

1500 CLAIM SUBMISSION

SUBMITTING 1500 PROFESSIONAL CLAIMS THROUGH
THE OHCA SECURE PROVIDER PORTAL.



CLASS DESCRIPTION

This class will provide an in-depth look at the 1500 professional claims submission process on the secure provider portal. Attendees will learn more about the policy and procedures of submitting Medicaid primary, Medicaid secondary, HMO co-pay and Medicare crossover claims. General coding for services will not be addressed in this presentation.

Recommended Audience:

- Billing staff who submit 1500 professional claims.

DISCLAIMER

- SoonerCare policy is subject to change.
- The information included in this presentation is current as of January 2021.
- Stay informed with current information found on the new OHCA public website: <https://oklahoma.gov/ohca>.

AGENDA

- Claim Basics
- Claim Submission
 - Medicaid Primary
 - Medicaid Secondary
 - HMO Co-pay
 - Medicare Crossover
- Claim Functions
- Resources
- Questions

CLAIM BASICS

CLAIM ID NUMBERS

Claims accepted into the SoonerCare provider portal are issued a tracking number known as the Internal Control Number (ICN) or the claim ID number.

- 13-digit number
- Contains four pieces of identifying information
- Example Claim ID: 2220000606000

CLAIM ID NUMBERS

ICN Orientation: RRYJJJJIIIIII

- **RR**: The first two digits represent the region code or the type of claim being processed.
- **YY**: The next two digits refer to the calendar year the claim was received.
- **JJJ**: These three digits refer to the Julian date the claim was received.
- **IIIIII**: The last six digits refer to the claim number that is assigned when the claim is received.

CLAIM ID NUMBERS

Code	Description
10	Paper claims without attachments
11	Paper claims with attachments
20	Electronic claims without attachments
21	Electronic claims with attachments
22	Internet claims without attachments
23	Internet claims with attachments
49	Recipient linking claims
59	Provider reversals/voids
91	Batches requiring manual review
92	HMO Copays – paper
94	Web HMO Copays – with attachment

Region codes indicate the claim submission method used.

CLAIM STATUS

Once a claim has adjudicated, it is assigned one of four statuses by the OKMMIS system:

- **Paid** – claim has paid all or some of the line items.
- **Denied** – claim is denied either at the header or detail levels.
- **Suspended** – claim is still in process and may require manual review by a resolutions department.
- **Resubmit** – claim was received during the system cycle process time and will finish processing once the cycle is complete.

TIMELY FILING

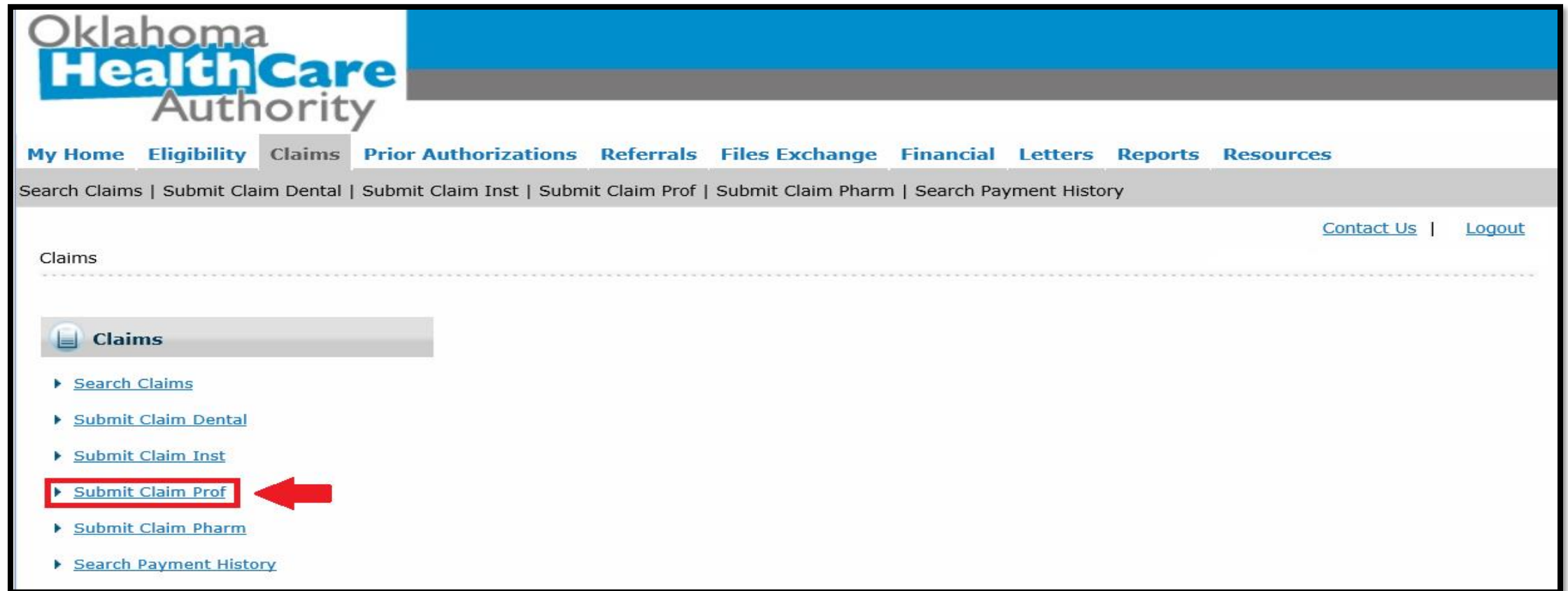
- Claims must be filed within the first six months from the date of service to establish timely filing.
- Proof of timely filing must be attached if a claim is received after six months from the date of service.
- Timely filing proof is considered a claim from the OHCA secure provider portal that reflects the ICN and line item details or a copy of an OHCA remittance advice with the same information.

CLAIM SUBMISSION

MEDICAID PRIMARY

- Medicaid is considered primary if it is the member's only source of coverage.
- Medicaid is the payer of last resort.
 - Exceptions to this are Indian Health Services and those eligible for the Crime Victims Compensation Act.
- Providers are reimbursed based on fee schedule allowable rates.

