DHS
Oregon Department
of Human Services

DMAP 505
Billing Instructions

Division of Medical Assistance Programs
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Introduction

The *DMAP 505 Billing Instructions* handbook is designed to help those who bill the Department's Division of Medical Assistance Programs (DMAP) for Medicare-Medicaid crossover services complete the Medicare/Medicaid Billing Invoice correctly the first time. This will give you step-by-step instructions so that you, the provider, can be paid more quickly. This is to be used in conjunction 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.

This handbook also includes helpful hints on how to avoid common billing errors.

The *DMAP 505 Billing Instructions* are designed to assist the following providers:*

- Doctors of Medicine
- Physicians' Assistants
- Nurse Practitioners
- Podiatrists
- Certified Registered Nurse Anesthetists
- Independent Laboratories
- Naturopaths
- Vision
- Chiropractors
- Durable Medical
- Physical Therapy
- Occupational Therapy
- Audiologists
- Home Enteral/Parenteral IV

*This list does not include all provider types that use the DMAP 505. Before using the DMAP 505 claim form, refer to your specific provider guidelines to determine whether you should bill DMAP using this form, or submit a claim to Medicare. If in doubt of which claim form to use, contact DMAP Provider Services at 800-336-6016 for assistance.

Claims processing

The federal government requires DMAP 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 submitted by mail go first to the DHS Office of Document Management (ODM) Imaging Unit.

- The document is scanned through an Optical Character Recognition (OCR) machine and the claim is given an Internal Control Number (ICN). The scanner converts 2,500 to 3,000 documents per hour into images.
- 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 archived on compact discs, which are stored in a CD jukebox which staff access via intranet.

Once the claim is scanned through the Optical Character Reader, staff can immediately access submitted claim information by checking certain MMIS screens. The system processes most paper claims within 30 days. The fewer questions the computer asks, the more quickly it can process the claim.

The system performs daily edits for presence and validity of data. Once a week, the system audits all claims to ensure that they conform to medical policy. Every weekend, a payment cycle runs, and checks are produced for claims that successfully pass all edits and audits.

DMAP staff members will only see the claim if MMIS cannot make a payment decision based on the information submitted. The system directs the claim to DMAP staff for specific medical or administrative review. This type of claim is a *suspense (suspended) claim*.

DMAP does not return denied claims to providers. Instead, DMAP mails a listing of all claims paid and/or denied to the provider (with payment if appropriate). The listing is called a Remittance Advice (RA).

About the DMAP 505

When to use this form

The DMAP 505 claim form is unique. It is specifically used for clients who receive both Medicare and Medicaid services. When you submit your CMS 1500 claim form to Medicare, Medicare electronically transmits the billing information to DMAP. This transmission is called a *crossover*.

You must use the DMAP 505 form if:

- Medicare transmits incorrect information to DMAP, and DMAP denied payment; or
- You billed an out-of-state Medicare carrier or intermediary.

Accepted versions

DMAP will only accept 2007 versions of the DMAP 505 form. We will return claims submitted on the 11/99 OMAP 505 form with a request to resubmit them on the correct form.

How to order this form

You can order this form from DMAP using the Provider Forms Request Card (see Appendix). You can also download a PDF version of this form on DMAP's Forms page at www.oregon.gov/DHS/healthplan/forms/omapforms.shtml.

DMAP 505 form (revised 8/07)

DHS Oregon Department of Human Services

Medicare/Medicaid Billing Invoice for Medical Practitioner Claims

1. Patient's Name (Last, First, MI)	2. Patient's birthdate/sex MM DD YY M F	3. Insured's ID # (include all letters and numbers)
4. Patient's address (number, street)	5. Patient's Relation to Insured Self Spouse Child Other	6. Insured's Name (Last, First, MI)
City / State	7. Was condition related to: a. Patient's employment Y N	8. Insured's address (number, street)
Zip Code / Phone (Area Code)	b. Accident Auto Other	City / State
9. Other insured's name (Last, First, MI)	a. Other insured's Plan name	Zip Code / Phone (Area Code)
Other insured's Plan address (number, street)	b. Other insured's policy number	10. Insured's group # (or group name)
City / State	Zip Code / Phone (Area Code)	12. I authorize payment of medical benefits to undersigned physician or supplier for services described below.
11. Patient's or authorized person's signature – I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. *Signed* *Date*		*Signed (insured or authorized person)*
13. Date of current: MM DD YY ◀ Illness (first symptom) or Injury (accident) or Pregnancy (LMP)	14. If emergency, check here	15. First date patient had same or similar illness MM DD YY
16. Name of referring provider or other source	16a. 16b. NPI	17. Dates patient unable to work in current occupation From MM DD YY To MM DD YY
18. Outside lab? Yes No $ Charges	19. Prior authorization number	20. Hospitalization dates related to current services From MM DD YY To MM DD YY

