DHS Oregon Department of Human Services

Provider Matters

For the week of July 26, 2009

Provider Matters gives providers a single place to look for the latest issues affecting claim processing and other transactions in the Medicaid Management Information System (MMIS). It includes general issues affecting all provider types and claims, as well as issues specific to certain providers or claim types. You can eSubscribe to OHP Provider Announcements to find out when a new issue is posted.

Once system corrections are in place, DHS will reprocess affected claims whenever possible. In the issues that follow, you will see when DHS can reprocess the claim(s), requiring no action on your part; and when DHS cannot and what steps need to be taken to get the claim processed.

If you need to submit a refund for an overpayment, transitional payment or other transaction, **do not send checks to DMAP**. Instead, send them to the following address:

DHS Receipting Unit
ATTN: [Reason for check]
500 Summer St NE, 4th Floor
Salem, OR 97301

Include your DHS provider number and any documentation needed to link your check to the appropriate claim or transaction.

New this week

Area	Issue	Description	Workaround	Resolution
Payment/ Remittance Advice	Incorrect EOB for DME claims billed through POS	When billing DMAP for DME or diabetic supplies through POS, the following message may appear: • EOB 0154 – Bill Medicare D [even if the client does not have Medicare Part D coverage] • EOB 1100 – Non-participating manufacturer	Please know that when you bill DMAP for DME supplies using Point of Sale, EOB messages 0154 and 1100 mean that the product/service isn't covered by DMAP.	DHS has requested corrected EOBs.

Area	Issue	Description	Workaround	Resolution
Reminder	Do not bill DME supplies through Point of Sale (POS)	If you bill DMAP for DME or diabetic supplies using Point of Sale, you may receive the following EOB messages: • EOB 044 – Bill DME not Point of Sale • EOB 0154 – Bill Medicare Part D • EOB 1100 – Non-participating manufacturer • NCPDP code 70 – Product/Service not covered	N/A	Bill for DME and diabetic supplies using the professional claim format (837P, CMS-1500 or professional Web claim). Pharmacies must be enrolled as DME providers in order to bill DMAP for these items.
Reminder	Medicare B billing for pharmacies	DMAP continues to reimburse Medicare Part B coinsurance payments for Medicare-Medicaid clients. Please bill the Medicare Part B carrier before billing DMAP for the Medicare coinsurance amount(s). For more information, refer to the Pharmaceutical Services supplemental information for call the Oregon Pharmacy Call Center at 888-202-2126.		

Billing issues

Area	Issue	Description	Workaround	Resolution
Claims that require reports or manual pricing	Submit on paper with documentation to avoid denials	The 837 transaction and Provider Web Portal do not contain fields that staff can refer to for reports or manual pricing. This means that electronic claims that require reports or manual pricing (*e.g.*, unlisted procedure codes) deny for additional documentation. When this happens, EOB messages you may see on the paper RA include: • 0393 – Resubmit with full description and documentation of acquisition cost • 0073 – Claim was manually priced • 0070 – This service is part of another procedure and is not paid separately… • 0140 – Procedure code or type of service (TOS) does not match description of service…. • 0185 – Report required for consultant to manually price… • 0365 – This service requires prior authorization for payment. • 0537 – Claim was reviewed by medical staff….	Until further notice, submit claims that require reports or manual pricing on **paper with supporting documentation** attached. If you have electronic claims requiring reports or manual pricing that have denied, **resubmit on paper with supporting documentation.**	DHS has requested that the Provider Web Portal include fields to accommodate NDC, number and dosage so that users can submit Web claims with drug codes for manual pricing.
Durable Medical Equipment	Out-of-State DME claims denying because PA is required	If the claim indicates a Medicare allowable greater than zero and the provider is out of state, the claim should bypass PA edits. Instead, the claim is denying when PA is required for the procedure.	None at this time.	DHS tested a solution to this issue on 7/23/09.