MEDICAID PRIMARY



The screenshot shows the Oklahoma HealthCare Authority website. The header includes the logo and a navigation menu with items: My Home, Eligibility, Claims, Prior Authorizations, Referrals, Files Exchange, Financial, Letters, Reports, and Resources. Below the navigation is a search bar with options: Search Claims, Submit Claim Dental, Submit Claim Inst, Submit Claim Prof, Submit Claim Pharm, and Search Payment History. On the right side, there are links for Contact Us and Logout. The main content area is titled 'Claims' and contains a sub-menu with the following items: Search Claims, Submit Claim Dental, Submit Claim Inst, Submit Claim Prof (highlighted with a red box and a red arrow pointing to it), Submit Claim Pharm, and Search Payment History.

Select Submit Claim Prof under the Claims tab.

MEDICAID PRIMARY

Submit Professional Claim: Step 1 ?

* Indicates a required field.

Claim Type

EVV SERVICES ONLY timely filing

HCA-17

Two types of professional claims:

- Professional – Medicaid primary, Medicaid secondary or non-Medicare HMO policies.
- Professional Crossover – Medicare only.

Select *Professional* as the Claim Type.

MEDICAID PRIMARY

Provider Information			
This panel contains provider information.			
Billing Provider ID		ID Type	NPI
Name			
Zip Code	Contract Code	Taxonomy	SC Provider Number
Referring Provider ID	<input type="text"/>	ID Type	<input type="text"/>
Ordering Provider ID	<input type="text"/>	ID Type	Ordering Zip Code <input type="text"/>
Other Facility ID	<input type="text"/>	ID Type	<input type="text"/>

Referring and/or Ordering Provider are required if applicable.

- **Referring Provider** is used if the member has a Patient Centered Medical Home (PCMH) and the service requires a referral.
- **Ordering Provider** is the individual provider that ordered the service. Some services require an ordering provider.

MEDICAID PRIMARY

- Member ID is always required. The member demographics will auto populate if the member ID is valid.
- Other Insurance needs to be left at *None*.
- Select **Continue** to proceed to step 2.

Patient Information

Enter the Member ID. If Member ID is valid, the rest of the member information will populate.

***Member ID**

Last Name First Name Middle
Birth Date

Claim Information

Enter information applicable to the claim. If Other Insurance information needs to be entered, then Include should be selected in the Other Insurance dropdown. The Other Insurance details can be entered on Submit Step 2.

Date Type Date of Current


Accident Related Expected Delivery Date

Patient Account Number To Date

From Date CLIA Number

***Other Insurance** HMO Copay

Total Charged Amount \$0.00




MEDICAID PRIMARY


Diagnosis Codes

Select the row number to edit the row. Click the **Remove** link to remove the entire row.

#	ICD Version	Diagnosis Code	Action
<u>1</u>			

1 *ICD Version *Diagnosis Code





- **Diagnosis Code** field is required. Enter the diagnosis code without the decimal point and select the **Add** button.
- Click **Continue** to proceed to step 3.

MEDICAID PRIMARY

- Charge Amount must be entered, or claim will deny or pay at \$0.
- Most claims will require a Rendering Provider ID. Certain provider types do not require it.
- If an Ordering Provider is entered in Step 1, it will carry over to Step 3 on all line items.
- Select **Add** to enter additional service lines.

Service Details

Select the row number to edit the row. Click the **Remove** link to remove the entire row.

Svc #	From Date	To Date	Place of Service	Procedure Code	Charge Amount	Units	Action
1							

1 *From Date 11/02/2020 To Date 11/02/2020 *Place of Service 11-Office EMG

*Procedure Code 99213-OFFICE/OUT Modifiers *Diagnosis 1 Pointers

Charge Amount 120.00 *Units 1 Unit Type Unit EPSDT

CLIA Number DMH Contract Source

Rendering Provider ID 123456789 ID Type NPI Zip Code Contract Code

Taxonomy SC Provider Number


Ordering Provider ID 234567891 ID Type NPI Zip Code

NDC for Item 1


[Add](#) ←

MEDICAID PRIMARY

- The National Drug Code (NDC) information must be entered for vaccine codes.
- Select the + sign to expand the NDC box. Enter the information and select **Add** to save to the line item of service.

NDC for Item 2 

Add


NDC for Item 2 

If applicable, only one NDC/UPN is allowed per service detail line. When adding an NDC/UPN, the Code Type, Quantity and Unit of Measure fields are required.

Code Type NDC

NDC/UPN

Quantity Unit of Measure


Add 

MEDICAID PRIMARY

Service Details											
Svc #	From Date	To Date	Place of Service	EMG	Procedure Code	Mod	Diag Code Ptrs	Charge Amount	Units	EPSDT	Rendering Provider ID
<u>1</u>	12/02/2020	12/02/2020	11		99213		1	\$120.00	1.00 Unit		

No Other Insurance Details exist for this claim

No Attachments exist for this claim

Back to Step 1 | **Back to Step 2** | **Back to Step 3** | Print Preview |  Confirm | Cancel

- Review the claim to verify the information was entered correctly.
- Information can be changed by selecting **Back to Step 1, 2 or 3**.
- Select **Confirm** to finalize the claim.

MEDICAID PRIMARY

- Upon confirmation, the claim will adjudicate and the claim ID will populate.
- Status is either Paid, Denied, Suspended or Resubmit.
- Claim Options are Print Preview, Edit, New or View.

Oklahoma Health Care Authority

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[Claims](#) > Claim Receipt

Submit Professional Claim: Confirmation ?

Professional Claim Receipt

Your Professional Claim was successfully submitted. The claim status is Paid.

The Claim ID is **22 XXXXXXXXXXXX**.

Click **Print Preview** to view the claim details as they have been saved by the agency.

Click **Edit** to resubmit the claim.

Click **View** to view the details of the submitted claim.

[Print Preview](#) [Edit](#) [New](#) [View](#)

MEDICAID SECONDARY

- Medicaid is considered secondary when other insurance or coverage is responsible for payment.
- SoonerCare members may have other insurance in addition to SoonerCare:
 - A commercial group plan through a member's employer.
 - An individually purchased plan.
 - Insurance available as a result of an accident or injury.

MEDICAID SECONDARY

- Providers must verify if a member has other insurance prior to services rendered.
- The primary insurance guidelines must be met for SoonerCare to consider payment.
- Providers accept the SoonerCare allowable as payment in full and may not bill the member for any remaining balance.