21. Diagnosis or nature of illness or injury (relate items 1, 2, 3, or 4 to item 22D by line)
1. 2. 3. 4.

22. A. Date(s) of service From MM DD YY To MM DD YY	B. Place of service	C. Procedures, services or supplies (explain unusual circumstances) CPT/HCPCS	Modifier	D. Diagnosis code	E. Days or units	F. EPSDT Family Plan	G. Charges billed Medicare	H. Medicare's allowed charges	I. Rendering provider number
									DMAP:
									NPI:
									DMAP:
									NPI:
									DMAP:
									NPI:
									DMAP:
									NPI:
									DMAP:
									NPI:
									DMAP:
									NPI:

23. Federal tax ID # SSN EIN		24. Total charge	25. Total Medicare payment
26. Patient's account #	27. Accept assignment? Y N	28. Ins (not Medicaid/Medicare)	29. Balance due
30. Service facility location information		31. Billing provider information and phone number	
NPI #:	DMAP #:	NPI #:	DMAP #:

DMAP 505 (Rev 08/07)

DMAP 505 - Required boxes

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

Box	Field	Description
1	**Patient Name**	**Enter the client name exactly as it is printed on the Medical Care Identification.** DO NOT use "nicknames".
3	**Insured ID Number**	**Use the eight (8)-digit DMAP Medicaid Prime Identification Number.** The number is printed on the Medical Care Identification or it can be obtained through the Automated Information System (AIS Plus) at 800-522-2508.
7	**Was Condition Related To:**	Check the appropriate box when an injury is involved.
9	**Other Health Insurance Coverage**	**If Medicare did not make a payment to you, enter the appropriate two (2)-digit third party resource (TPR) explanation code.** If there is another third party resource, you must enter the appropriate two (2)-digit code explaining what both insurance actions were. See Appendix for TPR explanation codes.
14	**If Emergency Check Here**	If the service normally requires prior authorization, but the service was provided in an emergency situation, check this box.
16a	**ID - Referring Physician or Other Source**	**Enter the six (6)-digit DMAP provider number of the referring provider.** • If the referring provider is not enrolled with DMAP, enter six (6) nines (999999) for the provider number. • If the client has a Primary Care Manager (PCM), enter the PCM's name six (6)-digit DMAP provider number in this Box.
16b	**NPI – Referring Physician or Other Source**	**Enter the ten (10)-digit National Provider Identifier (NPI) of the referring provider.** If the client has a PCM, enter the PCM's NPI in this box.

Box	Field	Description
19	**Prior Authorization Number**	**If the service was prior authorized, enter the nine (9)-digit Prior Authorization number that was issued for the service.** • DO NOT bill prior-authorized and non-authorized services on the same claim form. You must submit separate DMAP 505 claim forms. • Check your provider guidelines to see if you need to obtain prior authorization for the service being billed.
21	**Diagnosis or Nature of Illness or Injury**	**Enter the primary diagnosis/condition of the client by entering current ICD-9-CM codes.** The diagnosis code must be the reason chiefly responsible for the service being provided as shown in the medical records. • Enter up to four (4) codes in priority order. The codes must be carried out to their highest degree of specificity. • DO NOT enter the decimal point. *Note*: This box indicates 1,2,3,4. Your diagnosis codes must be listed in that order. Refer to Box 22 D.
22	**Supplemental information**	**In the shaded area across Fields 22A through 22H, enter supplemental information about the service rendered.** Enter the appropriate qualifier(s), followed by the information. • If entering more than one item of information on a line, make sure each item begins with a qualifier and is separated by at least 1 blank space from other items on the same line. • See *Appendix* for more information about entering supplemental information.
22 A	**Date of Service**	**This box must list numeric dates of service.** If the "From – To" dates are used, a service must be on consecutive days and provided no more than once per day. As example: Correct.....05-01-07 thru 05-05-07.....5 units Incorrect.....05-01-07 thru 05-06-07.....5 units

