/05 am	5/18/05 pm	6/14/05 am	6/14/05 pm	YTD Total
Number of Attendees	37	127	125	77	86	452
Number of Evaluations	21	80	97	52	52	302
Percent of Evaluations Completed	56.76	62.99	77.60	67.53	60.47	66.81
Section Ratings (Average on 1 - 5 Scale)						
Billing accurately the first time	4.17	3.81	4.09	4.04	4.00	4.02
Understanding billing errors	4.25	3.90	4.00	3.35	3.84	3.87
Improving communication	4.44	4.03	3.94	3.90	4.00	4.06
Serving our OHP clients	4.00	3.86	3.85	4.04	3.67	3.88
Available information, tools and resources	3.00	4.13	4.02	3.97	3.94	3.81
Provided information to conduct business with OMAP	4.32	3.99	3.82	3.71	3.98	3.96
Presentation and materials easy to read and follow	3.85	4.34	4.14	4.00	4.06	4.08
Knowledge level before you arrived	3.80	3.34	3.20	3.45	3.12	3.38
Knowledge level after the training	4.30	4.01	3.82	3.92	3.75	3.96
Presenters helpful answering questions	4.39	4.17	4.00	3.79	3.87	4.04
Advertising user friendly	4.27	4.07	4.11	4.06	4.14	4.13
Registration easy to follow	4.15	4.32	4.35	4.13	4.45	4.28
Overall rating of today's training	4.35	4.03	3.85	3.69	3.87	3.96
% who want information on future trainings		40.00	26.80			33.40

Attachment 4 - Sample of Claim Screening Notice

Important Billing Reminder to Complete OMAP 505 Critical Fields

We've recently changed our claim processing procedures to include a screening of certain critical fields on paper claims before entering them into our MMIS payment system.

This screening is only for certain fields, not all required fields. The screening allows us to identify incomplete claims and return them to you for completion. We will highlight your returned claim showing the incomplete field.

Reasons for Returning Claims

In the screening, our staff are checking to make sure the following fields (shaded in the sample at right) on the OMAP 505 are complete:

1 Patient's Name - *enter the name as it appears on the OMAP Medical Care ID.*

6 Insured ID Number - *enter the 8 alphanumeric characters found in field 11 of the client's OMAP Medical Care ID.*

23A Diagnosis or Nature of Injury - *list up to four (4) diagnosis codes in priority order. DO NOT enter the decimal point.*

For each service provided, enter:

- 24A Date of Service - *list numeric dates of service, i.e., 03/01/05.*
- 24B Place of Service - *list the 1- or 2-character code.*
- 24C Procedures, Services or Supplies - *list the five (5)-digit procedure code.*
- 24E Days or Units - *enter the correct number of days or units for this procedure.*

24G Charges Billed Medicare - *enter the total amount billed to Medicare.*

24H Medicare's Allowed Charges - *enter the amount Medicare allowed.*

27* Total Charge - *enter the total amount for all charges listed in field 24G.*

31* Balance Due - *subtract the amounts in fields 28 and 30 from field 27 and enter the balance.*

34 I.D. Number - *enter your 6-digit OMAP billing or performing provider number.*

State of Oregon
Department of Human Services
Office of Medical Assistance Programs

MEDICARE / MEDICAID BILLING INVOICE
FOR MEDICAL PRACTITIONER CLAIMS

OMAP 505 (Rev. 11/99)

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

1. PATIENT'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL) (1)
2. PATIENT'S DATE OF BIRTH
3. INSURED'S NAME (*Last Name, first name, middle initial*)
4. PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE) TELEPHONE NO.
5. PATIENT'S SEX MALE FEMALE
6. INSURED'S I.D. NO. (*Include all letters & Numbers*) (6)
7. PATIENT'S RELATIONSHIP TO INSURED SELF SPOUSE CHILD OTHER
8. INSURED'S GROUP NO. (*Or Group Name*)
9. OTHER HEALTH INSURANCE COVERAGE. Enter Name of Policyholder and Plan Name and Address and Policy or Medical Assistance Number
10. WAS CONDITION RELATED TO: A. PATIENT'S EMPLOYMENT YES NO B. ACCIDENT AUTO OTHER
11. INSURED'S ADDRESS (*Street, city, state, ZIP code*)
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (*Read back befor signing*) *I Authorize the Release of any Medical Information Necessary to Proces this Claim and Request Payment of MEDICARE Benefits Either to Myself or to the Party Who Accepts Assignment Below.* *SIGNED* *DATE*
13. *I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW* *SIGNED (Insured or Authorized Person)*

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)
15. DATE FIRST CONSULTED YOU FOR THIS CONDITION
16. IF PATIENT HAS HAD SAME OR SIMILAR SYMPTOMS? YES NO
16A. IF EMERGENCY CHECK HERE
17. DATE PATIENT ABLE TO RETURN TO WORK
18. DATES OF TOTAL DISABILITY FROM THROUGH — DATES OF PARTIAL DISABILITY FROM THROUGH
19. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE (e.g., PUBLIC HEALTH AGENCY)
20. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED DISCHARGED
21. NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE)
22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? YES NO CHARGES:
23. A. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE 1, 2, 3, ETC. OR DX CODE (23A) 1. 2. 3. 4. — EPSDT YES NO — FAMILY PLANNING YES NO — PRIOR AUTHORIZATION NO.