MEDICAID SECONDARY

Submit Professional Claim: Step 1 ?

* Indicates a required field.

Claim Type

EVV SERVICES ONLY timely filing

HCA-17

Two types of professional claims:

- Professional – Medicaid primary, Medicaid secondary or non-Medicare HMO policies.
- Professional Crossover – Medicare only.

Select *Professional* as the **Claim Type**.

MEDICAID SECONDARY

Provider Information			
This panel contains provider information.			
Billing Provider ID		ID Type	NPI
Name			
Zip Code	Contract Code	Taxonomy	SC Provider Number
Referring Provider ID	<input type="text"/>	ID Type	<input type="text"/>
Ordering Provider ID	<input type="text"/>	ID Type	Ordering Zip Code <input type="text"/>
Other Facility ID	<input type="text"/>	ID Type	<input type="text"/>

Referring and/or Ordering Provider are required if applicable.

- **Referring Provider** is used if the member has a Patient Centered Medical Home (PCMH) and the service requires a referral.
- **Ordering Provider** is the provider that ordered the service. Some services require an ordering provider.

MEDICAID SECONDARY

If the primary insurance paid:

- Select *Include* under the **Other Insurance** section and **Continue** to step 2.
- After entering the **Diagnosis**, enter the amount the primary insurance paid in the **TPL Amount** field.
- No Explanation of Benefits (EOB) required if primary made a full or partial payment.

Claim Information

Enter information applicable to the claim. If Other Insurance information needs to be entered, then Include should be selected in the Other Insurance dropdown. The Other Insurance details can be entered on Submit Step 2.

Date Type Date of Current

Accident Related Expected Delivery Date

Patient Account Number To Date

From Date

CLIA Number

*Other Insurance HMO Copay

Total Charged Amount \$0.00

Continue **Cancel**

Diagnosis Codes

Select the row number to edit the row. Click the **Remove** link to remove the entire row.

#	ICD Version	Diagnosis Code	Action
1	*ICD Version <input type="text"/>	*Diagnosis Code <input type="text"/>	

Add **Reset**

Other Insurance Details

TPL Amount

Back to Step 1 **Continue** **Cancel**

MEDICAID SECONDARY

If the primary insurance denied or applied to deductible:

- Select **Denied** under the **Other Insurance** section and **Continue** to step 2.
- Enter the diagnosis. Because primary insurance denied, the TPL Amount field is not present.
- Explanation of Benefits (EOB) **must** be attached after entering the service details.

Claim Information

Enter information applicable to the claim. If Other Insurance information needs to be entered, then Include should be selected in the Other Insurance dropdown. The Other Insurance details can be entered on Submit Step 2.

Date Type Date of Current

Accident Related Expected Delivery Date

Patient Account Number To Date


From Date

CLIA Number

*Other Insurance

HMO Copay

Total Charged Amount \$0.00





Diagnosis Codes

Select the row number to edit the row. Click the **Remove** link to remove the entire row.

#	ICD Version	Diagnosis Code	Action
1			

1 *ICD Version *Diagnosis Code





MEDICAID SECONDARY

- Add the service details.
- The primary EOB is not required if the primary insurance made a payment.
- The primary EOB must be attached to the claim if the primary insurance denied or the payment applied to deductible.
- Select Submit.

Service Details

Select the row number to edit the row. Click the **Remove** link to remove the entire row.

Svc #	From Date	To Date	Place of Service	Procedure Code	Charge Amount	Units	Action
1							

1 *From Date 11/06/2020 To Date 11/06/2020 *Place of Service 11-Office EMG

*Procedure Code 99213-OFFICE O/P Modifiers *Diagnosis Pointers 1

Charge Amount 120.00 *Units 1 Unit Type Unit EPSDT


CLIA Number DMH Contract Source

Rendering Provider ID 123456789 ID Type NPI Zip Code Contract Code

Taxonomy SC Provider Number



Ordering Provider ID 987654321 ID Type NPI Zip Code


NDC for Item 1

 [Add](#)

Attachments

Click the **Remove** link to remove the entire row.

#	Transmission Method	File	Control #	Attachment Type	Action
	Click to add attachment. 				


[Back to Step 1](#) [Back to Step 2](#)  [Submit](#) [Cancel](#)


MEDICAID SECONDARY

Attachments

Click the **Remove** link to remove the entire row.

#	Transmission Method	File	Control #	Attachment Type	Action
Click to collapse.					
*Transmission Method FT-File Transfer ▾					
*Upload File <input type="text"/> Browse...					
*Attachment Type <input type="text"/> ▾					
Description <input type="text"/>					





If the primary insurance denied or the payment applied to the deductible, the EOB must be attached.

- Click the + icon to expand the attachments section.
- Choose the attachment type and **Add** the attachment.
- Select **Submit**.

MEDICAID SECONDARY

- Review the claim to verify the information was entered correctly.
- Any necessary changes may be entered by selecting **Back to Step 1, 2 or 3**.
- Select **Confirm** to finalize the claim.

Claim Information

Date Type _ Date of Current _
Accident Related _
Patient Account Number _ Expected Delivery Date _
From Date 11/02/2020 To Date 11/02/2020
CLIA Number _ HMO Copay Yes
Total Charged Amount \$60.00

[Expand All](#) | [Collapse All](#)

Diagnosis Codes +


Service Details -

Svc #	From Date	To Date	Place of Service	EMG	Procedure Code	Mod	Diag Code Ptrs	Charge Amount	Units	EPSDT	Rendering Provider ID
1	11/02/2020	11/02/2020	11		99213		1	\$60.00	1.00 Unit		

