

# **Provider Billing and Procedures Manual**

**Oklahoma Health Care Authority  
August 2020**



**OKLAHOMA**  
Health Care Authority

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# Chapter 1: General Information

The Oklahoma Health Care Authority (OHCA) is the state agency responsible for the administration of the Oklahoma Medicaid program. OHCA has a contractual agreement with DXC Technology (DXC), *previously Hewlett Packard Enterprise (HPE)*, to be the fiscal agent for the Oklahoma Medicaid program. OHCA's primary objective is to maintain a system that will accurately and effectively process and pay all valid Oklahoma Title XIX Medicaid program provider claims.

A provider's participation in the Oklahoma Medicaid program is voluntary. However, providers who choose to participate in Medicaid must accept the Medicaid payment as payment in full for services covered by Medicaid. The provider is restricted from charging the Medicaid member the difference between the usual customary charge and Medicaid's payment. Services not covered under the Medicaid program can be billed directly to the member.

This publication is the primary reference for submitting and processing claims, prior authorization requests, remittance advice and other related documents. This manual is not a legal description of all aspects of Medicaid law.

**This manual is intended to provide basic program guidelines for providers that participate in the Oklahoma Medicaid program. *Every effort has been made to ensure the accuracy of this manual.* If there are any instances where the guidelines appear to contradict relevant provisions of the [Oklahoma Medicaid policies and rules](#), the policies and rules will prevail. This manual does not take precedence over federal regulation, state statutes or administrative procedures. This manual was developed by OHCA and DXC for Oklahoma Medicaid providers.**

The Provider Billing and Procedure Manual will receive periodic reviews, changes and updates. The online version of this manual is the most current version and is available on the OHCA website at <http://www.okhca.org/providers.aspx?id=100>, click on the OKMMIS Provider Billing & Procedure Manual link.

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# Chapter 2: Contacts and Resources

## Provider Policies

A provider is any individual or facility that qualifies and meets all state and federal requirements and has a current contract with OHCA to provide health care services under SoonerCare or other OHCA-administered medical service programs.

## Payments

Payments to providers under SoonerCare are made for services identified as personally rendered services performed on behalf of a specific patient. There are no exceptions to personally rendered services unless otherwise specified in coverage guidelines.

Payments are made on behalf of SoonerCare-eligible individuals for services within the scope of OHCA’s medical programs. Services cannot be paid under SoonerCare for ineligible individuals, services not covered under the scope of OHCA’s medical programs or services not meeting documentation requirements. These claims will be denied, or payment will be recouped in some instances upon post-payment review.

For additional information on provider policies, go to [www.okhca.org](http://www.okhca.org). Select the **Policy** link under **Providers**. When the page appears, select the Policies & Rules + symbol to expand that option. Click **OHCA Rules** link and select **Chapter 30**.

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**Providers**

- Types
- Claim Tools
- Forms
- Secure Sites
- Policies & Rules**
  - HIPAA
  - OHCA Rules**
- Training
- Updates
- Help

Home > Providers > Policies and Rules

### OHCA Policies and Rules

Search Entire Policy  
OHCA Policies and Rules Main Page

Browse chapters by clicking on the plus sign to the right of each chapter below.

Chapters	
Chapter 1	ADMINISTRATIVE OPERATIONS
Chapter 2	GRIEVANCE PROCEDURES AND PROCESS
Chapter 10	PURCHASING
Chapter 25	SOONERCARE
<b>Chapter 30</b>	MEDICAL PROVIDERS-FEE FOR SERVICE
Chapter 35	MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY
Chapter 40	DEVELOPMENTAL DISABILITIES SERVICES
Chapter 45	INSURE OKLAHOMA
Chapter 50	HOME AND COMMUNITY BASED SERVICES WAIVERS

**Disclaimer.** The OHCA rules found on this Web site are unofficial. The official rules are published by the Oklahoma Secretary of State Office of Administrative Rules as Title 317 of the Oklahoma Administrative Code. To order an official copy of these rules, contact the Office of Administrative Rules at (405) 521-4911.

## Provider Contracts

In order to be eligible to participate in Oklahoma SoonerCare programs, providers must have an approved provider contract on file with OHCA. Through this contract, the provider certifies all information submitted on claims is accurate and complies with all applicable state and federal regulations. This contract is effective once it is signed by the provider and has been reviewed and approved by OHCA.

### 1.1.1 Provider Contract Maintenance

Provider contracts must be renewed every four years, excluding provider contracts for Nursing Homes and LBHP-under supervision. It is the responsibility of the provider to maintain records and contracts with OHCA.

All information changes including address, phone number, bank (including electronic funds transfer data) and group member changes must be promptly reported. Failure to maintain current provider information can result in delay or denial of payments for services rendered. Changes for all provider record information should be made through the OHCA SoonerCare Provider Portal.

For additional information on provider enrollment criteria, call the OHCA toll-free at 1-800-522-0114 or at 405-522-6205 (Oklahoma City area), then select option 5. You can also go to [www.okhca.org](http://www.okhca.org), select Enrollment listed in the Providers section, select the New Contracts link, and then create a user account.

## Provider Resources

### 1.1.2 OHCA Call Tree

Toll-free: 800-522-0114, or in Oklahoma City area: 405-522-6205.

Option	Unit	Call Types	Availability
1	OHCA Call Center	Policy and billing questions.	8 a.m. to 5 p.m. M-F
2, 1	Internet Help Desk	Internet PIN resets or assistance with the SoonerCare Provider Portal.	8 a.m. to noon & 1-5 p.m. M-F
2, 2	EDI Help Desk	Batch transactions assistance.	8 a.m. to noon & 1-5 p.m. M-F
3, 1	Adjustments	Paid claim adjustments or outstanding A/R inquiries.	7:30 a.m. to 4 p.m. M, W, Th, F Noon to 4 p.m.
3, 2	Third Party Liability	Health insurance injury/accident questionnaires, third party insurance inquiries, estate recovery or subrogation issues.	8 a.m. to 5 p.m. M-F
4	Pharmacy Help Desk	Pharmacy issues.	8 a.m. to 7 p.m. M-F 9 a.m. to 5 p.m. Sat 11 a.m. to 5 p.m. Sun
5	Provider Contracts	Provider contracts.	8 a.m. to 5 p.m. M, Tu, T, F 1 p.m. – 5 p.m. Wed
6, 1	Pharmacy Help Desk	Pharmacy authorizations.	8:00 a.m. to 7 p.m. M-F 9 a.m. to 5 p.m. Sat 11 a.m. to 5 p.m. Sun
6, 2, 1	Behavioral Health Authorization (OP)	For Out-Patient Behavioral Health authorizations.	8 a.m. to 5 p.m. M-F
6,2,2	Behavioral Health Authorization (IP)	For In-Patient Behavioral Health authorizations.	8 a.m. to 5 p.m. M-F
6, 3	Medical Authorizations	Medical authorization status.	8 a.m. to 5 p.m. M-F
6,4	Prior Authorizations	For prior authorizations for DME, medical services and emergency services for aliens.	8 a.m. to 5 p.m. M-F
6, 5	Dental Authorizations	Dental authorizations (status only).	8 a.m. to 5 p.m. M-F



## Provider Inquiries

Telephone inquiries are received between 8:00 a.m. and 5:00 p.m., Monday through Friday. Pharmacy Help Desk is available extended hours seven days per week.

### Phone Numbers

Toll-free: 800-522-0114

Oklahoma City area: 405-522-6205

Reference the OHCA Call Tree provided above for additional information regarding option numbers, call tree units, call types, and availability for the following available services.

### Available Services

Information available to providers through the call tree options include:

- Policy Questions
- Pharmacy Help Desk
- Provider Contracts
- Adjustments
- Third Party Liability (TPL)
- PIN resets
- Prior Authorization
- Medical
- Dental
- Behavioral Health

### Before You Call

When calling the OHCA Call Center, **have the following information available** to expedite researching the inquiry:

- ✓ The 10-character (nine numbers, alpha character) SoonerCare provider number.
- ✓ The SoonerCare member's ID number.
- ✓ The date(s) of service.
- ✓ The billed amount.

### 1.1.3 Call Centers

The OHCA is committed to providing customer service to the provider community, members and other interested parties. OHCA Call Center representatives answer inquiries regarding warrant information, proper billing procedures, prior authorizations and SoonerCare policy.

### 1.1.4 Claims

#### Mailing Paper Claims

Original, corrected and re-filed claims are submitted to the fiscal agent at the appropriate addresses listed below. Claims mailed to addresses other than the assigned P.O. Box may result in payment delays.

#### Paper Claim Mailing Addresses

<b>Form UB-04 (Hospital or Home Health)</b>	DXC Technology P.O. Box 18430 Oklahoma City, OK 73154
<b>Dental (ADA)</b>	DXC Technology P.O. Box 18110 Oklahoma City, OK 73154
<b>Form 1500</b>	DXC Technology P.O. Box 54740 Oklahoma City, OK 73154
<b>HMO Copay/Personal Care Services (Individual; not agency)</b>	DXC Technology P.O. Box 18500 Oklahoma City, OK 73154
<b>Long-Term Care Nursing Facilities</b>	DXC Technology P.O. Box 54200 Oklahoma City, OK 73154
<b>Pharmacy</b>	DXC Technology P.O. Box 18650 Oklahoma City, OK 73154
<b>Waiver Provider</b>	DXC Technology P.O. Box 54016 Oklahoma City, OK 73154

### **Written Inquiries**

When inquiring in writing about the status of a SoonerCare claim, use the SoonerCare Claims Appeal and Review form: HCA-17. Follow the instructions provided on the form. Attach a copy of the original claim and any supporting documentation, such as a copy of the remittance/denial, Medicare EOMB, consent forms or medical records required for review.

Mail Claims Appeal and Review forms, policy questions and any other written correspondence regarding hard-to-resolve SoonerCare claims to:

#### **OHCA**

Attention: Provider Services  
P.O. Box 18506  
Oklahoma City, OK 73154-0506

### **1.1.5 Eligibility Verification System (EVS)**

The EVS system is available from 5:00 a.m. to 1:00 a.m. Information is accessible by entering the provider's 9-digit SoonerCare ID number and alpha-character location code, as well as your 4-digit PIN. If you do not have a PIN, please call 1-800-522-0114 (option 2, option 1).

The automated voice response (AVR) system provides a nationwide toll-free telephone number to help providers obtain pertinent information. Providers can enter information on a touch-tone phone or by the AVR speech application.

#### **EVS Phone Numbers**

Nationwide toll-free: 1-800-767-3949  
Oklahoma City area: 405-840-0650

#### **Available Services**

The following is a list of information that can be obtained through the AVR:

- Member eligibility with fax-back capabilities.
- Provider warrant information.
- Prior authorization with fax-back capabilities.
- Claim status inquiry.

More information regarding the EVS can be found in the Member Eligibility Verification chapter of this manual (chapter 4).

### 1.1.6 Member Inquiries

When inquiring by telephone, please call between 8:00 a.m. and 5:00 p.m., Monday through Friday.

#### Phone Numbers

Members toll-free: 800-522-0310

Oklahoma City area: 405-522-7171

#### Available Services

Information available for members through the call tree options include:

- Eligibility
- Claim status
- SoonerCare Member Services
- Pharmacy Help Desk
- Enrollment Agent
- Spanish assistance: 8:00 a.m. to 5:00 p.m. M-F

### 1.1.7 SoonerCare Provider Portal

The SoonerCare Provider Portal is OHCA's secure website, offering providers several services from submitting claims on the web to fast verification of claim status. The SoonerCare Provider Portal is available 24 hours a day, 7 days a week, except during scheduled maintenance.

- New providers are assigned a PIN to access the website. To access the SoonerCare Provider Portal, go to [www.okhca.org](http://www.okhca.org), in the Providers section click Provider Portal. For additional information regarding logging in for the first time and entering the SoonerCare Provider Portal, contact the Internet Help Desk or a Provider Education Specialist. Contact information for Provider Education Specialists is available in the next subsection of this chapter.

### **Available Services**

The following services are available to SoonerCare Provider Portal users:

- Global messaging.
- Claims submission and resubmission.
- Search and void claims.
- Create and search provider referrals.
- Create prior authorizations.
- View authorization status/notice.
- Search Fee Schedule/search provider.
- View Payment History.
- View/download Remittance Advice.
- Eligibility verification.
- Treatment History.
- Managed Care/Capitation reports.
- Update Provider File.
- Provider letters.

For additional information on the SoonerCare Provider Portal, please refer to the SoonerCare Provider Portal chapter of this manual (chapter 3).

#### **1.1.8 Provider Training and SoonerCare Education Specialists**

SoonerCare has a team of Provider Education Specialists with in-depth knowledge of Oklahoma SoonerCare billing requirements and claim-processing procedures. Training is offered on billing, EVS and AVR, Electronic Data Interchange (EDI), and the SoonerCare Provider Portal. Provider Education Specialists provide training through on-site provider visits, webinars and workshops. They encourage providers to utilize electronic submission through the provider portal because it is fast, easy to use and saves money.

## Training Objectives

The focus of the Provider Education Specialist is to:

- Train newly enrolled providers and billers.
- Establish and maintain relationships with contracted providers to ensure correct claim adjudication and resolution.
- Conduct targeted outreach for provider types and specialties.
- Create and present policy, portal and program updates to existing providers through training workshops.
- Conduct policy and portal training through webinars and bi-monthly SoonerCare 101 training.

Providers may contact SoonerCare Education to request a visit for training at the provider's location.

Email: [SoonerCareEducation@okhca.org](mailto:SoonerCareEducation@okhca.org)

Phone: 405-522-7422

Fax: 405-530-3288

Provider Education Specialists are responsible for arranging their own schedules. They are available Monday through Friday for on-site provider visits. On-site provider visits are normally scheduled two weeks in advance. Since Provider Education Specialists are often out of the office, please allow a minimum of 48 hours for telephone calls and emails to be returned.

## Provider Workshops

Provider Education Specialists are responsible for the development and presentation of educational workshops about all procedural aspects of the Oklahoma Medicaid Management Information System (OKMMIS).

OHCA and DXC present scheduled workshops throughout the year to educate providers on Oklahoma SoonerCare claim processing procedures. Workshops are announced in bulletins, global messages, newsletters and on the OHCA website at [www.okhca.org](http://www.okhca.org). Group training can also be arranged at the request of individual provider groups or associations.

### **Be Prepared**

The following information should be provided to assist your Provider Education Specialist in planning the visit or workshop:

- ✓ Individual or Group SoonerCare Provider ID.
- ✓ Number of attendees.
- ✓ Time and location of the event.
- ✓ Issues to be addressed.
- ✓ Point of contact, in case additional information is needed prior to the event.

### **Contact Information**

Providers may contact the SoonerCare Coordinator to request assistance from a Provider Education Specialist by going to, [www.okhca.org](http://www.okhca.org). Select Training in the Providers section, then select **SoonerCare Provider Representatives** under **Contact Us** located on the right side of the webpage.