Box	Field	Description
22 B	**Place of Service**	**List the two (2)-digit Place of Service (POS) code for where the service was provided.** Use the standard CMS codes available in your CPT or HCPCS book.
22 C	**Procedure Code**	**List the five (5)-digit procedure code for the service provided.** Use only CPT or HCPCS codes, followed by two (2)-digit modifier as appropriate, as listed in specific DMAP provider guidelines.
22 D	**Diagnosis Code**	**Only list one (1) number that cross-references the diagnosis as listed in Box 21.** DO NOT enter the actual ICD-9-CM code here.
22 E	**Days or Units**	**This number must match the number of days being provided as indicated in Box 22A, UNLESS a unique procedure code is being used.** • As example: Procedure code 97110 (therapeutic exercise), 1 unit = 15 minutes, you treated the client for 45 minutes, the number of units that must be recorded is 3, not 1. • If you are NOT using a unique procedure code, the units must match the number of consecutive days.
22 G	**Charges Billed Medicare**	Enter the amount you billed Medicare for each service provided.
22 H	**Medicare's Allowed Charges**	Enter the amount Medicare allowed for each service provided.
22 I	**Provider Number**	**List the six (6)-digit DMAP number and ten (10)-digit NPI of the "performing" provider.** When clinics or group practices bill DMAP using their specific billing provider number in Box 31, this field must be completed to indicate who performed the service being billed. • Enter the DMAP number in the shaded half of this field. • Enter the NPI in the non-shaded half of this field.

Box	Field	Description
24	**Total Charge**	**Enter the total amount for all charges listed in Box 22G.** All lines listed under Box 22G should add up to the total amount billed.
25	**Medicare Total Payment**	**Enter the total amount paid by Medicare.** DO NOT enter the amount of write-offs.
26	**Your Patient's Account Number**	If a patient account number is provided in this box, DMAP will print this information on the Remittance Advice (RA).
28	**Insurance Other Than Medicaid/ Medicare**	**Enter any amount paid by any other health insurance resource, other than Medicare.** If the amount is zero, place a "0" in this box. DO NOT include: • DMAP co-payments • Previous payment amounts that DMAP has made.
29	**Balance Due**	**Enter the total balance due.** Box 24 minus the total of Boxes 25 and 28 equals Box 29, "balance due".
31	**Provider Number**	**Enter the ten (10)-digit NPI and six (6)-digit DMAP number of the billing or performing provider.** Payment will be made to this provider. • Enter the NPI and DMAP number in the shaded boxes at the bottom of this field.

Helpful tips

Additional information is available on DMAP's Web site at www.oregon.gov/DHS/healthplan. Click on "Tools for Providers," then "Billing Tips."

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 at DMAP's Web site. Click on "Tools for Providers," then "Policies." Click "more" for a list of current guideline pages.
- If you do not have internet access, you may contact DMAP at 800-527-5772 and ask to have provider guidelines mailed to you.

COMPLETE only the boxes that are required. To save time, make a template from a blank claim, and keep copies of the claims you submit. In the supplemental information for your provider type, you may also find a sample of a completed DMAP 505 form to use as a guide.

BEFORE billing DMAP…

- **MAKE SURE** that you billed prior resources and reported the correct dollar amount in Box 25.
- **DO NOT** attach prior resource EOB's.
- **USE** the correct 2-digit third party resource (TPR) explanation code in Box 9 when other insurance made **no** payment, and **always** when there is more than one resource available.

VERIFY client eligibility on the date the service is being provided.

If possible, photocopy the Medical Care ID and/or verify with one of the services listed on DMAP's Electronic Eligibility Verification Web page at www.oregon.gov/DHS/healthplan/tools_prov/electronverify.shtml.

- **Automated Information System (AIS) by phone:** Call 800-522-2508;
- **AIS Plus on the Web:** Go to the Electronic Eligibility Verification Web page, then click "AIS" to register for Web-based access;
- **Electronic Eligibility Verification Service (EEVS) vendor**: Go to the Electronic Eligibility Web page, or call 800-336-6016 for a copy of the vendor list.

The client name and number on the DMAP 505 needs to match the Medical Care

Identification (ID). A Medical Care ID number is always eight characters and is reported in Box 3 of the Medical Care ID. The General Rules supplemental information book shows an example of a Medical Care ID.

USE only one prior authorization number in Box 19. DO NOT bill authorized services and services that do not require authorization on the same claim form.

USE the correct combination of procedure code and modifier appropriate for the service billed under your provider type. DMAP will determine the Type of Service (TOS) based on the provider ID number, procedure code, and modifier, as applicable, that you submit to us on your claim.

- If you do not enter this information correctly, our system will assign your claim the wrong type of service, which may cause the claim to deny or be paid incorrectly for the services performed. This may result in a paper RA that indicates the claim was rejected due to a TOS error.
- Refer to your provider guidelines to determine which type of service corresponds with your procedure code that is reported in Box 22C.