24. A. DATE OF SERVICE	B* PLACE OF SERVICE	C. FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN PROCEDURE CODE (IDENTIFY)	(*EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES*)	D. DIAGNOSIS CODE	E. DAYS OR UNITS	F. 'TOS'	G. CHARGES BILLED MEDICARE	H. MEDICARE'S ALLOWED CHARGES	I. PROVIDER NUMBER
(24A)	(24B)	(24C)			(24E)		(24G)	(24H)	

25. SIGNATURE OF PHYSICIAN OR SUPPLIER (INCLUDING DEGREE(S) OR CREDENTIALS) (I CERTIFY THAT THE STATEMENTS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART THEREOF) SIGNED DATE:
26. ACCEPT ASSIGNMENT (GOVERNMENTCLAIMS ONLY) YES NO
27. TOTAL CHARGE (27)
28. MEDICARE TOTAL PAYMENT (28)
29. YOUR SOCIAL SECURITY NO.
30. INSURANCE OTHER THAN MEDICAID/MEDICARE
31. BALANCE DUE (31)
32. YOUR PATIENT'S ACCOUNT NO. REMARKS:
33. YOUR EMPLOYER I.D. NO.
34. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE & PHONE NO. I.D. NO. (34)

Help us make sure your payment is correct and prompt -- check your claims for accuracy and completeness before you submit them to us. **Many claims suspend because of math errors in fields 27 through 31.*

OMAP PA #05-028

Attachment 5 - Misdirected Claims Notice

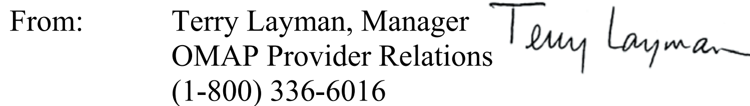
Oregon

Theodore R. Kulongoski, Governor

Department of Human Services
Health Services
Office of Medical Assistance Programs
500 Summer Street NE, E44
Salem, OR 97301-1079
Toll-Free (1-800) 336-6016
Salem (503) 378-3697
FAX (503) 378-3697
TTY (503) 378-6791

Date: ______________

To:



From: Terry Layman, Manager
OMAP Provider Relations
(1-800) 336-6016

Subject: Misdirected Claims

Your office sent one or more claims in error to the OMAP administrative office. As a courtesy to expedite the processing of these claims, we have forwarded them to the correct address shown below.

✓	Claim Type	Correct PO Box
	CMS-1500: Medical	PO Box 14955
	CMS-1500: Speech-Language Pathology, Audiology and Hearing Services, and Private Duty Nursing	PO Box 14018
	OMAP 505	PO Box 14015
	5.1 Universal Drug Claim Form	PO Box 14951
	ADA Claim Form Versions 2000 and 2002/2004	PO Box 14953
	UB-92	PO Box 14956
	TADS	PO Box 14954
	OMAP 742	PO Box 14958
	Out of State Claims (from providers located more than 75 miles from the Oregon border)	PO Box 14016
	Administrative Exam Claims	PO Box 14165
	Individual Adjustment Requests	PO Box 14952

In the future, please send paper claims to the correct PO Box in Salem, OR 97309.

All original claims received by the OMAP administrative office after June 30, 2005 will be returned to sender.

Provider Relations will continue to process problem claims, administrative errors, and claims over 1 year old. These types of claims must include a cover letter explaining the problem or requested action, and complete documentation.