Attachments -

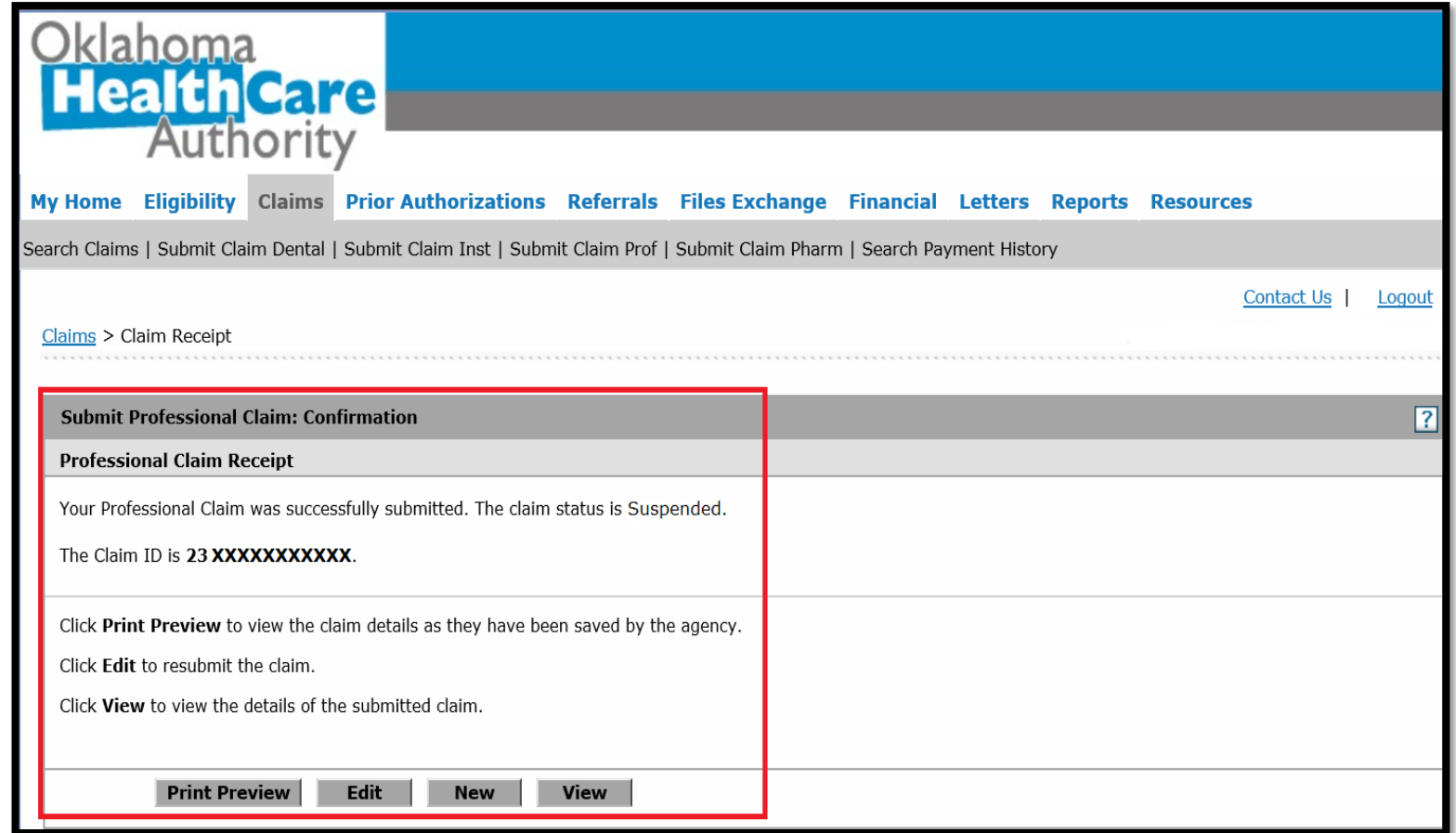
#	Transmission Method	File	Control #	Attachment Type
1	FT-File Transfer	Primary EOB.pdf	20201228558193	EB-Explanation of Benefits

No Other Insurance Details exist for this claim

Back to Step 1 **Back to Step 2** **Back to Step 3** **Print Preview**  **Confirm** **Cancel**

MEDICAID SECONDARY

- Upon confirmation, the claim will adjudicate and the claim ID will populate.
- The claim ID will start with a 23, which means the claim is a web claim with attachments.
- The status of the claim is **Suspended** because the primary EOB documents need to be reviewed.



Oklahoma
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[Claims](#) > Claim Receipt

Submit Professional Claim: Confirmation ?

Professional Claim Receipt

Your Professional Claim was successfully submitted. The claim status is Suspended.

The Claim ID is 23XXXXXXXXXX.

Click **Print Preview** to view the claim details as they have been saved by the agency.

Click **Edit** to resubmit the claim.

Click **View** to view the details of the submitted claim.

[Print Preview](#) [Edit](#) [New](#) [View](#)

HMO CO-PAY

- Medicaid is considered secondary when the patient has a private Health Maintenance Organization (HMO) plan.
- OHCA reimburses providers for co-payments and services not covered by commercial plans under a cap arrangement.
 - 1500 Professional - \$200
 - UB-04 - \$1,000

HMO CO-PAY

- HMO co-pay claims submitted through the OHCA secure provider portal will begin with a region code of 94.
- All HMO co-pay claims must have the primary EOB attached.
- The co-pay amount should only be billed as one line item of service.

HMO CO-PAY CHANGES (MEDICARE)

Effective Nov. 1, 2020, claims for dual-eligible members who also have a Medicare Part C HMO policy are no longer filed as an HMO co-pay claim (region 92/94).

- These claims will need to be filed as a crossover.
- With this change, HMO claims will pay the same percentage of coinsurance and deductible Part C PPO claims currently pay.

HMO CO-PAY

Submit Professional Claim: Step 1 ?

* Indicates a required field.

Claim Type	<input type="text" value="Professional"/> <input type="text" value="Crossover Professional"/>
EVV SERVICES ONLY timely filing	<input type="text" value="No"/>
HCA-17	<input type="text" value="No"/>

Two types of professional claims:

- Professional – Medicaid primary, Medicaid secondary or non-Medicare HMO policies.
- Professional Crossover – Medicare only.

Select *Professional* as the **Claim Type**.

HMO CO-PAY

Provider Information			
This panel contains provider information.			
Billing Provider ID		ID Type	NPI
Name			
Zip Code	Contract Code	Taxonomy	SC Provider Number
Referring Provider ID	<input type="text"/>	ID Type	<input type="text"/>
Ordering Provider ID	<input type="text"/>	ID Type	Ordering Zip Code <input type="text"/>
Other Facility ID	<input type="text"/>	ID Type	<input type="text"/>

Referring and/or Ordering Provider are required if applicable.