#### **1.1.9 OHCA Public Site**

The OHCA administers the state of Oklahoma's Medicaid agency program known as SoonerCare. Primary programs under SoonerCare include: SoonerCare Traditional, SoonerCare Choice and SoonerPlan. The OHCA public site, [www.okhca.org](http://www.okhca.org), (see screen sample below) provides information for Medicaid members and providers, including data on programs, and health and medical policies.

OKLAHOMA Health Care Authority

about us | individuals | providers | research | policy | contact us | search

SFY 2019 ANNUAL REPORT

View All Banners

**member portal**

**SoonerCare**  
Oklahoma Health Care Authority

Change your mailing address at  
**MySoonerCare.org**

**quick links**

- How to Change Your SoonerCare Mailing Address
- About SoonerCare 2.0
- New Out of State Provider Rules for Members
- Enroll In SoonerCare
- NEW: ABA information
- Suspect Medicaid Fraud? Click here to file a report

**individuals**

- How to Apply | Enroll Online
- Find A Provider | After Hours OK
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- Member Letters | Updates
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**research and statistics**

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- OHCA Board | Committees
- Calendar | Order Publications
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### 1.1.10 OHCA Webpages

**Calendar:** The Calendar page can be used to find dates and details on meetings and other upcoming events.

**Contact Us:** Use the Contact Us page to find everything from OHCA addresses and telephone numbers to driving directions to the OHCA office.

**Provider:** The Provider page provides information on becoming a Medicaid provider, provider-type details, claim management tools, program reference resources, rule and policy data, free training opportunities and SoonerCare updates.

**Publications:** The Publications page includes links to most OHCA publications, forms and OHCA information on statistical reports and data.



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# Chapter 3: SoonerCare Provider Portal

## Introduction

Any SoonerCare provider can access the Provider Portal with a Provider ID and an OHCA-generated personal identification number (PIN). Once the provider has established a Provider Portal account, the account administrator can create new clerks and grant each clerk role-specific access. The Provider Portal is free of charge and is available to any SoonerCare provider with internet access.

## Important Website Notes

- Passwords are case sensitive.
- Challenge questions are NOT case sensitive.
- All dates should be entered in MMDDYYYY format.
- Dollars and cents should be separated by a decimal.
- Line totals will not be calculated automatically; the user must multiply the units by the unit rate to ensure the correct total billed amount.
- Do not populate the TPL amount unless another payer has paid a specific amount toward the claim.
- Decimals should not be used when entering diagnosis codes.

## Section A: Accessing the SoonerCare Provider Portal

The SoonerCare Provider Portal can be accessed on most computer systems, with the following recommendations:

- Microsoft Internet Explorer browser version 7.0 and higher or Mozilla Firefox browser version 2.0 and higher, although other browsers may work.
- 128-bit key encryption.
- Customized security settings to access information across domains.
- Disable pop-up ad blocker (or set settings to allow all for this website).

## Getting to the SoonerCare Provider Portal

1. Navigate to [www.okhca.org](http://www.okhca.org).
2. Select the Provider Portal link located under the Providers section of the home page or select Secure Sites from the Providers menu after selecting the Providers link.
3. You can do directly to the login page at [ohcaprovider.com](http://ohcaprovider.com).

## Registering for a Provider Portal Account

Each new Provider Portal account (users who have never registered with OHCA) will require registration (creating a permanent username, password and challenge questions/answers).

### Register Now

1. Select Register Now from the Provider Portal home page. Instructions for registration step 1 of 2 will vary by role:
  - **Providers**—Enter SoonerCare Provider Number, Service Location and PIN in the corresponding fields.
  - **Billing Agents**—Enter Trading Partner ID and PIN in the corresponding fields.
  - **Clerks**—Enter First Name, Last Name, Birth Date, Last 4 of DLN, and Clerk Code in the corresponding fields (clerk codes are generated by the provider).

Instructions for registration step 2 of 2—Security Information will be the same for all types:

1. Enter a user ID. Select Check Availability to verify whether the user ID is available for use in the SoonerCare Provider Portal. Enter a password in the Password and Confirm Password fields. Passwords must be 8-20 characters in length, contain a minimum of one numeric digit, one uppercase letter and one lowercase letter.
2. Enter a name in the Display Name field. This will be the name that appears on the Provider main menu. Enter a phone number and extension, if applicable. Enter an email in the Email and Confirm Email fields.
3. Select a site key and enter a passphrase.
4. Select three questions from the Challenge Question #1-3 drop-down lists. Enter an answer in the respective Answer to #1-3 fields. For providers only: after reading

the User Agreement enter your name in the please sign by typing your full name here field.

5. Once all fields have been entered, click Submit. A confirmation message will be sent to the email address on file, as entered in the email field.

## Types of Web Users

### Providers

Providers will receive a letter by email containing the provider's access PIN. This PIN, used in conjunction with the Provider ID, will grant the provider initial access to the SoonerCare Provider Portal. Only providers with an active SoonerCare contract will receive a PIN letter. Separate PIN letters will be mailed to each location. It is recommended that providers initialize their account and immediately create users (clerks) that will be used to operate the Internet application daily. Operating daily under the master user (Provider) poses certain security risks and should only be used when managing the account.

### Billing Agents

Billing agents are given logon credentials directly from DXC. When users initialize their accounts, they will be prompted to establish a password, challenge questions and answers, site key token and contact information upon initializing their accounts. *Billing Agents do not have the ability to create, grant access to, or revoke permissions of other users.*

### Clerks

The provider or billing agent who created the clerk will give clerks logon credentials. Users will be required to establish a password, challenge questions and answers, site key token and contact information upon initializing their accounts. *Clerks do not have the ability to create, grant access to, or revoke permissions of other users.*

### Enrollment Agents

Each provider can assign one (1) active clerk to be their enrollment agent. In addition to their other functions, this enrollment agent will have access to renew or make changes to the provider's contract with OHCA; including licensing information, banking details, and ownership information where applicable.

## Forgot Password

Users who forget their passwords may still gain access to the SoonerCare Provider Portal through the self-authentication process. The self-authentication process requires the user to change his or her password by selecting the Forgot Password? link from the Site Token Password page.

In the Forgot Password window, the user should answer the designated challenge question. Once the answer has been validated, a message will be sent to the email on record with a temporary password. Though not required, it is recommended that the user create a new password instead of using the temporary password.

## Section B: Web Features

The OHCA SoonerCare Provider Portal has many features to help providers with anything related to Medicaid billing. This section will cover several SoonerCare Provider Portal features.

### Broadcast/Global Messages

There are two (2) types of broadcast/global messages—unsecure and secure. Unsecure messages will only display on the login splash page; all providers will see these messages. Secure messages can be directed to an individual provider, a specific provider type, or to the entire provider community. These messages will display to the end-user once they have logged in to the provider portal.

Broadcast Messages will always display any active messages not checked as read. Next to each message is the following check box: “Please acknowledge receipt of message by checking this box.” Once this is selected, the message will no longer appear on the provider Home Page once the page has been refreshed.

### Main Page

The Main page is also the user’s home page. The Main page shows the display name, taxonomy number and contains shortcut links to areas of the website.

### My Home

The My Home tab at the top of the page will always bring the user back to their main page.

## My Profile

The My Profile page allows the user to edit options specific to their logon including their display name, phone number and email address. This page also allows the user to change their password, token, site key, and challenge questions and answers.

## Manage Accounts

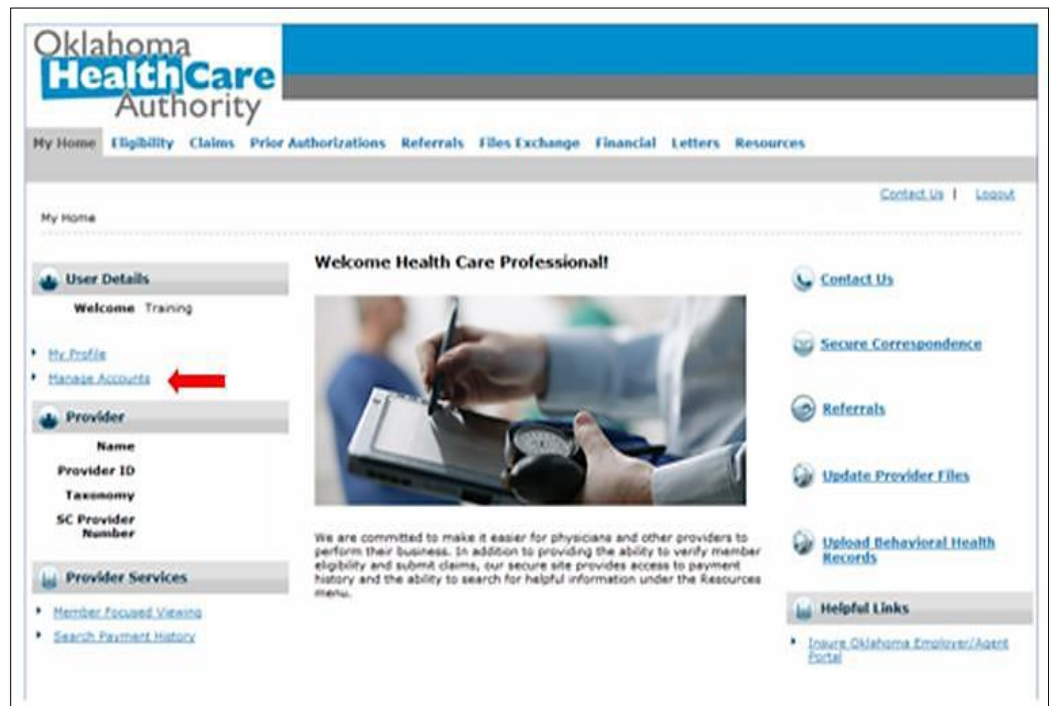
The Manage Accounts page is designed to establish the security credentials for users and clerks, as well as allow users to update and maintain user account data. Only a provider-level sign on will give a user access to the Manage Accounts page.

### Provider

After users access the website for the first time and initialize their account, they may access the Manage Accounts page. The provider can delegate assignments by using the Add New Clerk, Add Registered Clerk, Add Registered Billing Agent, Designate Billing Agent and Enrollment Agent tabs.

Once the Provider has submitted the billing agent or clerk information, the billing agent or clerk can establish his or her username, password, contact name, email and phone number by selecting the Register Now link on the portal logon page.

The status and authorized functions for billing agents and clerks are maintained by the provider using the Manage Accounts page.



**Adding a New Clerk**

Adding a clerk is done by selecting the Add New Clerk tab.

1. In the First and Last Name fields, enter the clerk's name.
2. In the Birth Date field, enter the clerk's birth date.
3. Enter the last four DLN of the clerk.
4. Select the check boxes of the functions the clerk will have authorization to access.
5. Click **Submit** once the information has been added.
6. Click **Confirm** to confirm the additions made to the new clerk.
7. Once the confirmation is complete, an informational message will appear with a clerk code. The clerk code is used for the new clerk to register for the SoonerCare Provider Portal with the Register Now link. The clerk code can also be used if the existing clerk is registering under another provider.

**Granting Access to Other Providers of Existing Billing Agent/Clerk**

After a clerk or agent is created, he or she will automatically have access to the provider account under which he or she was created. For the clerk or agent to access other providers' accounts, access must be granted.

**Add Registered Clerk**

1. Select the Add Registered Clerk tab.
2. Enter the last name of the clerk.
3. Enter the existing clerk code generated by the previous provider.
4. Select the check boxes of the functions the clerk will have authorization to access.
5. Click **Submit** after adding the information.
6. Click **Confirm** to complete adding the registered clerk.

**Add Registered Billing Agent**

1. Select the Add Registered Billing Agent tab.
2. Enter the display name of the billing agent.
3. Enter the existing agent code. If the agent code is unknown, the agent code is in My Profile-Role Qualifiers from the billing agent user account.

4. Select the check boxes of the functions the clerk or billing agent will have authorization to access.
5. Click **Submit** once the information has been added.
6. Click **Confirm** to confirm the additions made to the new clerk/billing agent.

### **Revising Billing Agent or Clerk Access**

When a billing agent or clerk no longer needs access to your provider account, or if functions need to be added/removed, you may edit account privileges.

1. From the Add New Clerk, Add Registered Clerk, or Add Registered Billing Agent tabs, a list of available users will appear at the bottom of each webpage.
2. For clerks, select the name of the clerk to update access. For billing agents, select the billing agent code.
3. Edit the Status and/or the Functions of the clerk or billing agent.
4. Click **Submit** after adjustments have been made.
5. Click **Confirm** to confirm the changes.

### **Designate Billing Agent**

The Designate Billing Agent function is used to allow billing agents to receive Capitation Summaries, Remittance Advice, and Roster transactions.

1. Select the Designate Billing Agent tab.
2. Select the transaction from the Transaction Type drop-down list.
3. Select the billing agent from the Billing Agent drop-down list.
4. Click Designate to Receive.

If all Transaction Types are designated to the billing agent, the Transaction Type drop-down list will be disabled.

To remove a Transaction Type from a billing agent, select the Remove link associated with the transaction to be removed. Any transactions removed will then appear in the Transaction Type drop-down list and can be added again later.

### **Enrollment Agent**

The Add Enrollment Agent function is used to allow an agent to initiate, update or renew the provider contract.



1. First, the agent will need to be set up as a clerk and given at least one role. This will allow them to become an option in the drop-down list.
2. The agent will then need to register and log in to the portal so their status changes from “Active Pending” to “Active”. This will allow them to become an option in the drop-down list.
3. Select the specific Enrollment Agent from the drop-down list.
4. Click the Add Enrollment Agent button. The Enrollment Agent will then be added.
5. An Enrollment Agent can be removed by clicking the Remove button.

### Switch Provider

The Switch Provider page is **only available to clerks and billing agents**. This feature allows the user to select the provider he or she wishes to access. The provider must add access to the billing agent or other user by using Add Registered Clerk or Add Registered Billing Agent through Manage Accounts before this functionality is available. To switch to a different provider:

1. Select the Switch Provider tab from the main page.
2. Select the Switch Provider option from the menu.
3. Enter at least one criterion.
4. Click Search.
5. Select the radio button next to the provider from the Available Providers results list.
6. Click Submit.
7. Click Close.

### Eligibility Tab

The purpose of the Eligibility tab is to verify eligibility of SoonerCare members. To run a query, a valid Member ID, Social Security Number, Birth Date, Name or Case Number is required. These are combined with the From Date of Service and To Date of Service fields. The resulting data appears below the search criteria. Calendar buttons next to the dates of service fields will activate a calendar pop-up feature to aid date selection.

## Treatment History (Dental)

**Search Treatment History** ?

Medical **Dental**

\* Indicates a required field.  
 This search feature retrieves PAID claim records for a particular member ID as of the timeframe submitted.  
 Enter the member ID, date of service, and procedure code or tooth number, then click **Search**. Click **Reset** to clear all fields.

**Member Information**

\*Member ID  Last Name  First Name  Birth Date

**Service Information**

Either Procedure Code or Tooth Number is required.

Procedure Code  \*Date of Service

Tooth Number  Any Tooth

**Search** **Reset**

This section lists the steps to follow when making an inquiry on a member's dental history.

Starting on the Provider main page, select the Eligibility link to display the Eligibility screen, and then select the Treatment History link. Another option is to select the Eligibility tab to display the drop-down list, and then select the Treatment History link.