(PL 05-086)

"Assisting People to Become Independent, Healthy and Safe"
An Equal Opportunity Employer

HSB 1014 (4/00)

Attachment 6 - *First Pass* Provider Announcement

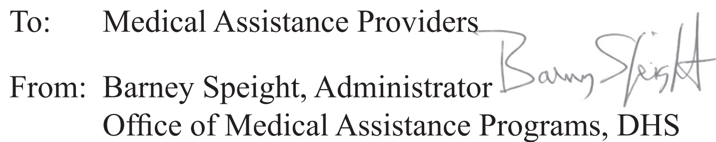
Oregon

Theodore R. Kulongoski, Governor

Department of Human Services
Health Services
Office of Medical Assistance Programs
500 Summer Street NE, E44
Salem, OR 97301-1079
Voice - (503) 945-5772
FAX - (503) 373-7689
TTY - (503) 378-6791

February 14, 2005

To: Medical Assistance Providers



From: Barney Speight, Administrator
Office of Medical Assistance Programs, DHS

Introducing: *First Pass*

An OMAP initiative designed to process claims timely and accurately on the first submission

First Pass is a series of actions designed to ensure Medicaid claims are processed accurately and timely. Under ***First Pass,*** we are analyzing our current procedures to find ways to improve our service and streamline processes. We're taking a critical look at how we enroll and train new providers, our customer service, the instructional materials and other information we provide, and other factors that impact claims processing and payment. Some of the changes we've already made as a result of ***First Pass*** include:

- ***Screening critical fields on the CMS-1500 -*** We now screen paper claims containing fewer than seven lines before entering them into our system. Screening and returning incomplete claims "up front" gives you an opportunity to correct and resubmit your claims earlier. *We've reduced our paper claims backlog by 14% since implementing this change.* We will soon be expanding this practice to include screening of all claim forms.
- ***Electronic Funds Transfer (direct deposit)*** - In October 2004, we introduced this cost-effective process to many providers submitting claims in the HIPAA Electronic Data Interchange (EDI) format. We look forward to expanding this option to all electronic submitters; stay tuned for more details.

Changes to come include:

- ***Provider Training*** - We're designing a new series of trainings for provider staff called OHP Billing FUN-damentals. The trainings, scheduled to begin in May, will cover basic information, such as how to read a Medical ID, and navigating through our system. It will also include a panel of subject experts to answer your questions.

"Assisting People to Become Independent, Healthy and Safe"
An Equal Opportunity Employer

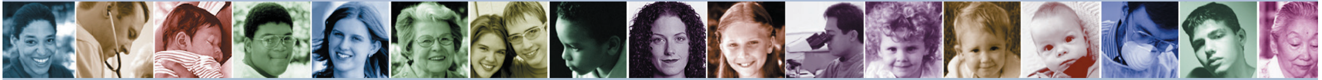
HRB 1014 (4/00)

Attachment 7 - First page of Connections

First Pass Connections

An informational newsletter for OMAP providers

Visit the First Pass Web page at: http://www.oregon.gov/DHS/healthplan/first-pass/main.shtml



Fast Information for Faster Claims Processing

May 2005 Issue 1

Inside this Issue

1 Process improves for new providers

1 Spotlight on common billing problems

2 Checking our Pulse – recent statistics and comparisons

2 OMAP shifts to exclusive Web-based communications

3 Tip Off – billing tips you can use

3 Electronic Toolbox – saving you time and money

3 HIPAA news – CMS finalizes rule on NPI

4 Upcoming Trainings and Events

4 Contacts and Resources

Process Improves for New Providers

The Office of Medical Assistance Programs (OMAP) enrolls approximately 200 new providers every month.

To help these providers familiarize themselves with OMAP's policies, Provider Enrollment Representatives will soon begin a new "welcome aboard" process of calling all providers within one month of their enrollment.

Representatives will make sure the new provider has received their initial OMAP enrollment packet, review materials and answer questions.

We believe this initial contact will help get our new providers off to a good start and forge a strong relationship between our providers and OMAP staff.

Spotlight on Common Billing Problems

Listed below are some of the billing errors from claims we processed in the first quarter of 2005:

Problem: OMAP denied 173,700 detail lines because the provider should have billed the client's managed care plan instead of OMAP.

Resolution: Be sure to verify eligibility before you submit your claim.

Tools: AIS Plus phone line – 1-800-522-2508
AIS Web – https://register.fhsc.com/webreg/
OMAP Medical ID Card (fields 8a and 8b)
Provider Relations Unit – 1-800-336-6016

Problem: OMAP denied 79,244 detail lines because the provider did not include a billing provider number on the claim.

Resolution: Make sure to include your OMAP provider number in the appropriate location of the claim.

Tools: Provider Relations Unit
Provider Supplements – http://www.dhs.state.or.us/policy/healthplan/guides/main.html

Problem: OMAP denied 105,600 detail lines because we had already processed a duplicate claim.

Resolution: Be sure to review the explanation in the "Claims Message Codes" field of your Remittance Advice (RA)

Tools: RA, Provider Relations Unit

Attachment 8 - Sample of First Pass Flash!

First Pass Flash!