- **Referring Provider** is used if the member has a Patient Centered Medical Home (PCMH) and the service requires a referral.
- **Ordering Provider** is the provider that ordered the service. Some services require an ordering provider.

HMO CO-PAY

- Enter the Member ID number.
- Leave Other Insurance at *None*.
- Change HMO Copay to *Yes*.

Patient Information

Enter the Member ID. If Member ID is valid, the rest of the member information will populate.

*Member ID

Last Name First Name Middle
Birth Date

Claim Information

Enter information applicable to the claim. If Other Insurance information needs to be entered, then Include should be selected in the Other Insurance dropdown. The Other Insurance details can be entered on Submit Step 2.

Date Type Date of Current

Accident Related

Patient Account Number Expected Delivery Date

From Date - To Date -

CLIA Number

*Other Insurance HMO Copay

Total Charged Amount \$0.00


HMO CO-PAY


Diagnosis Codes

Select the row number to edit the row. Click the **Remove** link to remove the entire row.

#	ICD Version	Diagnosis Code	Action
1			

1 *ICD Version *Diagnosis Code





- **Diagnosis Code** field is required. Enter the diagnosis code without the decimal point and select the **Add** button.
- Select the **Add** button after entering each diagnosis.

HMO CO-PAY

Service Details

Select the row number to edit the row. Click the **Remove** link to remove the entire row.

Svc #	From Date	To Date	Place of Service	Procedure Code	Charge Amount	Units	Action
1							

1 *From Date 11/02/2020 To Date 11/02/2020 *Place of Service 11-Office EMG

*Procedure Code 99213-OFFICE/OUT Modifiers *Diagnosis Pointers 1

Charge Amount 120.00 *Units 1 Unit Type Unit EPSDT

CLIA Number DMH Contract Source

Rendering Provider ID 123456789 ID Type NPI Zip Code Contract Code

Taxonomy SC Provider Number

Ordering Provider ID 234567891 ID Type NPI Zip Code

NDC for Item 1

[Add](#) ←

Only one Service Detail line item should be submitted with the co-pay amount.

HMO CO-PAY

Attachments

Click the **Remove** link to remove the entire row.

#	Transmission Method	File	Control #	Attachment Type	Action
Click to collapse.					
<div style="border: 2px solid red; padding: 5px;"><p>*Transmission Method FT-File Transfer ▾</p><p>*Upload File <input type="text"/> <input type="button" value="Browse..."/></p><p>*Attachment Type <input type="text"/> ▾</p><p>Description <input type="text"/></p></div>					
<input type="button" value="Add"/> <input type="button" value="Cancel"/>					
<input type="button" value="Back to Step 1"/> <input type="button" value="Back to Step 2"/>		<input type="button" value="Submit"/> <input type="button" value="Cancel"/>			

- Upload the EOB from the primary insurance by clicking the + icon to expand the attachments section.
- Choose the correct **Attachment Type** and **Add** the attachment.
- Select **Submit**.

HMO CO-PAY

- Review the claim to verify the information was entered correctly.
- Any necessary changes may be entered by selecting **Back to Step 1, 2 or 3**.
- Select **Confirm** to finalize the claim.

Claim Information

Date Type	—	Date of Current	—
Accident Related	—	Expected Delivery Date	—
Patient Account Number	—	To Date	11/02/2020
From Date	11/02/2020	HMO Copay	Yes
CLIA Number	—	Total Charged Amount	\$60.00

[Expand All](#) | [Collapse All](#)

Diagnosis Codes +


Service Details -

Svc #	From Date	To Date	Place of Service	EMG	Procedure Code	Mod	Diag Code Ptrs	Charge Amount	Units	EPSDT	Rendering Provider ID
<u>1</u>	11/02/2020	11/02/2020	11		99213		1	\$60.00	1.00 Unit		

Attachments -

#	Transmission Method	File	Control #	Attachment Type
<u>1</u>	FT-File Transfer	Primary EOB.pdf	20201228558193	EB-Explanation of Benefits

No Other Insurance Details exist for this claim

Back to Step 1 **Back to Step 2** **Back to Step 3** **Print Preview**  **Confirm** **Cancel**

HMO CO-PAY

- HMO co-pay web claim IDs begin with a **94** region code.
- The claim is in a **Suspended** status because the primary EOB documents need to be reviewed.

The screenshot displays the Oklahoma HealthCare Authority website interface. At the top, the logo for 'Oklahoma HealthCare Authority' is visible. Below the logo is a navigation menu with links for 'My Home', 'Eligibility', 'Claims', 'Prior Authorizations', 'Referrals', 'Files Exchange', 'Financial', 'Letters', 'Reports', and 'Resources'. A search bar is located below the navigation menu, with the text 'Search Claims | Submit Claim Dental | Submit Claim Inst | Submit Claim Prof | Submit Claim Pharm | Search Payment History'. On the right side of the page, there are links for 'Contact Us' and 'Logout'. The main content area shows a breadcrumb trail: 'Claims > Claim Receipt'. A red box highlights a section titled 'Submit Professional Claim: Confirmation' which contains the following text: 'Professional Claim Receipt', 'Your Professional Claim was successfully submitted. The claim status is Suspended.', 'The Claim ID is 94XXXXXXXXXX.', 'Click **Print Preview** to view the claim details as they have been saved by the agency.', 'Click **Edit** to resubmit the claim.', and 'Click **View** to view the details of the submitted claim.' At the bottom of this section are four buttons: 'Print Preview', 'Edit', 'New', and 'View'.

MEDICARE CROSSOVER

- Members who have Medicare as primary and Medicaid as secondary are considered dual eligible.
- Providers must be in network with Medicare and Medicaid for OHCA to pay as secondary.
- A claim must be submitted to Medicare prior to submitting a claim to OHCA for reimbursement.

MEDICARE CROSSOVER

- OHCA reimburses the coinsurance and deductible of Medicare up to a certain percentage.
- The claim must be submitted as a professional crossover.
- Medicare coinsurance, deductible and paid date must be reported under the crossover details section of the claim.
 - The Explanation of Medicare Benefits (EOMB) is not required when the Medicare payment is reported.
 - The HCA-28B form is not required.

MEDICARE CROSSOVER

Effective Nov. 1, 2020, claims for dual-eligible members who also have a Medicare Part C HMO policy are no longer filed as an HMO co-pay claim (region 92/94).