Area	Issue	Description	Workaround	Resolution
Inpatient claims (paper)	Overpayment for Medicare Part B claims	When a client has Medicare Part B coverage only and receives an inpatient service, the claim processes as a regular inpatient claim and does not deduct the amount paid by Medicare. This causes DHS to overpay these claims.	None at this time. **Do not refund DMAP at this time.**	DHS has identified this issue as a system defect; once it is fixed, DHS will attempt to **reprocess** the claims.
Pharmacy Point of Sale	EOB 1124 – "Cannot Prioritize Recipient's Programs"	DHS is unable to determine payment due to the benefit plans listed for the client on the claim.	Report this error to the Oregon Pharmacy Call Center at 888-202-2126. Ask the client to contact their DHS caseworker.	Once DHS updates the client records that caused the error, **rebill.** The claims will then process appropriately.
System errors	Denials for clients with no PCM	Providers may be receiving the following EOB in error: • 0151 ("Claim needs referring provider")	Contact Provider Services with the ICN of the claim in question.	DHS is currently researching this issue and will provide more information once it becomes available.
System errors	Missing procedure codes	Some procedure codes were not loaded into the new system, which may cause claims to deny with EOB 4801 ("No contract for billed procedure"). Because of the volume of codes in the system, DHS cannot determine the few codes that may not have been loaded.	If you believe a missing procedure code resulted in your claim denial, contact Provider Services. Provide your DHS provider number, ICN for the claim in question, and missing code(s).	DHS is researching and adding missing procedure codes on a case-by-case basis. Once you report the missing code, DHS will research the claim and let you know when you can resubmit the claim.

Electronic Data Interchange

Area	Issue	Description	Workaround	Resolution
Electronic Data Interchange	837P Medicare COBA transactions	An incoming 837P transaction from COBA failed to process in the DHS system, even though the file appears valid.	N/A	DHS has reported this error as a system defect.

Payment/remittance advice

Area	Issue	Description	Workaround	Resolution
835/Electronic Remittance Advice	Adjustment Reason Codes (ARCs)	835s contain Adjustment Reason Codes only; DHS is currently unable to send all adjustment reason codes in the outgoing 835.	Refer to your paper RA for more detailed EOB information.	DHS is currently testing corrected 835s that include all applicable adjustment reason codes.
835/Electronic Remittance Advice	Copayment ARC	The ARC indicating copayment should be "PR3" (Patient Responsibility). Instead, the 835 returns ARC "CO3" (Contractual Obligation).	Until this is fixed, please know that "CO3" will always indicate copayment.	DHS expects this to be fixed soon.
835/Electronic Remittance Advice	Out of balance 835s	835s with EOBs that list the "PR" (Patient Responsibility) ARC are out of balance. DHS cannot deliver 835s that are out of balance.	N/A	DHS tested a solution to this issue on 6/26/09.
Electronic funds transfer (EFT)	Generic payee identifier	The payee identifier in the new system is "OR DHS MMIS" (not the DHS provider ID).	None at this time.	DHS is currently researching this issue.

Area	Issue	Description	Workaround	Resolution
Remittance Advice (Paper and Electronic)	Missing RAs	Providers have reported not receiving their paper or electronic RA as expected.	If you have questions regarding a missing RA and need a paper replacement while the issue is bring researched, contact EDI Support Services (888-690-9888). You will be contacted within 1 business day.	DHS will research missing RA issues on a case-by-case basis. Once you report the missing RA, DHS will research the issue and let you know when you can expect to receive your RA normally.
Remittance Advice (Paper)	EOB 1124 – "Cannot Prioritize Recipient's Programs"	DHS is unable to determine payment due to the benefit plans listed for the client on the claim. Non-pharmacy claims will suspend for DHS to work.	Claims with this EOB will appear in the "Claims in Process" section of the paper RA. **No action is required on your part.**	Once DHS updates the client records that caused the claims to suspend, the claims will process appropriately.
Remittance Advice (Paper)	Non-Claim-Specific Refund information on paper RA	On the paper RA, the "Non-Claim Specific Refunds from Providers" section of the Financial Transactions has incorrect data. The reason code, client number & client name listed in this section do not match the information from the original refund(s).	N/A	DHS is currently researching this issue.