1. Select the Dental tab.
2. Enter the member ID in the Member ID field. Member data auto-populates.
3. Enter a Procedure Code in the Procedure Code field, if applicable.
4. Select the date span from the Date of Service drop-down list.
5. Select a tooth number from the Tooth Number drop-down list, if applicable.
6. Select Search.

Results display and procedures can be sorted by the Service Date column. To print a copy of the treatment details, select the Procedure Code link, and then select Print Preview. A new window displays, and the procedure codes can be printed.

## Treatment History (Medical)

**Search Treatment History**

Medical Dental

\* Indicates a required field.  
This search feature retrieves PAID claim records for a particular member ID as of the timeframe submitted.

Enter the member ID, date of service, and procedure type/code, then click **Search**. Select **Lifetime** to view treatment history for the procedure identified over the lifetime of the patient. Click **Reset** to clear all fields.

**Member Information**

*Member ID	Last Name	First Name	Birth Date
------------	-----------	------------	------------

**Service Information**

\*Service From Date   To Date    Lifetime

\*Procedure Code Type   \*Procedure Code

This section lists the steps to follow when making an inquiry on a member's medical history.

Starting on the Provider main page, select the Eligibility link to display the Eligibility screen, and then select the Treatment History link. Another option is to select the Eligibility tab to display the drop-down list, and then select the Treatment History link.

1. Select the Medical tab.
2. Enter the member ID in the Member ID field. Member data auto-populates.
3. Enter a service from date in the Service From Date field.
4. Enter a thru date in the To Date field.
5. To view services over a lifetime, select the Lifetime check box. The Service From Date and To Date fields will be disabled.
6. Select the procedure code type from the Procedure Code Type drop-down list.
7. Enter a procedure code in the Procedure Code field.
8. Select Search.

Results display and procedures can be sorted by the Date of Service column.

## Claims Tab

The Claims tab facilitates the communication of claim data between the OHCA and the provider community.

Providers without access to HIPAA-compliant Practice Management software, a clearinghouse or a virtual access network (VAN) still can submit claims electronically. Direct Data Entry (DDE) enables the provider to submit individual claim information electronically to OHCA/DXC without the constraint of having to submit the data in HIPAA-compliant format. DDE claim pages are available on the OHCA SoonerCare Provider Portal for claim types (i.e., professional, institutional, dental and pharmacy).

These pages contain separate boxes/fields where claim data must be populated. As with paper claim forms, box/field population requirements depend on the billing situation. However, if a provider attempts to submit a claim via the DDE page and has not populated all required fields, the system will prompt a pop-up box stating which required fields are unpopulated.

DDE processes can only be performed for one claim at a time.

## Search Claims

Users may inquire about claims already submitted to the OHCA/DXC using member ID, claim ID, status, dates of service and paid dates. A results box from the search will appear below the search criteria in the form of a summary list. Results will appear with navigation links below the box to view the next or previous list of results from the query. Each summary result item is linked to the claim detail page in the Claim ID field.

Steps:

1. Select Claims from the main menu to navigate to the Search Claims screen or move the mouse pointer over the Claims tab, highlight and select Search Claims.
2. If known, the claim ID number can be entered in the Claim ID field. All other fields may be left blank.
3. If known, the member ID number can be entered in the Member ID field.
4. Enter a date in the Service From and To fields.
5. If known, the claim type can be selected from the Claim Type drop-down list.

6. The Claim Status field can be set to Denied, Paid, Suspended or Resubmit.
7. If known, the claim paid date can be entered in the paid Date field.
8. Click Search.

From the search results, click [+] to expand the claim being viewed. Click the Claim ID to view detailed claim information. Select the Export results link to export claim results to an Excel spreadsheet.

## Claim Submission

Providers need to confirm they are logged in under the correct provider number location prior to beginning claim submission process, then select the claim type.

### Resubmit Claim – Denied Claims Only

1. Pull up Denied claims (from the Claim Status field), along with any other search criteria.
2. Select Claim ID link of claim for correction.
3. Click Edit.
4. Change information in field containing incorrect data, select Resubmit, and then click Confirm.

### Void Claim – Paid Claims Only

1. Pull up Paid claims (from the Claim Status field), along with any other search criteria.
2. Select Claim ID link of claim to be voided.
3. Click Void. This will create an account receivable for the amount previously paid, which will be deducted from a future warrant. When available, the name of the person voiding the claim will appear when searching for a claim status.

### Copy Claim – Paid Claims Only

1. Pull up Paid claims (from the Claim Status field), along with any other search criteria.
2. Select Claim ID link of claim to be copied.
3. Click Copy.

4. Select the radio button that best fits the claim being submitted. Each radio button will display the fields that will be copied over to a new claim.
5. Click Copy.
6. After the new claim appears, make any additions to the new claim and submit.

## **Pricing Page**

The Search Fee Schedule page allows users to inquire on pricing information for procedures, drugs and DRG through the Internet. Selecting the tabs for Procedure, NDC or DRG will change the available options for searching. A drop-down list is available for the user to select the associated benefit package and the resulting data will be based on that selection. The search results summary will appear in list form below the criteria. This summary will be linked to a detail page.

### **Procedure Pricing**

The detail page for procedure pricing will display the vital procedural components. The results link will only appear if data is located for the entered procedure code and other criteria. Displayed data may include:

- Allowed Amount
- Prior Authorization Required
- Age Restriction
- Maximum Units
- Gender
- Lifetime Limitation
- Diagnosis Restrictions
- Specialty Restrictions
- Attachment Required
- Ambulatory Surgical Facility Fee
- Ambulatory Payment Classification Fee
- Discounted

## **NDC (Drug) Pricing**

The detail page for drug pricing will display vital data regarding the drug. The results link will only appear if data is located for the NDC code entered. Displayed data may include:

- State Maximum Allowable Cost (SMAC)
- Maximum Allowable Cost (MAC)
- Est. Acquisition Cost Wholesale (EACW)
- Est. Acquisition Cost Wholesale Percentage (EACW%)
- Est. Acquisition Cost Percentage (EAC%)
- Est. Acquisition Cost (EAC)
- Prior Authorization Required
- Maximum Units
- Maximum Days' Supply
- Age Restrictions
- Gender Requirement
- Unit of Measure (Pharmacy Claims)
- Unit of Measure (Claims other than Pharmacy)

## **DRG Pricing**

The detail results for DRG pricing is based on the DRG entered and the discharge date. Results will only appear if data is located for the DRG criteria entered. Displayed data may include:

- Peer Group
- Diagnosis Related Group (DRG)
- Rate

## **Prior Authorizations Page**

The Prior Authorizations page allows the user to submit new PA requests, inquire about pending PA requests and inquire/copy notices.

### **Prior Authorization Submission (Create Authorization)**

The Create Authorization link allows users to request a prior authorization.

The header section requests information about the patient and provider. Enter appropriate information in these fields. Below the header section is a diagnosis summary box the user can utilize to add a primary diagnosis (the first diagnosis entered) and additional diagnosis codes. The Service Detail section is used to enter service type codes and related details. The Medical Justification box is used as a free-form text box for additional information from the provider to OHCA PA analysts.

The next section is used to add attachments. The user uploads the file, enters a description of the attachment and selects **Add**. The user is instructed to add the attachment first and then add the service by selecting Add Service to associate the attachment with the service. When complete, users will select **Submit**.

If required information is missing, the user will be prompted to enter that information and then the user will select **Submit** again.

### **Prior Authorization Inquiry (View Authorization Status)**

1. Select the Prior Authorizations link on the main menu.
2. Select the View Authorization Status link.
3. To view authorizations beginning with today's date or greater, select the Prospective Authorizations tab.
4. To search for authorizations using different criteria, select the Search Authorizations tab. If you have the PA number, enter it in the Authorization Tracking Number field.
5. If you do not have the PA number, you may search for it by entering the Member ID, Assignment Code, Code Type/Code, Day Range or Service Date.
6. Click Search.

Search results are displayed in a list box. If additional results exist, they may be viewed by using the pagination numbers below the list box. Selecting the Authorization Tracking Number will open the PA detail window.

Search results may also be exported to a Microsoft Excel spreadsheet by selecting the Export results link.

### **Prior Authorization Summary**

The Prior Authorization Summary page appears when a user searches for a PA using the View Authorization Status page. The header section outlines information about the patient and provider. Below the header section is the Service Provider/Service Details



Information section that displays the line items and notes.

To view additional authorization-specific information, select [+] for each header listed.

Line item boxes are used to review procedure code-related details and status. The Reason comments section relates to each line item highlighted in the Line Item summary box.

The Remarks column is used to review notes entered by an OHCA PA analyst. Select the View link to view comments:

- To view the original request sent, click View Original Request.
- To print a copy of the Summary, click Print Preview. A copy will appear in a new window and can be printed by selecting Print.
- To return to the Search Authorization tab, select Back to View Authorization Status.

### **Prior Authorization Notices**

Go to the Prior Authorizations menu, select the View Authorization Status link, then select the Authorization Notices tab and search using one of the following:

- Member ID or member name to access recent PA notices submitted under your provider number for that member.
- The Authorization tracking number of a specific PA. This brings up only the notices related to that number.
- Enter either a Day Range or From and To dates of service.
- Select Search to view the PA notices under your provider number.
- Select the date listed under the Date Sent column. This will bring up the PA notice letter, which can be printed.

On each column, providers can select the column links that allow them to sort in ascending or descending order.

### **Additional Information for Successful Use**

- When searching by either a specific PA number, member ID or member name the Date Span fields are auto populated with a 6-month span. The From date field counts back six months from the To date field. The To date field is the current day the search is being conducted.
- The Web program holds a 60-day rolling submission history. For example, if the PA request was entered into the system on 01/01/20, it will be available for online viewing until 03/02/20.
- When logged on to a Group Provider number, the system will bring up PA information for every provider in that group.
- On the Authorization Notices menu, a message counter (Unread Notices) has been added that counts the number of unread PA notices under the provider logon.

## **Referrals**

### **Create Referrals (Indian Health ONLY)**

The Create Referral tab under Referrals will allow the user to create a new referral. The Member Information will allow the user to enter the Recipient ID, which will populate the member's name and date of birth. The Remaining Referral Information will allow entry of the Referred To Provider by NPI. The user will choose between Initial Visit Only and Ongoing Referral, then enter the Referral Start Date and Referral End Date, and the Reason for Referral.

### **Search Referral**

The Search Referral allows providers to search for a referral using the following:

- Referral Tracking Number
- Recipient ID
- Referring or Servicing Provider

## Trade Files Page (Batch Submission)

The Trade Files option is available to providers to facilitate file transfers between the provider community, billing agents, clearinghouses, other involved agencies and the OHCA.

### File Upload

The File Upload page allows users to select a file from a local hard drive and upload it to the OHCA. Users of this feature include providers who wish to upload batch claim submissions and managed care providers who wish to upload PCP information. Batch upload is an Internet submission option that is available to providers who wish to submit large claim batches or inquiries. To use the Batch Upload option providers must use HIPAA-compliant software or clearinghouse/VANs that can submit required data in HIPAA-compliant ANSI X12 Addenda format. Once the provider has ensured the batch claim data have been converted into the corresponding HIPAA-compliant format and has successfully completed authorization testing with the DXC team, they then can upload an entire batch file/transaction into the Oklahoma Medicaid Management Information System (OKMMIS).

If users wish to upload a batch, they must navigate to the Files Exchange menu. Select the Upload Files link from the Files Exchange Option to access the file upload page (see screen sample below).

The screenshot shows the 'File Upload' page within the OHCA provider portal. The page has a green header with the OHCA logo and navigation tabs. The 'Files Exchange' tab is selected, and the 'Upload Files' link is active. The main content area is titled 'File Upload' and contains a form with the following elements:

- A search bar with 'Upload' and 'Search' buttons.
- A note: '\* Indicates a required field.'
- A text area labeled 'File Upload - Place holder for configurable text'.
- A dropdown menu for '\* Transaction Type' with 'Select' as the current value.
- A file selection field for '\* Select File to Upload' with a 'Browse...' button.
- A text input field for '\* Save as Filename'.
- 'Upload' and 'Reset' buttons at the bottom of the form.

From this page, the user will select the Transaction Type from the drop-down list. Select Browse to locate the file to upload. At this point, the user will have the ability to change the file name in the Save as Filename box. Once the information is complete, the user will select Upload.

The user will receive an Upload File Confirmation pop-up window upon successful completion of the file upload. This window will verify the name the file was saved under (see screen sample below).



The Upload process is now complete for the user. This process must be repeated for all files uploaded via the web upload tool.

Select the Search tab to search for uploaded files. Use the drop-down list to select the Transaction Type. Enter a partial filename in the Filename field. The search results will display the Transaction ID and date the file was uploaded.

### **File Download**

The File Download page allows users to select a file from the Provider Portal and download it to their system. Available files will be listed as filename links. The download process will begin when the filename is selected. Users of this feature include providers who wish to download batch claims or response files and managed care providers who wish to download managed care roster information.

To download a file (i.e., an 835 Remittance Advice), select the Download Files link; the Download page will open. Files created for the specific user/provider will be found on this page (see screen sample below).

oklahoma health care authority

My Home Eligibility Claims Care Management **Files Exchange** Resources LTC

Download Files | Upload Files

Files Exchange > Download Files

Contact Us | Logout  
Friday 04/12/2013 05:54 PM EST

**File Download** ?

\* Indicates a required field.  
Enter your search criteria and click the **Search** button.

File Status

Category

\*From Date  \*To Date

**Search**

To download a file, select the appropriate option from the File Status drop-down list. Select a category type from the Category drop-down list. Enter a date range and click **Search**. A list of available files will appear. Select a file to start the download. (The file download will vary based on browser settings.)

**NOTE:** *If you are downloading multiple files, you will want to extract the file and rename it before downloading another file to avoid replacing the original file with your new file.*

## Help Page

Help pages for the SoonerCare Provider Portal site are dynamic, meaning that the help text that displays is unique to the page the user is viewing. Select the question mark (?) located at the right corner of each grey webpage header. This will open a separate window providing details of the webpage the user is currently navigating to.

## Logout Link

Selecting the Logout link ends the current session on the SoonerCare Provider Portal and redirects the user to the non-secure menu options. Clicking Login will take the user to the Log On page.

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# Chapter 4: Member Eligibility Verification

## Introduction

SoonerCare (Oklahoma Medicaid) is a health coverage program jointly funded by the federal and state governments that assists in payment of some or all medical bills for many people who can't afford them. The Oklahoma Healthcare Authority (OHCA) is the state agency that administers the program and determines financial eligibility using federal poverty income guidelines. Members should apply for SoonerCare and renew their benefits online at [www.mysooner.org](http://www.mysooner.org).

## Member ID Card

SoonerCare members can print their identification card at [www.mysooner.org](http://www.mysooner.org). Additionally, providers can print the member identification card once eligibility is confirmed. The newest version of the Medicaid Medical ID card is a white card with blue graphics. The ID card can be used for checking a member's eligibility. Shown below is an example of the previous and current versions of the medical ID card.