- These claims will need to be filed as a crossover.
- With this change, HMO claims will pay the same percentage of coinsurance and deductible Part C PPO claims currently pay.

MEDICARE CROSSOVER

Submit Professional Claim: Step 1 ?

* Indicates a required field.

Claim Type

HCA-17

Two types of professional claims:

- Professional – Medicaid primary, Medicaid secondary or non-Medicare HMO policies.
- Professional Crossover – Medicare only.

Select *Professional Crossover* as the Claim Type.

MEDICARE CROSSOVER

- Enter the Member ID number.
- Enter the From and To Date of service.
- Leave Other Insurance dropdown as *None*.
- Select Continue to proceed to step 2.

Patient Information

Enter the Member ID. If Member ID is valid, the rest of the member information will populate.

*Member ID

Last Name First Name Middle

Birth Date

Claim Information

Enter information applicable to the claim. If Other Insurance information needs to be entered, then Include should be selected in the Other Insurance dropdown. The Other Insurance details can be entered on Submit Step 2.

Date Type Date of Current

Accident Related Expected Delivery Date


Patient Account Number

*From Date *To Date

CLIA Number

*Other Insurance

Total Charged Amount \$0.00




MEDICARE CROSSOVER


Diagnosis Codes

Select the row number to edit the row. Click the **Remove** link to remove the entire row.

#	ICD Version	Diagnosis Code	Action
1			

1 *ICD Version *Diagnosis Code





- **Diagnosis Code** field is required. Enter the diagnosis code without the decimal point and select the **Add** button.
- Select the **Add** button after entering each diagnosis.

MEDICARE CROSSOVER

- Medicare crossover claims are processed at the detail line.
- Complete the Crossover Details section based on the Medicare claim submission. Select **Add**.
- The Medicare EOB is not required.

Service Details

Select the row number to edit the row. Click the **Remove** link to remove the entire row.

Svc #	From Date	To Date	Place of Service	Procedure Code	Charge Amount	Units	Action
1							

1 *From Date 11/02/2020 To Date 11/02/2020 *Place of Service 11-Office EMG

*Procedure Code 99213-OFFICE/OUT Modifiers *Diagnosis 1

Charge Amount 120.00 *Units 1 Unit Type Unit EPSDT

CLIA Number

Rendering Provider ID 012345678 ID Type NPI Zip Code Contract Code

Taxonomy

Ordering Provider ID 123456789 ID Type NPI Zip Code

NDC for Item 1

Medicare Crossover Details for Item 1

Medicare Crossover Details must be entered in this step if the From Date is on or after 01/01/2016.

Allowed Medicare Amount	\$110.00	Co-insurance Amount	\$10.00
Deductible Amount	\$0.00	Psychiatric Services Amount	\$0.00
Medicare Payment Amount	\$110.00	Medicare Payment Date	11/20/2020

Add ←

MEDICARE CROSSOVER

- Review the claim to verify the information was entered correctly.
- Any necessary changes may be entered by selecting **Back to Step 1, 2 or 3**.
- Select **Confirm** to finalize the claim.

Claim Information

Date Type _ Date of Current _
Accident Related _
Patient Account Number _ Expected Delivery Date _
From Date 11/02/2020 To Date 11/02/2020
CLIA Number _
Total Charged Amount \$120.00

[Expand All](#) | [Collapse All](#)


Diagnosis Codes +

Service Details -

Svc #	From Date	To Date	Place of Service	EMG	Procedure Code	Mod	Diag Code Ptrs	Charge Amount	Units	EPSDT	Rendering Provider ID
1	11/02/2020	11/02/2020	11		99213		1	\$120.00	1.00 Unit		

No Other Insurance Details exist for this claim

No Attachments exist for this claim

Back to Step 1 **Back to Step 2** **Back to Step 3** **Print Preview**  **Confirm** **Cancel**

MEDICARE CROSSOVER

- Upon confirmation, the claim will adjudicate, and the claim ID will populate.
- Claim status: Paid, Denied, Suspended or Resubmit.

Oklahoma HealthCare Authority

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[Claims](#) > Claim Receipt

Submit Professional Claim: Confirmation ?

Professional Claim Receipt

Your Professional Claim was successfully submitted. The claim status is Paid.

The Claim ID is **22 XXXXXXXXXXXX**.

Click **Print Preview** to view the claim details as they have been saved by the agency.

Click **Edit** to resubmit the claim.

Click **View** to view the details of the submitted claim.

[Print Preview](#) [Edit](#) [New](#) [View](#)

CLAIM FUNCTIONS

SEARCH CLAIMS

Claims may be searched by:

- Claim ID
- Member ID
- Service From and To dates (auto-populates with last 90-day range).

Search Claims ?

Medical/Dental **Pharmacy**

A minimum one field is required.
Either 'Paid Date' or 'Service From' and 'To' Date are required fields for the search when Claim ID is not entered.

Claim Information

Claim ID

Member Information

Member ID

Service Information

Service From To Claim Type

Paid Date Claim Status

SEARCH CLAIMS

Search Results									
To see additional claim information, or view a remittance advice, click on the '+' next to the Claim ID. To view the entire claim, click on the Claim ID.									
Total Records: 6									
	Claim ID	Claim Type	Claim Status	Service Date ▼	Member ID	Patient Acct Number	Billed Amount	Medicaid Paid Amount	Paid Date
+	2220xxxxxxxxx	Professional	Paid	11/06/2020			\$120.00	\$66.86	–
+	2320xxxxxxxxx	Professional	Denied	11/02/2020			\$170.00	\$0.00	–
+	2320xxxxxxxxx	Professional	Denied	11/02/2020			\$120.00	\$0.00	–
+	9420xxxxxxxxx	Professional	Denied	11/02/2020			\$60.00	\$0.00	–
+	2220xxxxxxxxx	Crossover Professional	Denied	11/02/2020			\$120.00	\$0.00	–
+	2320xxxxxxxxx	Professional	Denied	11/02/2020			\$120.00	\$0.00	–

Click on the blue **Claim ID** hyperlink to view the claim.

PAID CLAIM FUNCTIONS

Claims in a paid status allows the user to copy or void.