ALWAYS ENTER the DMAP 6-digit provider number you want DMAP to send payment to in Box 31. 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.

- If the performing provider is different from the billing provider, enter the performing provider information in Box 22I.
- A "performing" provider is the individual who provided the service; a "billing" provider bills on behalf of the performing provider.

CHECK your claim form for legibility so that it can be clearly read. Avoid tiny print, print that overlaps onto a line, entering more than 6 lines per claim, and poorly handwritten claim forms.

READ the explanation of benefit (EOB) codes on your Remittance Advice. They will tell you what the error is, if you should re-bill or submit an Individual Adjustment Request (DMAP 1036) form.

CONTACT Provider Services at 800-336-6016 for assistance in completing your DMAP 505 or other questions regarding a medical claim.

Appendix

Third Party Resource (TPR) explanation codes

Use in Box 9 on the DMAP 505.

Single insurance coverage

Use a single insurance code when the client has only one insurance policy in addition to Medicaid.

UD	Service Under Deductible
NC	Service Not Covered by Insurance Policy
PN	Patient Not Covered by Insurance Policy
IC	Insurance Coverage Canceled/Terminated
IL	Insurance Lapsed or Not in Effect on Date of Service
IP	Insurance Payment Went to Policyholder
PP	Insurance Payment Went to Patient
NA	Service Not Authorized or Prior Authorized by Insurance
NE	Service Not Considered Emergency by Insurance
NP	Service Not Provided by Primary Care Provider/Facility
MB	Maximum Benefits Used for Diagnosis/Condition
RI	Requested Information Not Received by Insurance from Patient
RP	Requested Information Not Received by Insurance from Policyholder
MV	Motor Vehicle Accident Fund Maximum Benefits Exhausted
AP	Insurance Mandated Under Administrative/Court Order Through an Absent Parent-and Not Paid Within 30 Days
OT	Other (if above codes do not apply, include detailed explanation of why no TPR payment was made)

Multiple insurance coverage

Use in Box 9 of the DMAP 505. Use a multiple insurance code when the client has more than one insurance policy in addition to Medicaid.

MP	Primary Insurance Paid – Secondary Paid
SU	Primary Insurance Paid – Secondary Under Deductible
MU	Primary and Secondary Under Deductible
PU	Primary Insurance Under Deductible - Secondary Paid
SS	Primary Insurance Paid – Secondary Service Not Covered
SC	Primary Insurance Paid – Secondary Patient Not Covered
ST	Primary Insurance Paid – Secondary Canceled/Terminated
SL	Primary Insurance Paid – Secondary Lapsed or Not in Effect
SP	Primary Insurance Paid – Secondary Payment Went to Patient
SH	Primary Insurance Paid – Secondary Payment Went to Policyholder
SA	Primary Insurance Paid – Secondary Denied - Service Not Authorized
SE	Primary Insurance Paid – Secondary Denied - Service Not Considered Emergency
SF	Primary Insurance Paid – Secondary Denied - Service Not Provided by Primary Care Provider/Facility
SM	Primary Insurance Paid – Secondary Denied - Maximum Benefits Used for Diagnosis/Condition
SI	Primary Insurance Paid – Secondary Denied - Requested Information Not Received from Policyholder
SR	Primary Insurance Paid – Secondary Denied - Requested Information Not Received from Patient
MC	Service Not Covered by Primary or Secondary Insurance
MO	Other (if above codes do not apply, include detailed explanation of why no TPR payment was made)

Supplemental information

In the shaded areas across fields 22A through 22H on the DMAP 505 form, you can enter supplemental information about the service(s) rendered.

DMAP accepts the following types of supplemental information, accompanied by the appropriate qualifier:

Qualifier	Information type
7	Anesthesia duration in hours and/or minutes with start and end times
ZZ	Narrative description of unspecified codes
N4	National Drug Codes (NDC). In addition, use the following qualifiers when reporting NDC units: • F2 – International Unit • GR – Gram • ML – Milliliter • UN – Unit
VP	Vendor Product Number – Health Industry Business Communications Council (HIBCC)
OZ	Product Number Health Care Uniform Code Council – Global Trade Item Number (GTIN), formerly Universal Product Code (UPC)
CTR	Contract rate

Supplemental information examples

The following examples show how to enter different types of supplemental information as listed above. They are not meant to provide direction on how to code for specific services.