**Old Version (Still Valid)**





**New Version**



Members are always encouraged to keep their card with them; however, this card is not required for the member to receive services. The purpose of the ID card is to provide enough information to verify eligibility of the member. The card by itself is not a guarantee of eligibility. Eligibility can be verified by using the member's ID number from their card, Social Security number with date of birth, first and last name along with date of birth, or the member's Case Number.

It is the provider's responsibility to verify the member's eligibility on a per visit basis to ensure the member's continued eligibility for Medicaid SoonerCare coverage. Failure to verify eligibility prior to rendering services could result in delay or denial of payment.

## Section B: Options to Verify Member Eligibility

As an Oklahoma SoonerCare provider, it is imperative to verify a member's eligibility prior to providing services *each* time a service is provided.



Providers can check member eligibility using one of four sources:

- Eligibility Verification System (EVS)
- SoonerCare Provider Portal
- Electronic Data Interchange (EDI)

Providers need a Personal Identification Number (PIN) to access the Provider Portal and EVS. If a provider forgets their PIN, they can obtain it by calling the Internet Help Desk at 405-522-6205 or toll-free at 800-522-0114 and selecting options 2, then 1.

## **EVS/AVR**

The EVS is a national toll-free telephone number to help providers obtain member eligibility, provider warrant, prior authorization and claim inquiry information. Providers can also request prior authorization and eligibility fax backs. There are two ways to use the EVS system: A caller may use the touch-tone system or the automated voice response (AVR)/speech recognition system. A PIN is required to access member eligibility information. The 4-digit PIN expires every six months. Providers may reset their PIN by remaining on the phone and following the prompts.

### **Touch-Tone System**

The touch-tone system allows a caller to go through the call using the telephone's number pad. The caller's telephone must have touch-tone capability; rotary style phones will not work on the touch-tone system.

### **Alpha Conversion**

Entering the provider's SoonerCare ID number can access eligibility information. This will be a 9-digit number and one alpha character location code that was assigned by the OHCA. A location conversion code has been established for the alphabet to be used in conjunction with the EVS. The codes are patterned to coincide with the location of numbers and letters on a telephone keypad. For example, the letter *A* converts to \*21. The number 21 represents the second button and the first letter on that button of the telephone keypad. The letter *R* converts to \*72, representing the seventh button, third letter. See the alpha conversion chart below.

### Alpha Conversion Chart for EVS

A=*21	F=*33	K=*52	P=*71	U=*82	Z=*12
B=*22	G=*41	L=*53	Q=*11	V=*83	
C=*23	H=*42	M=*61	R=*72	W=*91	
D=*31	I=*43	N=*62	S=*73	X=*93	
E=*32	J=*51	O=*63	T=*81	Y=*93	

### AVR/Speech Recognition

Providers without a touch-tone phone can access information using the AVR. The AVR system allows a caller to use a speech application. By speaking into the phone, a caller can use the system to get access information. The system is available seven days a week, from 5 a.m. to 1 a.m.

Toll-free: 800-767-3949

OKC Metro Area: 405-840-0650

### Provider Portal

Providers can verify member eligibility on the SoonerCare Provider Portal.

Follow these steps to verify a member's eligibility:

1. Select the Eligibility tab.
2. Select the Eligibility Verification link.
3. Enter search criteria to verify eligibility. The field options are Member ID, Case Number, SSN, First and Last Name, Date of Birth, and Dates of Service.

Each option requires that a date-of-service (DOS) range of up to 13 months also be entered. The Calendar option to the right of each date field may be used for quick selection of the date.

4. Click Submit.

Status A indicates the electronic request for eligibility was accepted by Oklahoma SoonerCare and does not reflect the eligibility of the member. The eligibility and benefit programs for the member will appear below the status.

5. Select a member ID from the search results to view eligibility details.
6. To print the eligibility results, click Print Preview. A new window displays, from which you can print the eligibility details.

Follow these steps to add third-party liability (TPL) to a member's eligibility:

1. Follow steps 1-5 in the section above for eligibility verification.
2. Click [+] to expand the TPL header.
3. Enter the name of the carrier in the Carrier Name field.
4. Enter the carrier ID in the Carrier ID field.
5. Enter the policy number in the Policy Number field.
6. Enter the group ID in the Group ID field.
7. Select the Person or Organization radio button from the Policy Holder field.
8. If you selected the Person radio button, enter the policy holder's first name, last name, and middle initial in the Policy Holder Last Name First Name and MI fields.  
  
If you selected the Organization radio button, enter the policy holder's organization in the Policy Holder Organization field.
9. Select the policy type from the Policy Type drop-down list.
10. Select the coverage type from the Coverage Type drop-down list.
11. Select the relationship from the Relationship drop-down list.
12. Enter the employer ID in the Employer ID field.
13. Enter the effective and end dates in the Effective and End Date fields.
14. Click Add.

### **Electronic Data Interchange (EDI)**

EDI is a way for providers to check eligibility on a larger scale than the previously listed options. Providers purchase third-party, HIPAA compliant software used to send a 270 transaction with their search criteria and receive a 271 response, which provides eligibility information. A 271 will provide information on the different programs the member is eligible for, as well as any TPL or Medicare information.

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# Chapter 5: Claim Completion

## Introduction

The following information is intended to provide procedures for submitting claims to the OHCA. For information on what services are covered by the Oklahoma SoonerCare program, please access the agency rules. Rules can be found at [www.okhca.org](http://www.okhca.org).

There are three main methods for submitting claims to the OHCA: paper (primarily special batch), direct data entry (DDE) via the SoonerCare Provider Portal and through electronic data interchange (EDI) batch transactions.

Below is a paper-to-electronic conversion table for the different claim submission types. Please refer to the EDI chapter of this manual for instructions on completing the HIPAA transaction types.

Paper (Primarily Special Batch)	DDE	HIPAA Transactions
1500	Professional	837P
UB-04	Institutional	837I
ADA 2012	Dental	837D
Pharmacy Drug Claim Form	Pharmacy	NCPDP, version 5.1
Compound Prescription Drug Claim Form	Pharmacy	NCPDP, version 5.1

## Section A: Paper Claim Recommendations

Effective 6/1/2020, primarily paper claims accepted are Special Batch Process Claims. See Special Batch Claims section for instructions.

Claim forms are prepared as follows:

1. Enter complete information with a typewriter, personal computer or ballpoint pen (blue or black ink). **Do not** use red ink.
2. Keep names, numbers, codes, etc., within the designated boxes and lines.
3. Provide the required information for every claim line. **Do not** use quotation marks or the words "same as above."
4. Verify accuracy of the information before submitting the claim.
5. Follow the instructions for preparing paper claim forms provided in this chapter.

6. 1500, UB-04, Pharm-1 Pharm-2 and ADA 2012 claim forms are scanned into the OKMMIS. Paper claim forms should be submitted on the original forms to facilitate the scanning process. Use only standard size original CMS 1500 and UB-04 claim forms with red drop-out ink.
7. Mail special batch paper claims to the appropriate mailbox address listed in the special batch claims section.
8. Send any necessary attachments with your claim. The attachments for a claim should be placed under the identified claim for processing; place claim form on top. Do **not** place the attachment on top of the claim form or it will be associated to previously processed claim. **Do not apply any staples to the claim or attachments.**

### Ordering Paper Claim Forms

UB-04, 1500 and ADA 2012 (dental) claim forms can be ordered from a standard form supply company. DXC does not distribute supplies of these forms. Drug and Compound prescription claim forms can be downloaded from the OHCA website.

## Section B: 1500, Professional, 837P

### The 1500 Health Insurance Claim Form

The **1500** Health Insurance Claim Form (formerly known as the HCFA-1500 and CMS-1500), is the required claim form used by medical providers for professional services, unless otherwise specified. The provider must purchase these forms. This section explains how to complete the paper 1500 Health Insurance Claim Form.


The form locator chart below indicates which fields are *required*, *not required*, *required, if applicable* or *not captured*. Where necessary, directions applicable to specific provider types are noted.

# 1500 Health Insurance Claim Form

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION



## HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

<input type="checkbox"/> PICA <span style="float: right;"><input type="checkbox"/> PICA</span>									
1. MEDICARE <input type="checkbox"/> (Medicare#)            MEDICAID <input type="checkbox"/> (Medicaid#)            TRICARE <input type="checkbox"/> (ID#/DoD#)            CHAMPVA <input type="checkbox"/> (Member ID#)            GROUP HEALTH PLAN <input type="checkbox"/> (ID#)            FECA BLX/LUNG <input type="checkbox"/> (ID#)            OTHER <input type="checkbox"/> (ID#)					1a. INSURED'S I.D. NUMBER (For Programs in Item 1)				
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)					3. PATIENT'S BIRTH DATE MM DD YY    SEX M <input type="checkbox"/> F <input type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial)		
5. PATIENT'S ADDRESS (No., Street)  CITY _____ STATE _____					6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street)  CITY _____ STATE _____		
ZIP CODE _____		TELEPHONE (Include Area Code) _____			ZIP CODE _____		TELEPHONE (Include Area Code) _____		
8. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)					10. IS PATIENT'S CONDITION RELATED TO:				
a. OTHER INSURED'S POLICY OR GROUP NUMBER					a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/>				
b. RESERVED FOR NUCC USE					b. AUTO ACCIDENT? PLAGE (State) YES <input type="checkbox"/> NO <input type="checkbox"/>				
c. RESERVED FOR NUCC USE					c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>				
d. INSURANCE PLAN NAME OR PROGRAM NAME					10d. CLAIM CODES (Designated by NUCC)				
12. 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.					11. INSURED'S POLICY GROUP OR FECA NUMBER				
SIGNED _____ DATE _____					13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.				
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY    QUAL. _____					15. OTHER DATE MM DD YY    QUAL. _____				
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE					18. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY				
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)					19. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY				
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)					20. OUTSIDE LAB? YES <input type="checkbox"/> NO <input type="checkbox"/> § CHARGES				
A. _____ B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____					22. RESUBMISSION CODE _____ ORIGINAL REF. NO. _____				
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY    B. PLACE OF SERVICE    C. EMG    D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS    E. DIAGNOSIS POINTER    F. § CHARGES    G. DAYS OR UNITS    H. FREQ (Per Day) Plan    I. ID. QUAL.    J. RENDERING PROVIDER ID. #					23. PRIOR AUTHORIZATION NUMBER _____				
1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____					NPI _____ NPI _____ NPI _____ NPI _____ NPI _____ NPI _____				
25. FEDERAL TAX I.D. NUMBER    SBN EIN <input type="checkbox"/> <input type="checkbox"/>					26. PATIENT'S ACCOUNT NO.    27. ACCEPT ASSIGNMENT? (For gov. claims, see back) YES <input type="checkbox"/> NO <input type="checkbox"/>				
28. TOTAL CHARGE \$ _____    29. AMOUNT PAID \$ _____    30. Paid for NUCC Use					31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)				
SIGNED _____ DATE _____					32. SERVICE FACILITY LOCATION INFORMATION a. NPI _____ b. _____				
33. BILLING PROVIDER INFO & PH # ( )					a. NPI _____ b. _____				

NUCC Instruction Manual available at: [www.nucc.org](http://www.nucc.org)    PLEASE PRINT OR TYPE    APPROVED OMB-0938-1197 FORM 1500 (02-12)



**1500 Claims Field Descriptions/Instructions**

<b>Field</b>	<b>Requirement</b>	<b>1500 Field Descriptions/Instructions</b>
1	Required	Insurance selection: Select the box for Medicaid.
1A	Required	Insured's ID Number: Enter the member's 9-digit SoonerCare ID number.
2	Required	Patient's Name: Enter the member's full last name, first name and middle initial. (Last, First, Middle Initial)
3	Not Required	Patient's Birth Date: Enter the member's birth date. (MM/DD/YY) Sex: Select the appropriate box.
4	Not Required	Insured's Name: Insured's last name, first name, middle initial. (Last, First, Middle Initial)
5	Not Required	Patient's Address: (No., Street), City, State, ZIP Code, Telephone (including area code).
6	Not Required	Patient relationship to insured
7	Not Required	Insured's Address: (No., Street), City, State, ZIP Code, Telephone (including area code).
8	Not Required	<i>Reserved for NUCC Use</i>
9	Not Required	Other Insured's Name: Other Insured's last name, first name, middle initial. (Last, First, Middle Initial)
9A	Not Required	Other Insured's Policy or Group Number
9B	Not Required	<i>Reserved for NUCC Use</i> Other Insured's Date of Birth: (MMDDYY) Sex: Select the appropriate box.
9C	Not Required	<i>Reserved for NUCC Use</i> Employer's Name or School Name
9D	Situational	Insurance Plan Name or Program Name: If other insurance is available, enter the commercial or private insurance plan name.
10	Situational	Is Patient's Condition Related to: Select the appropriate box for each of the three categories. 10A: Employment? – (current or previous) Check Yes or No to indicate if the services being billed are employment related. 10B: Auto Accident? – Check Yes or No to indicate if the services being billed are related to an auto accident. Plate (State) – Enter the 2-character state code, if applicable. 10C: Other Accident? – Check Yes or No to indicate if the services being billed are related to an accident of another type.
10D	<i>Not Captured</i>	<i>Claim Codes (Designated by NUCC)</i>
11	Situational	Insured's Policy Group or FECA Number: If member has more than one form of TPL (private or commercial insurance), enter policy number of second carrier.