Provider Web Portal

Area	Issue	Description	Workaround	Resolution
General	"Critical error" and "SOAP" messages	These messages occur when using the Provider Web Portal, often after clicking a "submit" button. "SOAP" messages may also occur when a user clicks the "submit" button more than once while waiting for the Web portal to respond.	If the workarounds posted in the Troubleshooting document don't work, report the issue to Provider Services. Include the time, date, your computer operating system, Internet browser and what you were doing when the message occurred.	DHS is working these issues on a case-by-case basis.
Institutional Web Billing	"Critical error" due to missing claim type	If you create an institutional claim and submit it without selecting claim type, a critical error will occur. Any information entered before submitting the claim is lost.	"Claim type" is a required field on all institutional Web claims. Always make sure you have selected a claim type (*i.e.*, "1 – Inpatient Claims"). This field is at the top of the institutional claim screen.	DHS is testing a fix to this issue so that instead of "Critical error," the Web portal displays an error message prompting users to enter the claim type.
Messages from DHS	DHS unable to send messages to Web portal users	DHS is unable to post messages in the "Messages" section of the Web portal.	To stay informed about MMIS updates, make sure to check the "What's New" link that is above the Messages section.	DHS is testing a fix to this issue.

Area	Issue	Description	Workaround	Resolution
Resubmitting claims	"Record is a duplicate" error message when attempting to resubmit denied claims that contain TPL	Providers may be unable to resubmit denied claims with third-party liability (TPL) information using the Web portal. When you click "Submit" on the corrected claim, you may receive the error message saying, "A record is a duplicate." This prevents the provider from submitting the claim.	Resubmit denied claims using the appropriate paper claim or Electronic Data Interchange format.	DHS has reported this error as a system defect.
Web billing	Enter modifiers in correct sequence	The Web portal is allowing users to enter modifiers in any modifier field (skipping fields or leaving the first field blank). When this happens, the 835 cannot be delivered until DHS manually corrects the modifier sequence in the 835. The modifier fields are not numbered, so users may not know what order the fields are supposed to be entered in.	Enter modifier information in this order: 1. Top left field 2. Top right field 3. Bottom left field 4. Bottom right field 	DHS has requested that the Web portal require users to enter modifiers in a specific order so that an error message occurs, prompting users to correct the modifier information.
Prior authorizations (PA)	Automatic logouts when users attempt new PA requests	When creating a new PA request, users may get bounced back to the log in screen after hitting the "add diagnosis" button.	N/A	DHS is currently researching this issue.

Reminders

Reminders in this section will drop off after two weeks. After that, refer to existing resources for where to find helpful reminders.

Topic	Reminder
7/1/09 pharmacy PA requirements	Starting 7/1/09, long-acting opioids, Daytrana, Amitza and Relistor prescriptions for fee-for-service clients require prior authorization (PA) through the Oregon Pharmacy Call Center. For more information, refer to: • The letter for prescribing providers and pharmacies, and • The letter sent to FFS clients with recent long-acting opioid prescriptions.