Claim Information

Claim Status Paid	Paid Date 12/08/2020
Date Type _	Date of Current _
Accident Related _	Expected Delivery Date _
Patient Account Number _	To Date 11/06/2020
From Date 11/06/2020	HMO Copay No
CLIA Number _	Total Charged Amount \$120.00
Related Claim ICN _	Total Paid Amount \$66.86
Total Co-pay Amount \$0.00	Total Allowed Amount \$66.86

[Expand All](#) | [Collapse All](#)

Adjudication Errors

+

Diagnosis Codes

+

Service Details

-

Svc #	From Date	To Date	Place of Service	EMG	Procedure Code	Mod	Diag Code Ptrs	Units	EPSDT	Charge Amount	Allowed Amount	Co-pay Amount
1 Paid	11/06/2020	11/06/2020	11	N	99213		1	1.00 Unit		\$120.00	\$66.86	\$0.00

No Other Insurance Details exist for this claim

No Attachments exist for this claim

Copy **Void** Print Preview RA Copy

PAID CLAIM FUNCTIONS

- Copy options for paid claims:
 - Member Information,
 - Service Information,
 - Member Information and Service Information
 - Entire Claim
- Claims voided after six months from the date of service are subject to timely filing limitations.
- Claims nearing the timely filing limitation should not be voided without instruction from OHCA.

PAID CLAIM FUNCTIONS


Copy claim:

- Select the information to copy.

Copy Professional Claim ?

Select the information you would like to have copied to the new claim. Press Copy to initiate the claim and continue entering claim information.

<input type="radio"/> Member Information	<input type="radio"/> Service Information	<input type="radio"/> Member and Service Information	<input type="radio"/> Entire Claim
Member ID	Service Facility Location	Copies data listed in previous 2 columns.	Copies data listed in columns 1 and 2 PLUS:
Member Count	Diagnosis Code(s)		Referring Provider
Last Name	Place(s) of Service		Ordering Provider
First Name	Procedure Code(s)		Other Facility
Birth Date	Modifier(s)		Accident Related
Patient Account Number	Diagnosis Pointer(s)		Pregnancy Indicator
	Detail Charge Amount(s)		Emergency Indicator(s)
	Units		Claim CLIA Number(s)
	Unit Type(s)		Other Insurance
	EPSDT		HMO Copay
	Service Details CLIA Number(s)		All Dates
	DMH Contract Source(s)		
	Rendering Provider(s)		
	SC Provider(s)		
	Ordering Provider(s)		
	NDC Code Type(s)		
	NDC Code(s)		
	NDC Quantity(s)		
	NDC Unit of Measure(s)		

 **Copy** **Cancel**

PAID CLAIM FUNCTIONS

The screenshot displays a software interface with a confirmation dialog box overlaid. The dialog box, titled "Confirmation", asks: "Are you sure you want to void this Professional Claim ID 2220XXXXXXXXX?". Below the text are two buttons: "OK" and "Cancel". A red arrow points to the "OK" button, which is also highlighted with a red rectangular border. The background interface includes sections for "Adjudication Errors", "Diagnosis Codes", and "Service Details". The "Service Details" section contains a table with columns for "Svc #", "From Date", "To Date", "Pla Se", "Charge Amount", "Allowed Amount", and "Co-pay Amount". A single row is visible with the following data: "1", "Paid", "11/06/2020", "11/06/2020", "11", "N", "99215", "1", "1.00 Unit", "\$120.00", "\$66.86", "\$0.00". Below the table, there are two status messages: "No Other Insurance Details exist for this claim" and "No Attachments exist for this claim". At the bottom of the interface, there are four buttons: "Copy", "Void", "Print Preview", and "RA Copy".

Svc #	From Date	To Date	Pla Se	Charge Amount	Allowed Amount	Co-pay Amount
1 Paid	11/06/2020	11/06/2020	11	\$120.00	\$66.86	\$0.00

Void claim:

- Select **OK** to Confirm.

DENIED CLAIM FUNCTIONS

Claims can be denied either at the header or detail levels.





- **Header:** contains information about the member and provider but not about the services performed.
 - The system will verify member's eligibility and provider's contract information, causing the entire claim to deny.
- **Detail:** contains information specific to the services performed.
 - The system verifies coverage of services, policy limitations or program restrictions which will cause specific service lines to deny and not the entire claim.

DENIED CLAIM FUNCTIONS

- The OHCA secure provider portal provides HIPAA and EOB remark codes for the denial reason.
- Denied claims can be edited for changes and resubmitted through the provider portal.
- Claims in a denied status cannot be voided.