11A	Not Required	Insured's Date of Birth: Enter the insured's birth date. (MMDDYY) Sex: Select the appropriate box.
11B	Not Required	<i>Other Claim ID (Designated by NUCC)</i> Employer's Name or School Name
11C	Situational	Insurance Plan Name or Program Name: If other insurance is available, enter the commercial or private insurance plan name.
11D	Situational	Is There Another Health Benefit Plan?: Check the appropriate box. Provide third or additional private or commercial insurance information on a separate piece of paper using directions provided for field 9.
12	Not Required	Patient's or Authorized Person's Signature
13	Not Required	Insured's or Authorized Person's Signature
14	Situational (if field 10 has box checked 'Yes')	Date of Current Injury, Illness, or Pregnancy (LMP): Enter the date (MMDDYY) for any of the following, if applicable: <u>Illness</u> – date of first symptom/onset of illness <u>Injury</u> (Accident) – date of accident <u>Pregnancy</u> – OB claims must indicate date member was first seen for the pregnancy  <b>Qualifier</b> —Enter applicable qualifier: 431 – Onset of Current Symptoms or Illness 481 – Last Menstrual Period
15	Not Required	Other Date: If patient has had same or similar illness, enter first date (MMDDYY).  <b>Qualifier</b> —Enter applicable qualifier: 454 – Initial Treatment 304 – Latest Visit or Consultation 453 – Acute Manifestation of Chronic Condition 439 – Accident 455 – Last X-ray 471 – Prescription 090 – Report Start 091 – Report End 444 – Report First Visit or Consultation
16	Not Required	Dates Patient Unable to Work in Current Occupation
17	Situational	Name of Referring Provider or Other Source: Enter the qualifier "DN" for the Referring Provider or "DK" for the Ordering Provider in the first small box.
17A	Situational	<i>Shaded</i> —ID Number of Referring Provider: (large box) Enter the 10-character Oklahoma SoonerCare provider ID number of the referring provider if the member is enrolled in the SoonerCare Choice or Insure Oklahoma Individual Plan programs. (Required, if applicable)

17B	Situational	<i>Unshaded</i> —NPI Number of Ordering or Referring Provider: Enter the 10-digit National Provider Identifier (NPI) number of the ordering physician or the 10-digit NPI from the referral form if the member is enrolled in the SoonerCare Choice or Insure Oklahoma Individual Plan programs. Referral form submission with the claim is not required.
18	Situational	Hospitalization Dates Related to Current Service: Enter the requested FROM and TO dates. (MM/DD/YY)
19	Situational	Additional Claim Information ( <i>Designated by NUCC</i> ): If the primary insurance carrier did not issue payment, write the words “Carrier Denied” in this box. A copy of the insurance payment detail or insurance denial must be attached to paper claims.
20	Not Required	Outside Lab Select the appropriate box. \$ Charges: 8-digit numeric field
21A-L	Situational	Diagnosis or Nature of Illness or Injury: Enter up to 12 ICD diagnosis codes, with up to seven (7) characters per code, in order of importance. These indicators will correspond to the appropriate procedures and be listed in box 24E.
22	Not Required	<i>SoonerCare Resubmission Code; Original Ref No.</i>
23	Situational	Prior Authorization Number: The prior authorization (PA) number is not required as the information is systematically verified. <b>The CLIA certification number is required to be put in this block when billing for laboratory services.</b>
24		Detail service lines should be listed in the unshaded areas of 24 A-J. A maximum of six (6) service lines are allowed per claim.
24A	Required	<b>Date(s) of Service:</b> <i>Unshaded</i> (bottom): Enter FROM and TO dates (MM/DD/YY) for the billing period for each service rendered.  <i>Shaded</i> (top): Enter NDC qualifier “N4” followed by the 11-digit NDC number (e.g., N49999999999); NDC should go directly over dates, do not enter any spaces or dashes.

24B

**Required****Place of Service:**

*Unshaded* (bottom): Enter the place of service code for the place services were rendered.

Place of Service Codes:

CODE DESCRIPTION

11	Office
12	Home
20	Urgent care facility
21	Inpatient hospital
22	Outpatient hospital
23	Emergency room
24	Ambulatory surgical center (ASC)
25	Birth center
26	Military treatment facility
31	Skilled nursing facility (SNF)
32	Nursing facility (NF)
33	Custodial care facility
34	Hospice
41	Ambulance – land
42	Ambulance – air or water
51	Inpatient psychiatric facility
52	Psychiatric facility – partial hospitalization
53	Community mental health center
54	Intermediate care facility/developmentally disabled (ICF/MR)
55	Residential substance abuse treatment facility
56	Psychiatric residential treatment center
61	Comprehensive inpatient rehabilitation facility
62	Comprehensive outpatient rehabilitation facility
65	End-stage renal disease treatment facility
71	State or local public health clinic
72	Rural health clinic (RHC)
81	Independent laboratory
99	Other unlisted facility

*Shaded* (top): Do not enter anything in this field.

24C

**Not Required****Emergency Indicator (EMG):**

*Unshaded* (bottom): If services are related to an emergency, enter Y; if not, enter N.

*Shaded* (top): Do not enter anything in this field.

24D	Situational	<p><b>Procedures, Services or Supplies (Explain unusual circumstances):</b> CPT/HCPCS; Modifier</p> <p><i>Unshaded</i> (bottom): Enter one (1) CPT or one (1) HCPCS code and up to four (4) modifiers for the service rendered.</p>
		<p><i>Shaded</i> (top): If your procedure code requires an NDC, enter the unit of measure as “UN” for unit, “F2” for international unit, “ML” for milliliter, or “GR” for gram, followed by the metric decimal quantity. (e.g., UN103.50). Do not use spaces or dashes; do not include a description or any information beyond what is indicated above. The NDC should be placed above the corresponding HCPCS code.</p>
24E	Situational	<p><b>Diagnosis Pointer:</b></p> <p><i>Unshaded</i> (bottom): Enter the alpha codes (A-L), in order of importance, which correspond to the ICD diagnosis code listed in field 21. A minimum of one (1) and maximum of four (4) diagnosis code pointers can be entered per line; do not enter the full diagnosis code.</p>
		<p><i>Shaded</i> (top): Do not enter anything in this field.</p>
24F	Required	<p><b>\$ Charges:</b></p> <p><i>Unshaded</i> (bottom): Enter the charges for each line item on the claim form.</p>
		<p><i>Shaded</i> (top): Do not enter anything in this field.</p>
24G	Required	<p><b>Days or Units:</b></p> <p><i>Unshaded</i> (bottom): Enter the appropriate number of units of services provided for the procedure code. Whole and decimal numbers are acceptable.</p>
		<p><i>Shaded</i> (top): Do not enter anything in this field.</p>
24H	Situational	<p><b>EPSDT Family Plan:</b></p> <p><i>Unshaded</i> (bottom): If the services provided were related to an EPSDT/Family Planning visit, enter Y; if not, enter N or leave blank.</p>
		<p><i>Shaded</i> (top): If Y is entered in the unshaded box as described above, the 2-digit referral type must be entered in the shaded area above the box.</p> <p>Appropriate codes are:  NU: Not Available  AV: Available, Not Used  ST: New Services Requested  S2: Under Treatment</p>
24I-J		<p>When entering the rendering provider's ID number, only use the shaded areas of 24I-J.</p> <p>When entering the provider's NPI number, use the unshaded area of 24J.</p>

24I	Not Required	<b>ID Qualifier:</b> <i>Unshaded</i> (bottom): This field is already populated with NPI, indicating that the provider number listed for the rendering provider is the NPI.
		<i>Shaded</i> (top): Enter the 2-character qualifier indicating the type of provider number being used for the rendering provider; enter 1D to indicate the type of provider number used is for Oklahoma SoonerCare.
24J	Situational	<b>Rendering Provider ID Number:</b> <i>Unshaded</i> (bottom): Enter the rendering provider's 10-digit NPI.
		<i>Shaded</i> (top): Enter the 10-character Oklahoma SoonerCare provider number of the rendering provider. This field can be left blank if billing and rendering numbers, including location code, are identical. (100000000A)
25	Not Required	Federal Tax ID Number
26	Not Required	Patient's Account Number: Enter the internal patient tracking number; if entered, this information will appear on the remittance advice.
27	Required	Accept Assignment: Oklahoma SoonerCare only accepts assigned claims.
28	Required	Total Charge: Add all amounts/charges in column 24F; enter the total amount/charge in this field. Each page must have a total. Claims cannot be continued to two or more pages.
29	Situational	Amount Paid: Enter the total dollar amount paid by a primary insurance carrier (for example, 45.00). You do not need to enter a dollar sign (\$). Do not include amount paid by Medicare. <i>*Used for HMO Copays</i>
30	<i>Not Captured</i>	<i>Reserved for NUCC Use</i>
31	Required	Signature of Physician or Supplier including degrees or credentials: The billing provider or authorized representative must sign and date this field. Include the date the claim was created. A signature stamp is acceptable; however, the statement "Signature on File" is not allowed. <i>Date</i> – Enter the date the claim was filed. Be sure not to write any portion of the date outside the designated box. The date billed must be on or after the date(s) of service.
32	Not Required	Service Facility Location Information: Enter the name and full address of the location where service was rendered.
32A	Not Required	Enter the 10-digit NPI number of the facility where the services were rendered.
32B	Not Required	Enter the 10-character Oklahoma SoonerCare provider ID number of the facility where the services were rendered. No spaces or dashes should be used.


33	Required	Billing Provider Info & Phone Number: Enter the name, full address, ZIP code and phone number of provider requesting payment for services listed on claim form. If the provider furnished the services as part of a group practice organization, enter the name, full address, ZIP code and phone number of the group practice organization.
33A	Not Required	Enter the 10-digit NPI number of the billing provider or group.
33B	Required	Enter the 10-character Oklahoma SoonerCare provider ID number of the billing provider. No spaces or dashes should be used. (100000000A)

### Direct Data Entry (DDE) Claim Submission – Professional

Use the Professional claim form example and directions below as a guide when submitting claims through DDE on the SoonerCare Provider Portal. Choose the Submit Claim Prof (see screen sample below) claim option from the Claims menu to open the form (see screen sample below).

Select **Professional** from the Claim Type drop-down list above the Provider Information heading.

The image shows a screenshot of a web form. On the left, the text 'Claim Type' is followed by a dropdown menu. The dropdown menu is open, displaying two options: 'Professional' (which is highlighted in blue) and 'Crossover Professional' (which is in a lighter blue/grey color). The dropdown menu has a small downward-pointing arrow on its right side.



[My Home](#) | [Eligibility](#) | **[Claims](#)** | [Prior Authorizations](#) | [Referrals](#) | [Files Exchange](#) | [Financial](#) | [Letters](#) | [Reports](#) | [Resources](#)

[Search Claims](#) | [Submit Claim Dental](#) | [Submit Claim Inst](#) | **[Submit Claim Pro](#)** | [Submit Claim Pharm](#) | [Search Payment History](#)

[Contact Us](#) | [Logout](#)  
 Monday 03/23/2020 10:41 AM CST

[Claims](#) > [Submit Claim Prof](#)

**Submit Professional Claim: Step 1**

\* Indicates a required field.

Claim Type Professional

EVV SERVICES ONLY timely filing No

This panel contains provider information.

<b>Billing Provider ID</b>	<b>ID Type</b>	<b>NPI</b>	<b>Name</b>
<b>Zip Code</b>	<b>Contract Code</b>	<b>Taxonomy</b>	<b>SC Provider Number</b>
<b>Referring Provider ID</b> <input style="width: 80%;" type="text"/>	<b>ID Type</b> <span style="border: 1px solid gray; padding: 2px;">▼</span>	<b>ID Type</b> <span style="border: 1px solid gray; padding: 2px;">▼</span>	<b>Ordering Zip Code</b> <input style="width: 80%;" type="text"/>
<b>Ordering Provider ID</b> <input style="width: 80%;" type="text"/>	<b>ID Type</b> <span style="border: 1px solid gray; padding: 2px;">▼</span>	<b>ID Type</b> <span style="border: 1px solid gray; padding: 2px;">▼</span>	
<b>Other Facility ID</b> <input style="width: 80%;" type="text"/>	<b>ID Type</b> <span style="border: 1px solid gray; padding: 2px;">▼</span>		

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

\*Member ID

<b>Last Name</b>	<b>First Name</b>	<b>Middle</b>
<b>Birth Date</b>		

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.

<b>Date Type</b> <span style="border: 1px solid gray; padding: 2px;">▼</span>	<b>Date of Current</b> <input style="width: 80%;" type="text"/>	
<b>Accident Related</b> <span style="border: 1px solid gray; padding: 2px;">▼</span>	<b>Expected Delivery Date</b> <input style="width: 80%;" type="text"/>	
<b>Patient Account Number</b> <input style="width: 80%;" type="text"/>	<b>From Date</b> - <input style="width: 80%;" type="text"/>	<b>To Date</b> - <input style="width: 80%;" type="text"/>
<b>CLIA Number</b> <input style="width: 80%;" type="text"/>	<b>*Other Insurance</b> <span style="border: 1px solid gray; padding: 2px;">None ▼</span>	<b>HMO Copay</b> <span style="border: 1px solid gray; padding: 2px;">No ▼</span>

**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			

1    \*ICD Version     \*Diagnosis Code

---

**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      To Date      \*Place of Service      EMG

\*Procedure Code     Modifiers       \*Diagnosis Pointers

Charge Amount     \*Units     Unit Type  Unit    EPSDT

CLIA Number     DMH Contract Source

Rendering Provider ID     ID Type     Zip Code     Contract Code

Taxonomy     SC Provider Number

Ordering Provider ID     ID Type     Zip Code

**NDC for Item 1** +

---

**Attachments** -

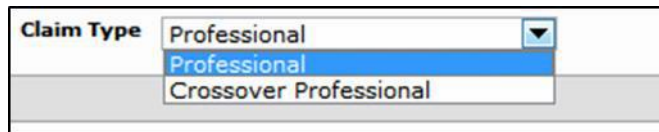
Click the **Remove** link to remove the entire row.

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

Library Reference: OKPBPM  
 Revision Date: August 2020  
 Version 6.2

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Select **Crossover Professional** from the Claim Type drop-down list above the Provider Information heading. The Crossover Details section should now be visible (see screen sample below).



The screenshot shows the 'Submit Professional Claim: Step 1' form on the Oklahoma HealthCare Authority website. The form is titled 'Submit Professional Claim: Step 1' and includes a help icon. A red asterisk indicates a required field. The 'Claim Type' dropdown is set to 'Crossover Professional'. The form is divided into several sections: 'Provider Information', 'Patient Information', and 'Claim Information'. The 'Provider Information' section includes fields for Billing Provider ID, ID Type (NPI), Name, Zip Code, Contract Code, Taxonomy, SC Provider Number, Referring Provider ID, ID Type, Ordering Provider ID, ID Type, Other Facility ID, and Ordering Zip Code. The 'Patient Information' section includes a Member ID field and fields for Last Name, First Name, Middle, and Birth Date. The 'Claim Information' section includes Date Type, Date of Current, Accident Related, Patient Account Number, Expected Delivery Date, From Date, To Date, CLIA Number, and Other Insurance. The 'Total Charged Amount' is displayed as \$0.00. At the bottom right, there are 'Continue' and 'Cancel' buttons.

Step 1 - date fields in the bottom portion of the claim is required.

**Submit Professional Claim: Step 2** ?

\* Indicates a required field.

Claim Type Professional  
 EVV SERVICES ONLY timely filing No

---

**Provider Information**

Billing Provider ID	ID Type NPI	Name	
Zip Code	Contract Code _	Taxonomy	SC Provider Number

---

**Patient and Claim Information**

Member ID	Gender Female
Member	Total Charged Amount \$0.00
Birth Date	
CLIA Number _	

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

---

**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 <input type="text" value="ICD-10-CM"/>	*Diagnosis Code <input type="text"/>
---	---	--------------------------------------

---

Step 3 – Provider will key the Crossover Information on each line of service as it appears on the Medicare EOB.

Service Details							
Svc #	From Date	To Date	Place of Service	Procedure Code	Charge Amount	Units	Action
1							
1	*From Date	To Date	*Place of Service			EMG	
	*Procedure Code	Modifiers				*Diagnosis Pointers	
	Charge Amount	*Units	Unit Type	Unit	EPSDT		
	CLIA Number						
	Rendering Provider ID	ID Type	Zip Code	Contract Code			
	Taxonomy						
	Ordering Provider ID	ID Type	Zip Code				
<b>NDC for Item 1</b>							
<b>Medicare Crossover Details for Item 1</b>							
Medicare Crossover Details must be entered in this step if the From Date is on or after 06/01/2016.							
	Allowed Medicare Amount	\$0.00		Co-insurance Amount	\$0.00		
	Deductible Amount	\$0.00		Psychiatric Services Amount	\$0.00		
	Medicare Payment Amount	\$0.00		Medicare Payment Date			
<a href="#">Add</a>							

Enter the Medicare allowed amount in the **Allowed Medicare Amount** field located under the Medicare Crossover Details heading. This is now on Step 3 and must be filled out for each line of service.