Topic	Reminder
Converted PA approvals	If you try using the Web portal to change a PA approval that converted from the old system to the new system, this may cause a mismatch of information needed for claim processing. To avoid this: • Call the office who authorized the service. • Once you call, the PA authority will help you resolve the PA issues that are preventing appropriate claim processing.
Do not send refund checks with the DMAP 1036	Do not attach refund checks/money orders with your DMAP 1036 Individual Adjustment Request. You can resolve overpaid claims by using the DMAP 1036 or submitting a refund; not both. Send all refund checks/money orders (with a copy of the RA) to: DHS Office of Financial Services, Receipting Unit 500 Summer St. NE, 4th Floor Salem, OR 97301
Only use CMS Place of Service (POS) codes	The system does not recognize the old DMAP one-digit POS codes. When entering a Place of Service, use the standard two-digit codes listed at the front of your CPT or HCPCS codebook. These codes are also on the CMS Web site at www.cms.hhs.gov/PlaceofServiceCodes. Entering the DMAP one-digit POS codes as 2-digit codes (with a leading zero) can cause claims to deny due to incorrect POS. For example: • DMAP POS code 3 identified the POS as the practitioner's office; however, CMS POS code 03 identifies the POS as a school setting. • Practitioner claims should indicate CMS POS code 11 (not 03) for the practitioner's office; otherwise, the claim will deny.
Trading partners must report new DHS provider numbers to EDI Support Services	When a DHS provider number has more than one associated NPI, Provider Enrollment must add new DHS provider numbers and service locations for the additional NPIs and the associated taxonomy codes. If you are a registered DHS trading partner, make sure to contact EDI Support Services whenever you obtain additional DHS provider numbers. Include the following information: • Your trading partner ID • New provider number(s) • The old NPI and old DHS number associated with your trading partner ID. EDI Support will be able to link your new DHS provider number(s) with your trading partner ID so that your ERA gets created when you bill using the new number(s).
DME crossover claims	Because of the way CMS handles taxonomy codes, electronic DME claims that crossover from Medicare to DHS are likely to deny. To bill DMAP for DME crossover claims: • Identify DME claim denials in the "Medicare Part B Crossover claims denied" section of your RA. • Then bill DMAP directly using the Provider Web Portal, DMAP 505 paper claim form, or 837 format.

Topic	Reminder
Paper claim formatting	Submit all paper claims with identifying numbers (*e.g.,* client ID, billing and rendering provider numbers) centered as much as possible in the required box. Do not enter the "1D" qualifier when entering DHS provider numbers on paper claims. When you include the qualifier, it is entered as part of the provider number so that the claims deny due to an invalid provider number. If you have any questions, contact Provider Services (800-336-6016).

Resolved issues

Issues in this section will drop off after one week.

Area	Issue	Description	Workaround	Resolution
Pharmacy Claim Processing	ProDUR error	A duplicate entry for diagnosis V147 in the ProDUR system prevented claims that contain diagnosis V147 from processing.	N/A	DHS resolved this issue on 7/24/09.

Resources

- **Provider guidelines (rulebooks and supplemental information):** Make sure you are using the current provider guidelines available for your provider type. To find the guidelines you need, go to www.oregon.gov/DHS/healthplan/tools_prov/newproviders.shtml.
- **Provider Web Portal:** Find everything you need to know about the Provider Web Portal at this link, including guides for all current functions, and quick references about set up, eligibility, and HSC List inquiries.
- **Remittance Advice:** Updated tutorials about how to read the paper RA and EOB information are now available.

Need help?

For all the latest provider contacts, download the current Provider Contacts List.

- **Specific claims and client eligibility** - Call Provider Services at 800-336-6016 or e-mail dmap.providerservices@state.or.us.
- **EDI and the 835 ERA** - Call EDI Support Services at 888-690-9888 or e-mail dhs.edisupport@state.or.us.
- **EFT information and updates** - Contact Provider Enrollment at provider.enrollment@state.or.us.
- **Pharmacy and prescriber questions (for technical help and fee-for-service prescription PAs)** - Contact the Oregon Pharmacy Call Center at 888-202-2126.
- **Prior authorization status** – Call the DMAP PA Line at 800-642-8635 or 503-945-6821 (outside Oregon).
- **Web portal help and resets** - Call Provider Services at 800-336-6016 or e-mail team.provider-access@state.or.us.