Anesthesia Services – Payment based on 15-minute units

22. A. Date(s) of service From MM DD YY	To MM DD YY	B. Place of service	C. Procedures, services or supplies (explain unusual circumstances) CPT/HCPCS	Modifier	D. Diagnosis code	E. Days or units	F. EPSDT Family Plan	G. Charges billed Medicare	H. Medicare's allowed charges	I. Rendering provider number
7Begin 1245 End 1415 Time 90 Minutes										DMAP: 123456
06 01 07	06 01 07	1	00770	P2	1	6		### ##	### ##	NPI: 1234567890

Anesthesia Services – Payment based on minutes as units

22. A. Date(s) of service From MM DD YY	To MM DD YY	B. Place of service	C. Procedures, services or supplies (explain unusual circumstances) CPT/HCPCS	Modifier	D. Diagnosis code	E. Days or units	F. EPSDT Family Plan	G. Charges billed Medicare	H. Medicare's allowed charges	I. Rendering provider number
7Begin 1245 End 1415										DMAP: 123456
06 01 07	06 01 07	1	00770	P2	1	90		### ##	### ##	NPI: 1234567890

Unspecified Code

22. A. Date(s) of service From MM DD YY	To MM DD YY	B. Place of service	C. Procedures, services or supplies (explain unusual circumstances) CPT/HCPCS	Modifier	D. Diagnosis code	E. Days or units	F. EPSDT Family Plan	G. Charges billed Medicare	H. Medicare's allowed charges	I. Rendering provider number
ZZ Kaye Walker										DMAP: 123456
06 01 07	06 01 07	4	E1399		1	1		### ##	### ##	NPI: 1234567890

NDC Code

22. A. Date(s) of service From MM DD YY	To MM DD YY	B. Place of service	C. Procedures, services or supplies (explain unusual circumstances) CPT/HCPCS	Modifier	D. Diagnosis code	E. Days or units	F. EPSDT Family Plan	G. Charges billed Medicare	H. Medicare's allowed charges	I. Rendering provider number
N400026064871 Immune Globulin Intravenous				UN2						DMAP: 123456
06 01 07	06 01 07	1	J1563		1	20		### ##	### ##	NPI: 1234567890

Vendor Product Number

22. A. Date(s) of service From MM DD YY	To MM DD YY	B. Place of service	C. Procedures, services or supplies (explain unusual circumstances) CPT/HCPCS	Modifier	D. Diagnosis code	E. Days or units	F. EPSDT Family Plan	G. Charges billed Medicare	H. Medicare's allowed charges	I. Rendering provider number
VPA122BIC5D6E7G										DMAP: 123456
06 01 07	06 01 07	1	A6410		1	1		## ##	## ##	NPI: 1234567890

Global Trade Item Number

22. A. Date(s) of service From MM DD YY	To MM DD YY	B. Place of service	C. Procedures, services or supplies (explain unusual circumstances) CPT/HCPCS	Modifier	D. Diagnosis code	E. Days or units	F. EPSDT Family Plan	G. Charges billed Medicare	H. Medicare's allowed charges	I. Rendering provider number
OZ00301134678906										DMAP: 123456
06 01 07	06 01 07	1	A6410		1	1		## ##	## ##	NPI: 1234567890

Provider Forms Request card

DHS
Oregon Department of Human Services

Division of Medical Assistance Programs

DMAP Forms Request

Instructions:

1. Fill in the Provider information at right (type or print clearly).
2. Order only those forms listed in the chart below. CMS 1500 Billing Forms are NOT available through DAS or DMAP.
3. Fill in the number of packages column.
4. Fold page in thirds, seal with adhesive strip, affix postage. Mail to:
   DHS/ODM Distribution Center
   550 Airport Rd SE
   Salem OR 97310

Provider Name		
Street Address **(NOT PO Box)**		
City	**State**	**ZIP**

Area Code & Phone

Forms available in packages of 50

CMS 1500 billing forms are available through business forms suppliers.

Form #	Title	Qty	Packages
DMAP 2420	DMAP Forms Request cards (5 max)		
DMAP 405T	Med. Transportation Order		
DMAP 406	Med. Transport. Eligibility Screening & Med. Transportation Order		
DMAP 505	Medicare/Medicaid Billing Inv. (cont.)		
DMAP 741	Hysterectomy Consent English Spanish		
DMAP 742	Consent to Sterilization English Spanish		
DMAP 1036	Individual Adjustment Request		

The above forms and other DMAP forms are available on DMAP's Web site at www.oregon.gov/DHS/healthplan

DMAP 2420 (05/07)