**DDE Professional Claim Submission Instructions**

<b>Provider Information</b>		
<b>Form Locator</b>	<b>DDE Professional Claim Submission Instructions</b>	<b>Requirement</b>
Billing Provider ID	Your Provider ID number and provider information should auto-populate. Verify it is correct; if it is not, you may need to log out and access the correct provider.	Required
Referring Provider ID	Enter the 10-character referral number from the referral form, if the member is enrolled in the SoonerCare Choice program. See 1500 form locator 17A.	Required, if applicable
Ordering Provider ID	Enter the ordering provider ID number.	Required, if applicable
ID Type	Select the applicable ID type from the drop-down list.	
Ordering ZIP Code	Enter the ZIP Code.	
<b>Patient Information</b>		
<b>Form Locator</b>	<b>DDE Professional Claim Submission Instructions</b>	<b>Requirement</b>
Member ID	Enter the member's SoonerCare ID number. The patient's last and first name, and birth date will auto-populate if the member's ID number is in the system.	Required
<b>Claim Information</b>		
<b>Form Locator</b>	<b>DDE Professional Claim Submission Instructions</b>	<b>Requirement</b>
Date Type	Select the applicable date type from the drop-down list.	Required, if applicable
Date of Current	Enter the date of current status from the date type selected.	Required, if applicable
Accident Related	Select the applicable option to describe the accident.	
Admission Date	Enter the date of admission.	
Patient Account #	The patient account number will be captured and appear on the remittance advice if entered into this field.	Not Required
Expected Delivery Date	Enter the expected delivery date if the claim is related to pregnancy.	

From Date	Key in the date from the Medicare EOB	Required
To Date	Key in the date from the Medicare EOB	Required
CLIA Number	Required when billing for laboratory services.	Required, if applicable
Other Insurance	Select the applicable option for other insurance.	
Total Charged Amount	This field will auto-populate.	
<b>Medicare Crossover Details (when Crossover Professional is selected)</b>		
<b>Form Locator</b>	<b>DDE Professional Claim Submission Instructions</b>	<b>Requirement</b>
Allowed Medicare Amount	Enter the allowed Medicare amount.	
Coinsurance Amount	Enter the coinsurance amount.	
Deductible Amount	Enter the deductible amount.	
Psychiatric Services Amount	Enter the psychiatric services amount.	
Medicare Payment Amount	Enter the Medicare payment amount.	
Medicare Payment Date	Enter the Medicare payment date.	Required
<b>Diagnosis Codes</b>		
<b>Form Locator</b>	<b>DDE Professional Claim Submission Instructions</b>	<b>Requirement</b>
ICD Version	Use the drop-down list to select a diagnosis type.	Required
Diagnosis Code	Enter at least three (3) characters to begin searching for a diagnosis code.	Required
<b>Other Insurance Details (when Other Insurance-Include is selected)</b>		
<b>Form Locator</b>	<b>DDE Professional Claim Submission Instructions</b>	<b>Requirement</b>
TPL Amount	Enter the TPL amount.	
<b>Service Information</b>		
<b>Form Locator</b>	<b>DDE Professional Claim Submission Instructions</b>	<b>Requirement</b>
From Date	Enter the beginning date of service.	Required
To Date	Enter the end date of service.	
Place of Service	Select the place of service code using the drop-down list.	Required
EMG	If the claim is related to an emergency, select from the drop-down list.	Required, if applicable
Procedure Code	Enter the CPT or HCPCS procedure code in the Procedure field. <i>See 1500 form locator 24D for additional information.</i>	Required
Modifiers	Enter modifier code(s) in the Modifier field(s).	Required, if applicable
Diagnosis Pointers	Use the drop-down lists to select the numeric codes (1, 2, 3 or 4) in order of importance, which correspond to the ICD diagnosis code listed in form locator 21. A minimum of one (1) and maximum of four (4) diagnosis code pointers can be entered on each line.	Required

Charge Amount	Enter the total dollar (\$) amount of charges for that specific detail in the Charges field. If units are greater than one (1), multiply the number of units by the amount billed per unit. This action will auto-populate the Total Charges field.	Required
Units	Enter number of units billed.	Required
Unit Type	Field is auto populated by default.	
EPSDT	If claim is related to an EPSDT service, select the appropriate referral type from the drop-down list. If nothing is entered, field will default to No.	Required, if applicable
ID Type	Select from the drop-down list to determine ID type.	
ZIP Code	Enter rendering provider's ZIP code +4, if applicable.	
Contract Code	Select from drop-down list, if applicable.	
Taxonomy	Enter rendering provider's taxonomy, if applicable.	
SC Provider Number	Enter the Oklahoma SoonerCare provider number.	
<b>NDC for Item #</b>		
<b>Form Locator</b>	<b>DDE Professional Claim Submission Instructions</b>	<b>Requirement</b>
Code Type	This field is auto populated by default.	
NDC/UPN	Enter NDC or UPN code in the Procedure field.	
Quantity	Enter quantity.	
Unit of Measure	Select type of measurement from drop-down list.	
<b>Attachments</b>		
<b>Form Locator</b>	<b>DDE Professional Claim Submission Instructions</b>	<b>Requirement</b>
Transmission Method	Select from the drop-down list how the attachment(s) will be sent.	Required, if applicable
Upload File	Click Browse to locate file to be uploaded; <i>available when FT-File Transfer is selected.</i>	Required, if applicable
Attachment Type	Select file type of the attachment from the drop-down list.	Required, if applicable
Description	Enter description of the attachment.	
HCA-13	If a hard-copy attachment is to be added, a system-generated HCA-13 Paper Attachment form will be available to print once the claim has been submitted by selecting BM-By Mail or FX-By Fax from the Transmission Method drop-down list. (See section F in this chapter for instructions on sending form HCA-13 by fax or mail.)  Unique attachment control numbers (Control #) are generated once an attachment is added.	Required, if applicable
Submit	When finished, click Submit.	Required

## Section C: UB-04, Institutional, 837I

### The UB-04 Universal Billing Claim Form

The **UB-04**, Universal Billing Claim Form, is used to bill for facility services covered under the OHCA's Medical Program, unless otherwise specified in this chapter. The provider must purchase these forms. This section explains how to complete the paper UB-04 claim form. The form locator chart indicates which fields are optional; required; required, if applicable or not captured.

Providers should use the UB-04 billing manual instructions unless otherwise specified. The UB-04 manual can be obtained by contacting the National Uniform Billing Committee at [www.nubc.org](http://www.nubc.org).





**UB-04 Claim Field Descriptions/Instructions**

<b>Field</b>	<b>Requirement</b>	<b>UB-04 Field Description/Instructions</b>
1	Required	Please Remit Payment To/Billing Provider Name and Address: Enter the name, full address and telephone number of the billing provider.
2	<i>Not Captured</i>	<i>Unlabeled field</i>
3A	Required	PAT CNTL # (Patient Control Number): Enter the internal patient account number (24 characters max). This number will also appear on the remittance advice.
3B	Required	MED REC # (Medical/Health Record Number): HIPAA-required number (24 characters max). This number is assigned by the provider to identify the medical health records of the patient.
4	Required	Type of Bill: Enter the 4-digit code indicating the specific type of bill.  The 4-digit code requires one digit from each of the following categories: 1 <sup>st</sup> digit – leading zero (0) – <i>optional</i> 2 <sup>nd</sup> digit – type of facility 3 <sup>rd</sup> digit – bill classification 4 <sup>th</sup> digit – frequency  Please refer to the National UB-04 Uniform Billing Manual for type of bill codes.
5	<i>Not Captured</i>	<i>FED TAX NO (Federal Tax Number)</i>
6	Required	Statement Covers Period, From/Through: Enter the beginning (from) and ending (through) service dates included in this bill. For services rendered on a single day, use the same From and Through dates. Total days must equal days indicated in fields 39-41 and total units located in field 46, with the exception of discharge day. (MMDDYY)
7	<i>Not Captured</i>	<i>Unlabeled field</i>
8A	<i>Not Captured</i>	<i>Patient Name (a)</i>
8B	Required	Patient Name: Enter member's name. ( <i>last name, first name, middle initial</i> )
9A-E	<i>Not Captured</i>	<i>Patient Address</i>
10	<i>Not Captured</i>	<i>Birthdate (Patient)</i>
11	<i>Not Captured</i>	<i>Sex (Patient)</i>
12	Required	Admission Date: Enter the date the patient was admitted for inpatient care. (MMDDYY)
13	Required	Admission Hour: Enter the 2-digit code for the hour during which the patient was admitted for inpatient care, using the 24-hour format (e.g., 7:00 pm = 19).
14	Required	Admission Type: Enter the code indicating the priority of this admission. Type must be numeric; refer to NUBC's UB-04 manual for additional detail.

15	Required	Source of Admission: Enter the code indicating how the patient was admitted; refer to NUBC's UB-04 manual for additional detail.
16	<i>Not Captured</i>	<i>DHR (Discharge Hour)</i>
17	Required	STAT (Patient Discharge Status): Enter the code indicating the member status at the end of service for the period covered on this bill. This is a 2-digit 01-99 code. Codes for patient status are detailed in the National UB-04 Uniform Billing Manual and indicate if the member is still a patient, deceased, discharged and other statuses; refer to NUBC's UB-04 manual for additional detail.
18-28	Not Required	Condition Codes: Enter the appropriate code(s); refer to NUBC's UB-04 manual for additional detail.
29	<i>Not Captured</i>	<i>ACDT State</i>
30	Required, if applicable	Referring Provider ID Number: Enter the 10-character referral number from the referral form if the member is enrolled in the SoonerCare Choice or Insure Oklahoma programs (e.g., 123456789A). Referral form submission with the claim is not required.
31-34 (A-B)	Required, if applicable	Occurrence Code and Date: Enter the applicable code and associated date to identify significant events related to this bill that may affect processing. Dates are entered in a <i>MMDDYY</i> format. A maximum of eight (8) codes and associated dates can be entered; refer to NUBC's UB-04 manual for additional detail.
35-36 (A-B)	Required, if applicable	Occurrence Span Code, From/Through: Enter the code and associated dates for significant events related to this bill. Each Occurrence Span Code must be accompanied by the span from and through date.
37	<i>Not Captured</i>	<i>Unlabeled field</i>
38	<i>Not Captured</i>	<i>Unlabeled field</i>
39-41 (A-D)	Required, if applicable	Value Codes: Enter code(s) and amount(s), as applicable. Value Code 80 specifies the number of covered days. <b>Days need to be listed in whole numbers; no decimals.</b>
42, lines 1-22	Required	Revenue Codes: Enter the applicable revenue code(s) identifying the specific accommodation(s), ancillary service(s), or billing calculation(s). The use of revenue code 001 is not required to indicate total billed; if programmed, please put 001 in field 42, line 23.
42, line 23	Not Required	<i>Unlabeled</i> ; Enter the revenue code 001.
43, lines 1-22	Required, if applicable	Description: Using no spaces or dashes, enter NDC qualifier "N4"; the 11-digit NDC number; the unit of measurement: "UN" for unit, "F2" for international unit, "ML" for milliliter or "GR" for gram; and the metric decimal quantity. For example: N49999999999UN999.99. Corresponding HCPCS code(s) should be placed on the same line as NDC.
43, line 23	<i>Not Used</i>	<i>Page ____ of ____; The OHCA does not accept multiple-page claims.</i>

44, lines 1-22	Required, if applicable*	HCPCS/Rates: Enter the Health Care Procedure Coding System (HCPCS) code(s) applicable to the service provided. Only one service code per line is permitted. <i>*Required for DME, outpatient, X-ray, lab, rural health, EKG, EEG and pharmacy</i>
45, lines 1-22	Required, if applicable*	Service Date: The date the indicated outpatient service was provided on a series bill. <i>*Required for all services except inpatient and long-term care</i>
45, line 23	Required	Creation Date: Enter the date billed.
46, lines 1-22	Required	Units of Service: Enter the number of units corresponding to the revenue code and/or HCPCS code billed.
47, lines 1-22	Required	Total Charges: Enter the total charges pertaining to the related revenue code detail line. On the detail line that has the revenue code 001, add all of the charge details together and enter the sum of all charges billed in form locator 47.
47, line 23	Required	Total: Enter the total charges from lines 1-22 combined.
48	<i>Not Captured</i>	<i>Non-Covered Charges</i>
48, line 23	<i>Not Captured</i>	<i>Unlabeled; Total non-covered charges from lines 1-22.</i>
49	<i>Not Captured</i>	<i>Unlabeled field</i>
50-55 (A-C)	Required	Enter the appropriate order of insurance coverage: A, Primary; B, Secondary; and C, Tertiary; for example, A, Medicare; B, Medicare Supplement; and C, SoonerCare. If the member only has SoonerCare coverage, it should be listed in A.
50A-C	Required	Payer Name: As applicable, enter the name of the recipient's primary, secondary and tertiary insurance on lines A, B and C. On claims with no TPL, SoonerCare information is entered on line A.
51A-C	<i>Not Captured</i>	<i>Health Plan ID</i>
52A-C	<i>Not Captured</i>	<i>REL INFO (Release of Information Certification Indicator)</i>
53A-C	<i>Not Captured</i>	<i>ASG BEN (Assignment of Benefits Certification Indicator)</i>
54A-C	Required, if applicable*	Prior Payments: Enter the amount paid by the insurance carrier identified in form locators 50 A-B, as applicable. <i>*Required, if TPL applies</i>  When a TPL carrier makes payment of a claim, the Explanation of Benefits (EOB) is not required. The EOB is always required if the TPL carrier denies the claim.
55A-C	Required, if applicable*	Estimated Amount Due: The amount estimated by the provider to be due from the indicated payer (estimated responsibility less prior payments). <i>*Used for HMO Copays only</i>
56	Not Required	NPI (National Provider Identifier): Enter the NPI of the billing provider.