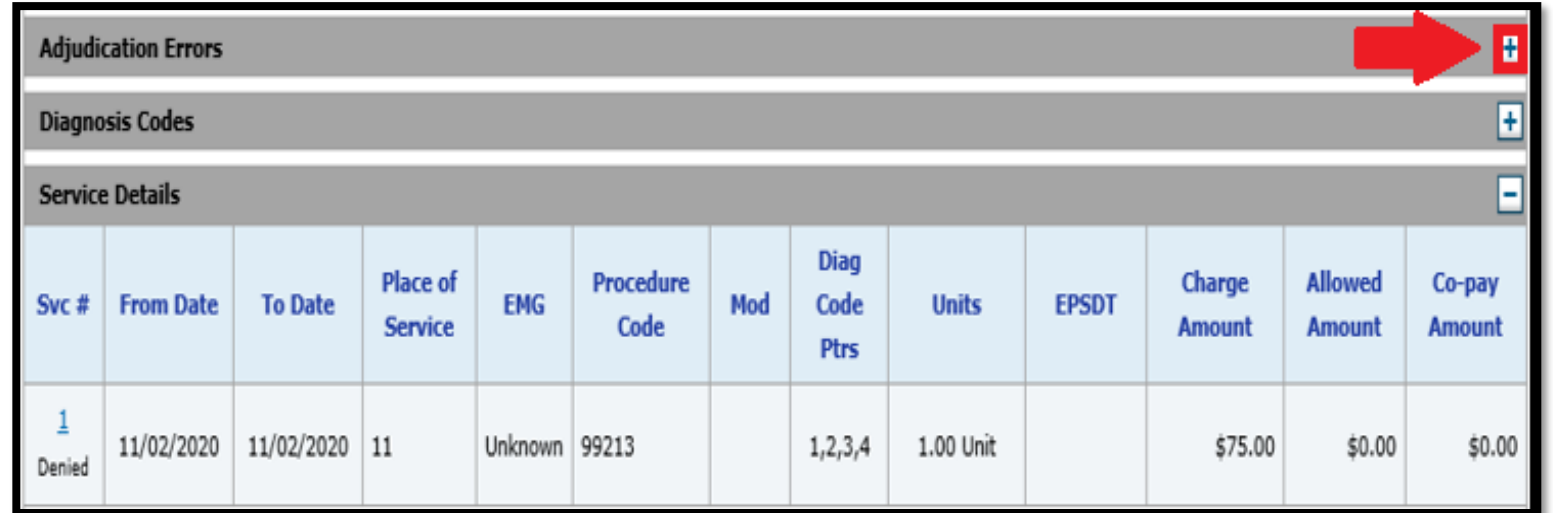
DENIED CLAIM FUNCTIONS

Claims in a denied status allow the user to view **Adjudication Errors** or **Edit** the claim.

Adjudication Errors 												
Diagnosis Codes 												
Service Details 												
Svc #	From Date	To Date	Place of Service	EMG	Procedure Code	Mod	Diag Code Ptrs	Units	EPSDT	Charge Amount	Allowed Amount	Co-pay Amount
<u>1</u> Denied	11/02/2020	11/02/2020	11	Unknown	99213		1,2,3,4	1.00 Unit		\$75.00	\$0.00	\$0.00
No Other Insurance Details exist for this claim												
No Attachments exist for this claim												
 Edit Print Preview												

DENIED CLAIM FUNCTIONS

Click the + sign icon on the **Adjudication Errors** bar to view the denial reasons.




Adjudication Errors												
Diagnosis Codes												
Service Details												
Svc #	From Date	To Date	Place of Service	EMG	Procedure Code	Mod	Diag Code Ptrs	Units	EPSDT	Charge Amount	Allowed Amount	Co-pay Amount
1 Denied	11/02/2020	11/02/2020	11	Unknown	99213		1,2,3,4	1.00 Unit		\$75.00	\$0.00	\$0.00

DENIED CLAIM FUNCTIONS

Adjudication Errors						
Claim / Service #	HIPAA Adj	Description	HIPAA Adj Remark	Description	EOB	Description
Service # 1	A1	Claim denied charges.	N115	This decision was based on a Local Coverage Determination (LCD). An LCD provides a guide to assist in determining whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd , or if you do not have web access, you may contact the contractor to request a copy	9998	CLAIM WAS PRICED IN ACCORDANCE WITH CURRENT OKLAHOMA HEALTH COVERAGE PROGRAM PO
Service # 1	18	Duplicate claim/service.	N109	This claim was chosen for complex review and was denied after reviewing the medical records.	4318	PROCEDURE DENIED DUE TO NEW VISIT FREQUENCY


The EOB description remarks provide a more detailed explanation of why the claim denied.

DENIED CLAIM FUNCTIONS

Adjudication Errors												
Diagnosis Codes												
Service Details												
Svc #	From Date	To Date	Place of Service	EMG	Procedure Code	Mod	Diag Code Ptrs	Units	EPSDT	Charge Amount	Allowed Amount	Co-pay Amount
1 Denied	09/24/2020	09/24/2020	11	Unknown	99383		1	1.00 Unit		\$115.00	\$0.00	\$0.00
No Other Insurance Details exist for this claim												
No Attachments exist for this claim												
 Edit Print Preview												

Select **Edit** to modify the claim.

DENIED CLAIM FUNCTIONS

Adjudication Errors +					
Diagnosis Codes +					
Service Details +					
Attachments -					
Click the Remove link to remove the entire row.					
#	Transmission Method	File	Control #	Attachment Type	Action
+ Click to add attachment.					
Back to Step 1		Back to Step 2			Resubmit Cancel

Click Resubmit once all edits are saved.

RESOURCES

BMI SCREENING INFORMATION

The Oklahoma Health Care Authority would like help in capturing body mass index screening information.

- The diagnosis code on the claim is used to capture the screening information.
- An appropriate BMI screening diagnosis code must be used
- The BMI screen diagnosis code cannot be used as the primary diagnosis – it must be secondary or further within the diagnosis hierarchy.
- There is no CPT code associated with this service.

HELPFUL TELEPHONE NUMBERS

- OHCA call center

800-522-0114 or 405-522-6205; option 1.

- Internet help desk.

800-522-0114 or 405-522-6205; option 2, 1.

- EDI help desk.

800-522-0114 or 405-522-6205; option 2, 2.

HELPFUL LINKS

- NEW Agency Website

<https://oklahoma.gov/ohca>

- Coronavirus Information

<https://oklahoma.gov/ohca/about/covid19/coronavirus.html>

- Managed Care

<https://oklahoma.gov/ohca/about/medicaid-expansion/soonerselect.html>

- Telehealth Services

<https://oklahoma.gov/ohca/providers/telehealth.html>

- OHCA Provider Portal.

www.ohcaprovider.com

HELPFUL LINKS

Provider Training:

- Upcoming webinar trainings
- Previous training materials
- Recorded webinars
- How-to videos
- Resources

Visit <https://oklahoma.gov/ohca/providers/provider-training>.

PROVIDER VISITS

A telephonic or virtual visit with a provider education specialist may be requested for specific training on a topic.

Providers may contact the SoonerCare coordinator to request assistance from a provider education specialist by sending an e-mail to SoonerCareEducation@okhca.org

PROVIDER VISITS

To assist the provider education specialists in planning and structuring the visit or group training, the following information is needed:

- Provider type attending the training
- Number of attendees
- Time and location requested
- Issues to be addressed
- Point of contact if additional information is needed prior to the event

POLICY & RULES

OHCA Policy and Rules:

- <https://oklahoma.gov/ohca/policies-and-rules/xpolicy.html>.
- Provider policies and rules and Oklahoma Health Care Authority Medicaid rules.
 - Chapter 25 – SoonerCare Choice.
 - Chapter 30 – Fee for Service.

QUESTIONS?



OKLAHOMA
Health Care Authority

GET IN TOUCH

4345 N. Lincoln Blvd.
Oklahoma City, OK 73105

oklahoma.gov/ohca
mysoonercare.org

Agency: 405-522-7300
Helpline: 800-987-7767