Fast Information for Faster Claims Processing

No. 1 3/05

The First Pass Initiative

First Pass is a one-year initiative developed by the Office of Medical Assistance Programs (OMAP) to ensure Medicaid claims are paid accurately and timely. We have created the ***First Pass Flash!*** to inform you of changes we're making to our procedures and give you critical information that affects timely processing of your claims.

Register now for OHP Billing *FUN*-damentals

On May 18, we will be conducting a free provider training in Salem. The training will cover:

- ✓ billing issues
- ✓ available resources—where to find provider tips, billing instructions and other printed information, and helpful contacts
- ✓ information on eligibility verification
- ✓ basic requirements for requesting payment authorization

Information is being mailed with OMAP Remittance Advices (RAs) through April 11, and is also posted on our Web site at: **http://www.oregon.gov/DHS/healthplan/first-pass/main.shtml#training**

DHS/OMAP Web site—we've moved!

We have a new Internet home page:

http://www.oregon.gov/DHS/healthplan/index.shtml

From this page, you can click your way to the OMAP information contained on our former Web page. Unfortunately, it was not possible to put redirect messages on all of our Web pages, so, if you have marked "favorites" or "book marked" pages on your computer, you will need to locate the new addresses and re-mark them.

Duplicate billings create multiple problems

As we've been working to reduce our paper claims backlog, we've discovered that a large portion of the claims that come in daily are duplicates. Because most of these claims are already being processed, the duplicate claim will ultimately be denied, but not before it's affected your workload and ours. Rebilling can actually clog our system, delaying timely processing of your original claim.

We've been sending a backlog update weekly with your RA. The update shows how many days it is currently taking us to process your claims. Please do not rebill a paper claim if the original date of submission falls within our backlog timelines.

Remember: claims billed electronically are processed in five days. For more information on Electronic Data Interchange (EDI), read the following article.

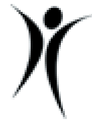
Electronic Data Interchange (EDI)—it's easier than you think

Electronic claims processing is faster and more cost effective than billing on paper. We are currently processing Medicaid primary and secondary claims in the new HIPAA compliant formats.

We are here to help you process claims in this new improved manner. For more information go to **http://egov.oregon.gov/DHS/admin/hipaa/testing_reg.shtml** or contact us at: 503-947-5347 or dhs.hipaatesting@state.or.us.

3/05 - First Pass Flash! - 05/023

Attachment 9 - Vendor Fair Announcement



DHS presents...

ELECTRONIC DATA INTERCHANGE (EDI) VENDOR FAIR

INTRODUCING
VENDORS WITH HIPAA TRANSACTION SOLUTIONS:
SOFTWARE,
BILLING SERVICES &
CLEARINGHOUSES

Come to the Fair ~ July 13, 2005

For more information, contact:

DHS Office of Medical Assistance Programs
EDI Outreach Coordinator
500 Summer St. NE, E-44
Salem, OR 97301-1079
Phone 1-800-527-5772

Attachment 10 - Sample HIPAA Bulletin

Electronic Data Interchange makes $ense: it's fast, accurate and cost effective.

Transactions and Codes Sets (TCS) compliance

OMAP HIPAA Bulletin

2

835 Remittance Advice for pharmacy providers

As many of you are aware, the federal government passed sweeping legislation, the Administrative Simplification Act, that affects the health care industry. Among other things, it provides for privacy and security when transferring health care information by use of transactions and codes sets outlined in the Health Insurance Portability and Accountability Act (HIPAA). The Centers for Medicare and Medicaid Services (CMS) regulate these requirements. The DHS Office of Medical Assistance Programs (OMAP) is a covered entity that must abide by HIPAA laws.

October 16, 2003, was the original deadline to implement HIPAA electronic transactions and code set standards. This bulletin updates you on OMAP's status in implementing the 835 Remittance Advice (RA) standard.

Oregon DHS HIPAA TCS Contingency Plan

CMS granted OMAP a Contingency Plan that gives us an additional 14 months to transition to the HIPAA-compliant transactions. It covers OMAP as a covered entity, and includes Medicaid providers as covered entities that do business with us in the electronic proprietary formats, such as the National Standard Format (NSF) and Universal Billing (UB)-92 formats.

The Contingency Plan allows us to continue to process claims data in both the electronic proprietary formats and the HIPAA-compliant 837 claims transactions formats until December 31, 2005.

Effective January 1, 2006, OMAP will no longer accept or transmit non-compliant, electronic proprietary formats.

Provider action needed

Effective January 1, 2006, the Office of Medical Assistance Programs (OMAP) will no longer provide paper or tape cartridge Remittance Advices to providers who submit data electronically to OMAP.

As OMAP's Pharmacy Benefit Administrator, First Health Services Corporation submits all pharmacy data to OMAP electronically. This means all pharmacy providers must convert to an electronic 835 Remittance Advice.