57A-C	Required	OTHER PRV ID (Other Billing Provider Identifier): <b>Enter the 10-character SoonerCare provider ID for the billing provider in the corresponding line 50A-C that indicates SoonerCare/Medicaid.</b>
58A-C	<i>Not Captured</i>	<i>Insured's Name: Enter insured's last name, first name and middle initial.</i>
59A-C	<i>Not Captured</i>	<i>P REL (Patient's Relationship to Insured)</i>
60A-C	Required	Insured's Unique ID: Enter the member's identification number for the respective payers entered in field 50A-C. The member's 9-digit SoonerCare identification number is required and should be listed in the same order as field 50A-C. Other carriers are optional.
61A-C	<i>Not Captured</i>	<i>Group Name</i>
62A-C	<i>Not Captured</i>	<i>Insurance Group No.</i>
63A-C	<i>Not Captured</i>	<i>Treatment Authorization Codes</i>
64A-C	<i>Not Captured</i>	<i>Document Control Number</i>
65A-C	<i>Not Captured</i>	<i>Employer Name</i>
66	<i>Not Captured</i>	<i>DX</i>
67	Required	PRIN DIAG CD (Principal Diagnosis Code): Enter the ICD diagnosis code describing the principal diagnosis.
67A-Q	Required, if applicable	Other Diag. Codes: Enter the ICD diagnosis codes corresponding to additional conditions existing at the time of admission or that developed subsequently and have an effect on the treatment received or the length of stay. When submitting an inpatient claim, enter the Point of Admission (POA) codes for each diagnosis entered.
68	<i>Not Captured</i>	<i>Unlabeled field</i>
69	Required	ADM DIAG CD (Admitting Diagnosis Code): Enter the ICD diagnosis code provided at the time of admission as stated by the physician.
70	<i>Not Captured</i>	<i>Patient Reason DX</i>
71	<i>Not Captured</i>	<i>PPS Code</i>
72A	<i>Not Required</i>	<i>ECl</i>
72B-C	<i>Not Captured</i>	<i>ECl</i>
73	<i>Not Captured</i>	<i>Unlabeled field</i>
74	Required, if applicable*	Principal Procedure Code/Date: Enter the ICD procedure code that identifies the principal procedure performed during the period covered by this bill and the date on which the principal procedure described on the bill was performed. Do not use HCPCS or CPT codes. *Required for surgery
74A-E	Not Required	Other Procedure Code/Date: Enter the ICD procedure codes identifying the significant procedures, other than the principal procedure, and the dates identified by codes on which the procedures were performed. Report the most important for the encounter and specifically any therapeutic procedures closely related to the principal diagnosis. Do not use HCPCS or CPT codes.

75	<i>Not Captured</i>	<i>Unlabeled field</i>
76	Required, if applicable	ATTENDING (Attending Provider ID/Name): NPI
77	Required, if applicable	OPERATING (Operating Provider ID/Name): NPI
78-79	<i>Not Captured</i>	<i>Other</i>
80-81	<i>Not Captured</i>	<i>Remarks/CC</i>

## Direct Data Entry (DDE) Claim Submission – Institutional

Use the Institutional claim form example and the directions below as a guide when submitting a claim through DDE on the SoonerCare Provider Portal. Required fields are indicated. To access this form, choose the Submit Claim Inst claim option (see screen sample below) from the Claims menu. Fields with an asterisk (\*) are always required. Other fields may be required under certain circumstances.

Detailed instructions on specific OHCA requirements on acceptable codes are in the corresponding UB-04 form (see screen samples below) locator information. Choose the **Institutional** option to obtain the fields. Provider will choose appropriate claim type: Inpatient or Outpatient.

**Oklahoma HealthCare Authority**

My Home Eligibility **Claims** Prior Authorizations Referrals Files Exchange Financial Letters Reports Resources

Search Claims | Submit Claim Dental | **Submit Claim Inst** | Submit Claim Prof | Submit Claim Pharm | Search Payment History

Claims > Submit Claim Inst Contact Us | Logout  
Monday 03/23/2020 11:59 AM CST

**Submit Institutional Claim: Step 1**

\* Indicates a required field.

Claim Type **Inpatient/Outpatient**

**Provider Information**

If Surgical Procedure Code(s) are to be submitted with the claim, an Operating Provider ID is required.

Billing Provider ID	Contract Code	ID Type	NPI	Name
Zip Code		Taxonomy		SC Provider Number
Institutional Provider ID		ID Type		
Attending Provider ID		ID Type		
Operating Provider ID		ID Type		
Referring Provider ID		ID Type		

**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.

\*Covered Dates  -

\*Admission Date/Hour  -  (hh:mm)

\*Admission Type

\*Admitting ICD Version  ICD-10-CM

Patient Status

Patient Account Number

Covered Days

Discharge Hour  (hh:mm)

\*Admission Source

\*Admitting Diagnosis

\*Type of Bill

Other Insurance  None

Total Charged Amount \$0.00

**Medicare Crossover Details**

Institutional Medicare Crossover Instructions

Deductible Amount  \$0.00

Blood Deductible Amount  \$0.00

Co-insurance Amount  \$0.00

\*Medicare Payment Date

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

**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 <input type="text" value="ICD-10-CM"/>	*Diagnosis Code <input type="text"/>	

---

**Emergency Diagnosis Code** -

Only one emergency diagnosis code is allowed per claim.

ICD Version       Diagnosis Code

---

**Condition Codes** -

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

#	Condition Code	Action
<u>1</u>		
1	*Condition Code <input type="text"/>	

---

**Occurrence Codes** -

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

#	Occurrence Code	From Date	To Date	Action
<u>1</u>		-	-	
1	*Occurrence Code <input type="text"/>	*From Date <input type="text"/>	To Date <input type="text"/>	

---

**Value Codes** -

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

#	Value Code	Amount	Action
<u>1</u>			
1	*Value Code <input type="text"/>	*Amount <input type="text"/>	

---

**Surgical Procedures** -

Operating Provider is required to be entered back on Step 1 to allow for entry of surgical procedure codes within this panel.



**Service Details** Expand All Collapse All

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

Svc #	Revenue Code	HCPCS/Proc Code	From Date	To Date	Units	Charge Amount	Action
1							

1 **\*Revenue Code**  **HCPCS/Proc Code**

**Modifiers**

**\*From Date**   **\*To Date**   **\*Units**  **\*Unit Type**

**Charge Amount**

**NDC for Item 1** +

**Medicare Crossover Details for Item 1** -

Medicare Crossover Details must be entered in this step if the Covered From Date is on or after 06/01/2016.

<b>Deductible Amount</b> <input type="text" value="\$0.00"/>	<b>Co-insurance Amount</b> <input type="text" value="\$0.00"/>
<b>Blood Deductible Amount</b> <input type="text" value="\$0.00"/>	<b>Medicare Payment Date</b> <input type="text"/> <input type="text"/>
<b>Medicare Payment Amount</b> <input type="text" value="\$0.00"/>	

**Attachments** -

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

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

[Go to Top](#)

Library Reference: OKPBPM  
 Revision Date: August 2020  
 Version 6.2

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**DDE Institutional Claim Submission Instructions**

<b>Provider Information</b>		
<b>Form Locator</b>	<b>DDE Institutional Claim Submission Instructions</b>	<b>Requirement</b>
Billing Provider ID	Your Provider ID Number and provider information should auto-populate. Verify this information is correct; if it is not, you may need to log out and access the correct provider.	Required
Institutional Provider ID	Enter the institutional provider ID number/NPI.	
Attending Provider ID	Enter the provider ID/NPI of the attending physician. <b>ID Type:</b> Select NPI from the ID Type drop-down list	
Operating Provider ID	Enter the Prescriber ID number/NPI of the operating provider. <i>*Required for submitting surgical procedures</i> <b>ID Type:</b> Select NPI from the ID Type drop-down list	Required, if applicable*
Referring Provider ID	Enter the NPI of the referring provider, if the member is enrolled in SoonerCare Choice. <i>See UB-04 form locator 7 for additional information.</i> <b>ID Type:</b> Select NPI from the ID Type drop-down list	Required, if applicable
<b>Patient Information</b>		
<b>Form Locator</b>	<b>DDE Institutional Claim Submission Instructions</b>	<b>Requirement</b>
Member ID	Enter the member's Oklahoma SoonerCare ID number in the client ID field. <i>The patient's last and first name, and birth date will auto-populate if the member's ID number is in the system.</i>	Required
<b>Claim Information</b>		
<b>Form Locator</b>	<b>DDE Institutional Claim Submission Instructions</b>	<b>Requirement</b>
Covered Dates	Enter the dates of coverage.	Required
Covered Days	Enter the number of eligible days. <i>UB-04 form locator 7 for additional information.</i> <i>*Required for inpatient and nursing home facilities</i>	Required, if applicable*
Admission Date/Hour	Enter the date and time of admission, using 24-hour format (e.g., 7:00 PM = 19:00).	Required, if applicable
Discharge Hour	Enter the time of discharge, using 24-hour format (e.g., 7:00 PM = 19:00).	Required, if applicable
Admission Type	Enter at least one (1) character to begin searching for an admission type.	Required, if applicable
Admission Source	Enter at least one (1) character to begin searching for an admission source.	Required, if applicable
Admitting ICD Version	Use the drop-down list to select a diagnosis type.	Required, if applicable
Admitting Diagnosis	Enter a diagnosis code. <i>See UB-04 form locators 67-75 for additional information.</i> <i>*Admission and Primary diagnosis are required for inpatient and nursing home services</i>	Required, if applicable*

Patient Status	Enter at least two (2) characters to begin searching for a patient status.	Required
Type of Bill	Enter the 3-digit bill code number. All positions must be fully coded; consult the National UB-04 Uniform Billing Manual for bill code types. 1 <sup>st</sup> digit – identifies facility type 2 <sup>nd</sup> digit – identifies bill classification 3 <sup>rd</sup> digit – identifies frequency	Required
Patient Account Number	Patient account number will be captured if entered in this field.	Not Required
Other Insurance	Select the applicable option for other insurance.	
Total Charged Amount	This field will automatically populate.	<i>Auto</i>
<b>Medicare Crossover Details (when applicable) <u>This is done at this level on Inpatient</u></b>		
<b>Form Locator</b>	<b>DDE Institutional Claim Submission Instructions</b>	<b>Requirement</b>
Deductible Amount	Enter the deductible amount.	
Coinsurance Amount	Enter the coinsurance amount.	
Blood Deductible Amount	Enter the blood deductible amount.	
Medicare Payment Date	Enter the Medicare payment date.	Required
<b>Diagnosis Codes</b>		
<b>Form Locator</b>	<b>DDE Institutional Claim Submission Instructions</b>	<b>Requirement</b>
ICD Version	Use the drop-down list to select a diagnosis type.	Required
Diagnosis Code	Enter at least three (3) characters to begin searching for a diagnosis code.	Required
Present on Admission	Use the drop-down list to select the applicable response. <i>*Inpatient only</i>	
<b>Emergency Diagnosis Codes</b>		
<b>Form Locator</b>	<b>DDE Institutional Claim Submission Instructions</b>	<b>Requirement</b>
ICD Version	Use the drop-down list to select a diagnosis type.	
Diagnosis Code	Enter at least three (3) characters to begin searching for a diagnosis code.	
<b>Other Insurance Details (when Other Insurance is selected)</b>		
<b>Form Locator</b>	<b>DDE Institutional Claim Submission Instructions</b>	<b>Requirement</b>
Payer Code	Use the drop-down list to select the other insurance type.	
Prior Amount	Enter the prior amount.	
Estimated Amount Due	Enter the estimated amount due.	
<b>Condition Codes</b>		
<b>Form Locator</b>	<b>DDE Institutional Claim Submission Instructions</b>	<b>Requirement</b>
Condition Code	Enter at least two (2) characters to begin searching for a condition code.	Not Required

<b>Occurrence Codes</b>		
<b>Form Locator</b>	<b>DDE Institutional Claim Submission Instructions</b>	<b>Requirement</b>
Occurrence	Enter at least two (2) characters to begin searching for an occurrence code; see <i>UB-04 form locators 32-36 for specific code information.</i>	Required, if applicable
From Date	Enter a beginning date.	Required, if applicable
To Date	Enter an end date.	Required, if applicable
<b>Value Codes</b>		
<b>Form Locator</b>	<b>DDE Institutional Claim Submission Instructions</b>	<b>Requirement</b>
Value Code	Enter at least two (2) characters to begin searching for a value code.	Required, if applicable
Amount	Enter a dollar amount including cents, e.g., Correct—\$45.00, Incorrect—\$45	Required, if applicable
<b>Surgical Procedures (when Operating Provider NPI is entered in Provider Information)</b>		
<b>Form Locator</b>	<b>DDE Institutional Claim Submission Instructions</b>	<b>Requirement</b>
Surgical Procedure Type	Use the drop-down list to select a procedure type.	Required, if applicable
Surgical Procedure Code	Enter at least three (3) characters to begin searching for a surgical procedure code.	Required, if applicable
Date	Enter a date.	Required, if applicable
<b>Service Details</b>		
<b>Form Locator</b>	<b>DDE Institutional Claim Submission Instructions</b>	<b>Requirement</b>
Revenue Code	Enter the 3-digit revenue code; <i>do not use the 001 revenue code for DDE claims.</i>	Required
HCPCS/ Proc Code	Enter the 5-digit HCPCS or CPT procedure code; see <i>UB-04 form locator 44 for additional information.</i>	Required, if applicable
Modifiers	Enter modifiers.	Required, if applicable
From Date	Enter the date on which the service performed started.	Required
To Date	Enter the date on which the service performed ended.	
Units	Enter the number of units billed at the detail level; see <i>UB-04 form locator 46 for additional information.</i>	Required
Unit Type	Select the unit of measurement type from the drop-down list.	Required
DMH Contract Source	Enter a contract source.	Required, if applicable
Charge Amount	Enter the amount billed (units billed multiplied by the rate).	Required
<b>NDC for Item # (Outpatient and Home Health)</b>		
<b>Form Locator</b>	<b>DDE Institutional Claim Submission Instructions</b>	<b>Requirement</b>
Code Type	Select the applicable code type from the drop-down list.	

NDC/UPN	Enter the National Drug Code (NDC) or UPN code in the Procedure field.	
Quantity	Enter the quantity	
Unit of Measure	Select the unit of measurement type from the drop-down list.	
If additional items are to be billed on this submission, click Add next to the line item window and repeat process. Click Remove to remove a line entry.		
<b>Attachments</b>		
<b>Form Locator</b>	<b>DDE Institutional Claim Submission Instructions</b>	<b>Requirement</b>
Transmission Method	Select from the drop-down list how attachments will be sent.	Required, if applicable
Upload File	Click Browse to locate file being uploaded; available when selecting FT-File Transfer.	Required, if applicable
Attachment Type	Select the type of file from the drop-down list.	Required, if applicable
HCA-13	<p>If a hard-copy attachment is to be added, a system-generated HCA-13 Paper Attachment form will be available to print once the claim has been submitted by selecting BM-By Mail or FX-By Fax from the Transmission Method drop-down list (<i>see section F in this chapter for instructions on sending an HCA-13 form by fax or mail</i>).</p> <p>Unique ACNs (control numbers) are generated once an attachment has been added.</p>	Required, if applicable
Description	Enter a description of the attachment.	Required, if applicable
Submit	When finished, click Submit.	Required

## Direct Data Entry (DDE) Claim Submission Inpatient/Outpatient Crossovers

Select the **Inpatient** or **Outpatient Crossover** claim type from the **Claim Type** drop-down list above the Service Information heading. The **Crossover Details** section should now be visible (see screen sample below). Part A Claims process at the header level, Part B process at the claim line level.

### Part A – Crossover Details at the Header Level

**Oklahoma HealthCare Authority**

My Home Eligibility **Claims** Prior Authorizations Referrals Files Exchange Financial Letters Reports Resources

Search Claims | Submit Claim Dental | Submit Claim Inst | Submit Claim Prof | Submit Claim Pharm | Search Payment History

Claims > Submit Claim Inst Contact Us | Logout  
Monday 03/23/2020 11:59 AM CST

**Submit Institutional Claim: Step 1**

\* Indicates a required field.

Claim Type: Crossover Inpatient

**Provider Information**

If Surgical Procedure Code(s) are to be submitted with the claim, an Operating Provider ID is required.

Billing Provider ID	Contract Code G	ID Type	NPI	Name
Zip Code		Taxonomy		SC Provider Number
Institutional Provider ID		ID Type		
Attending Provider ID		ID Type		
Operating Provider ID		ID Type		
Referring Provider ID		ID Type		

**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.

\* Covered Dates (mm/dd/yyyy) - (mm/dd/yyyy)

\* Admission Date/Hour (mm/dd/yyyy) (hh:mm)

\* Admission Type

\* Admitting ICD Version (ICD-10-CM)

Patient Status

Patient Account Number

Covered Days

Discharge Hour (hh:mm)

\* Admission Source

\* Admitting Diagnosis

\* Type of Bill

Other Insurance (None)

Total Charged Amount \$0.00

**Medicare Crossover Details**

Institutional Medicare Crossover Instructions

Deductible Amount \$0.00

Blood Deductible Amount \$0.00

Co-insurance Amount \$0.00

\* Medicare Payment Date (mm/dd/yyyy)

Continue Cancel

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**Part B – Crossover Details on each line of service**



Oklahoma HealthCare Authority

[My Home](#) [Eligibility](#) [Claims](#) [Prior Authorizations](#) [Referrals](#) [Files Exchange](#) [Financial](#) [Letters](#) [Reports](#) [Resources](#)

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[Claims](#) > [Submit Claim Inst](#)

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Monday 03/23/2020 11:59 AM CST

**Submit Institutional Claim: Step 1** ?

\* Indicates a required field.

Claim Type Crossover Outpatient

**Provider Information**

If Surgical Procedure Code(s) are to be submitted with the claim, an Operating Provider ID is required.

Billing Provider ID	Contract Code	ID Type	NPI	Name	SC Provider Number
Zip Code Institutional Provider ID Attending Provider ID Operating Provider ID Referring Provider ID			193400000X		
		ID Type	NPI		
		ID Type			
		ID Type			
		ID Type			

**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.

*Covered Dates <input type="text"/> - <input type="text"/>	Covered Days <input type="text"/>
Admission Date/Hour <input type="text"/> (hh:mm)	Discharge Hour <input type="text"/> (hh:mm)
Admission Type <input type="text"/>	Admission Source <input type="text"/>
Admitting ICD Version <span style="border: 1px solid gray; padding: 2px;">ICD-10-CM</span>	Admitting Diagnosis <input type="text"/>
Patient Status <input type="text"/>	*Type of Bill <input type="text"/>
Patient Account Number <input type="text"/>	Other Insurance <span style="border: 1px solid gray; padding: 2px;">None</span>
Total Charged Amount \$0.00	

Continue
Cancel

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**Service Details** Expand All Collapse All

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

Svc #	Revenue Code	HCPCS/Proc Code	From Date	To Date	Units	Charge Amount	Action
1							

1 \*Revenue Code  HCPCS/Proc Code

Modifiers

\*From Date   \*To Date   \*Units  \*Unit Type

Charge Amount

**NDC for Item 1** +

**Medicare Crossover Details for Item 1** -

Medicare Crossover Details must be entered in this step if the Covered From Date is on or after 06/01/2016.

Deductible Amount <input type="text" value="\$0.00"/>	Co-insurance Amount <input type="text" value="\$0.00"/>
Blood Deductible Amount <input type="text" value="\$0.00"/>	Medicare Payment Date <input type="text"/> <input type="text"/>
Medicare Payment Amount <input type="text" value="\$0.00"/>	

**Attachments** -

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

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

[Go to Top](#)

Under the **Crossover Details** heading, enter the information as it appears on the Medicare EOB.



## Section D: ADA 2012, Dental, 837D

### The ADA 2012 Paper Claim Form

The **ADA 2012** paper claim form is the required claim form used by dental providers for dental service billing. The provider is responsible for purchasing the ADA 2012 paper claim form. This section explains how to complete a paper ADA 2012 claim form. Please mail paper claims to the appropriate mailbox address below: The form locator chart indicates which fields are *optional*, *required* or *required, if applicable*.

# ADA Paper Dental Claim Form

**ADA American Dental Association® Dental Claim Form**

**HEADER INFORMATION**

1. Type of Transaction (Mark all applicable boxes)  
 Statement of Actual Services     Request for Predetermination/Preauthorization  
 EPSDT / Title XIX

2. Predetermination/Preauthorization Number

**INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION**

3. Company/Plan Name, Address, City, State, Zip Code

**OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)**

4. Dental?  Medical?  (If both, complete 5-11 for dental only.)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY)    7. Gender  M  F    8. Policyholder/Subscriber ID (SSN or ID#)

9. Plan/Group Number    10. Patient's Relationship to Person named in #5  
 Self     Spouse     Dependent     Other

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

**POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)**

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

13. Date of Birth (MM/DD/CCYY)    14. Gender  M  F    15. Policyholder/Subscriber ID (SSN or ID#)

16. Plan/Group Number    17. Employer Name

**PATIENT INFORMATION**

18. Relationship to Policyholder/Subscriber in #12 (Above)  
 Self     Spouse     Dependent Child     Other    19. Reserved For Future Use

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

21. Date of Birth (MM/DD/CCYY)    22. Gender  M  F    23. Patient ID/Account # (Assigned by Dentist)

**RECORD OF SERVICES PROVIDED**

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag Pointer	29b. Cdx	30. Description	31. Fee
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										

33. Missing Teeth Information (Place an "X" on each missing tooth.)

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

34. Diagnosis Code List Qualifier  (ICD-9 = B, ICD-10 = AB)

34a. Diagnosis Code(s)    A \_\_\_\_\_    C \_\_\_\_\_

(Primary diagnosis in "A")    B \_\_\_\_\_    D \_\_\_\_\_

31a. Other Fee(s) \_\_\_\_\_

32. Total Fee    \$0.00

35. Remarks

**AUTHORIZATIONS**

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X Patient/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X Subscriber Signature \_\_\_\_\_ Date \_\_\_\_\_

**ANCILLARY CLAIM/TREATMENT INFORMATION**

38. Place of Treatment  (e.g. 11=office; 22=GP Hospital)    39. Enclosures (Y or N)

(Use "Place of Service Codes for Professional Claims")

40. Is Treatment for Orthodontics?  No (Skip 41-42)     Yes (Complete 41-42)

41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment  No     Yes (Complete 44)

43. Replacement of Prosthesis  No     Yes (Complete 44)

44. Date of Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from  Occupational illness/injury     Auto accident     Other accident

46. Date of Accident (MM/DD/CCYY)    47. Auto Accident State

**BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)**

48. Name, Address, City, State, Zip Code

49. NPI    50. License Number    51. SSN or TIN

52. Phone Number    52a. Additional Provider ID    57. Phone Number    58. Additional Provider ID

**TREATING DENTIST AND TREATMENT LOCATION INFORMATION**

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X Signed (Treating Dentist) \_\_\_\_\_ Date \_\_\_\_\_

54. NPI    55. License Number

56. Address, City, State, Zip Code    56a. Provider Specialty Code

©2012 American Dental Association  
 J430D (Same as ADA Dental Claim Form - J430, J431, J432, J433, J434)

To reorder call 800.947.4746  
 or go online at [adacatalog.org](http://adacatalog.org)

**ADA 2012 Claims Field Descriptions/Instructions**

<b>Field</b>	<b>Requirement</b>	<b>ADA 2012 Field Description/Instructions</b>
1	Required	Type of Transaction: Mark the appropriate box; use the EPSDT/TXIX box for Oklahoma SoonerCare billing.
2	Not Required	Predetermination/Preauthorization Number
3	Not Required	Insurance Company/Dental Benefit Plan Information: Company/Plan Name, Address, City, State, Zip Code  <b>Enter the following information:</b> SoonerCare P.O. Box 18110, Oklahoma City, OK, 73154
4	Required, if applicable	Other Coverage (Dental/Medical): Mark the appropriate box.
5	Required, if applicable	Name of Policyholder/Subscriber in #4: The dental insurance carrier name goes in this field; this carrier must be billed before billing SoonerCare.
6	<i>Not Used</i>	<i>Date of Birth; this field is not used for Oklahoma SoonerCare billing.</i>
7	Not Required	Gender: Mark the appropriate box.
8	<i>Not Used</i>	<i>Policyholder/Subscriber ID (SSN or ID#); this field is not used for Oklahoma SoonerCare billing.</i>
9	Not Required	Plan/Group Number: Enter the number of the insurance company.
10	Not Required	Patient's Relationship to Person Named in #5: Mark the appropriate box.
11	Required, if applicable	Other Insurance Company/Dental Benefit Plan Name, Address, City, State, ZIP Code: This field is used for payment and/or denial information from the patient's other dental insurance. If a payment is received from patient's primary insurance, enter the amount of the payment in this field (e.g., 45.00; you do <b>not</b> need to use a dollar sign/\$). If the primary insurance carrier did not make reimbursement, write the words "Carrier Denied" in this box. A copy of the insurance payment detail or insurance denial must be attached to paper claims.
12	Not Required	Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, ZIP Code: Enter the member's name as it appears on their eligibility file. ( <i>Last, First, Middle</i> )
13	<i>Not Used</i>	<i>Date of Birth; this field is not used for Oklahoma SoonerCare billing.</i>
14	Not Required	Gender: Mark the appropriate box.
15	Required	Insured's ID Number: Enter the member's 9-digit SoonerCare ID number.
16	Not Required	Plan/Group Number: Enter the member or employer group plan or policy/certificate number.
17	Not Required	Employer Name: Enter SoonerCare.
18	Not Required	Relationship to Policyholder/Subscriber in #12 Above: Mark the box for "Self".

19	Not Captured	Reserved for Future Use
20	Required	Name (Last, First, Middle Initial, Suffix), Address, City, State, ZIP Code: Enter the member's name and full address.
21	Not Required	Date of Birth (MM/DD/CCYY): Enter member's date of birth. (MM/DD/CCYY)
22	Not Required	Gender: Mark the appropriate box.
23	Not Required	Patient ID/Account # (Assigned by Dentist): Enter the patient ID assigned by the dental office
Fields 24-31: Only one (1) unit may be billed per detail line.		
24	Required	Procedure Date: Enter the date the service was provided. (MM/DD/CCYY)
25	Required, if applicable	Area of Oral Cavity: The following are the only acceptable quadrants: UL—Upper Left, UR—Upper Right, LL—Lower Left, LR—Lower Right, Maxillary Arch 01, Mandibular Arch 02, L & R
26	Not Required	Tooth System
27	Required, if applicable	Tooth Number(s) or Letter(s): The International Tooth Numbering System for permanent, primary and supernumerary teeth.
28	Required, if applicable	Tooth Surface: The following are the only acceptable surfaces: M—Mesial, D—Distal, O—Occlusal, L—Lingual, F—Facial, B—Buccal, I—Incisal
29	Required	Procedure Code: This is the 5-digit HCPCS code listed in the current HCPCS Level II code book.
29A	Required, if applicable	Diagnosis Code Pointer: Enter the letter(s) from field 34 that identify the diagnosis code(s) applicable to the dental procedure. List the primary diagnosis pointer first.
29B	Required	Quantity: Enter the number of times (01-99) the procedure identified in field 29 is delivered to the member on the date of service shown in field 24.
30	Not Required	Description: Use this field to enter any additional information.
31	Required	Fee: Enter your customary fee for the procedure.
31A	Not Used	Other Fee(s): Payment amounts made by other insurance plans. This field is not used for Oklahoma SoonerCare billing.
32	Required	Total Fee: Enter the total of column 31 charges. Each page must have a total. Claims cannot be continued to two or more pages.
33	Not Required	Missing Teeth Information: Place an X on each missing tooth. Identify the missing teeth by using the international tooth numbering system for permanent and primary teeth to mark an X on numbers and letters corresponding with those teeth.
34	Not Required	Diagnosis Code List Qualifier: Enter the appropriate code to identify the diagnosis code source: B=ICD-9, AB=ICD-10
34A	Required, if applicable	Diagnosis Code(s): Enter up to four (4) applicable diagnosis codes after each letter (A-D). The primary diagnosis code is entered in the first field (A).
35	Not Required	Remarks
36	Not Used	Patient/Guardian Signature, Date: Signature and date are entered here. This field is not used for Oklahoma SoonerCare billing.

37	Not Used	Subscriber Signature, Date: Signature and date are entered here. This field is not used for Oklahoma SoonerCare billing.
38	Required, if applicable	Place of Treatment: Enter the 2-digit Place of Service Code for Professional Claims. Frequently used codes are: 11—Office, 12—Home, 21—Inpatient Hospital, 22—Outpatient Hospital, 31—Skilled Nursing Facility, 32—Nursing Facility
39	Not Required	Enclosures (Y or N)
40	Not Required	Is Treatment for Orthodontics? (No/Yes): Check the appropriate box. If “No” is selected, skip fields 41 and 42.
41	Not Required	Date Appliance Placed (MM/DD/CCYY): Enter date orthodontic appliance was placed.
42	Not Required	Months of Treatment: Enter number of months of treatment remaining for appliance.
43	Not Required	Replacement of Prosthesis (No/Yes): Check Yes if requesting replacement for an existing prosthesis. Otherwise, check No.
44	Not Required	Date of Prior Placement (MM/DD/CCYY): Enter date of previous placement.
45	Required, if applicable	Treatment Resulting From: Select the appropriate box, if applicable. If any boxes were selected in this field, complete fields 46 and 47 (if applicable).
46	Not Required	Date of Accident (MM/DD/CCYY): Enter date accident occurred.
47	Not Required	Auto Accident State: Enter the state in which the auto accident noted in field 45 occurred.
48	Required	Name, Address, City, State, Zip Code: Enter the name and information of dentist requesting payment for services listed on claim form. If the dentist furnished the services as part of a dental group practice, enter the name and information of the dental group practice.
49	Not Required	NPI (National Provider Identifier): Enter the NPI for the pay-to provider, if the services were furnished as part of a group practice.
50	Not Required	License Number
51	Not Required	SSN or TIN
52	Not Required	Phone Number: Enter the phone number, including area code, of the billing dentist/provider’s office.
52A	Required, if applicable*	Additional Provider ID: Enter the 10-character Oklahoma SoonerCare provider number for the billing group. (100000000A).
53	Required	Signature, Date: The provider/treating dentist who rendered the service(s) must sign and date this field. Rubber-stamped signatures are acceptable. Writing “Signature on File” is <b>not</b> acceptable.
54	Not Required	NPI (National Provider Identifier): Enter the NPI of the individual dentist providing the service.
55	Not Required	License Number: Enter the license number of the billing dentist.
56	Required, if applicable	Address, City, State, Zip Code: Enter the full address at which the services were rendered, if different from the address information indicated in field 48.

56A	Not Required	Provider Specialty Code: Enter the treating provider's specialty area.
57	Not Required	Phone Number: Enter the phone number of the office where treatment was performed.
58	Required	Additional Provider ID: Enter the rendering dentist's 10-character Oklahoma SoonerCare provider number.

### Direct Data Entry (DDE) Claim Submission – Dental

Use the Dental claim form example and directions below as guides when submitting a claim through DDE on the SoonerCare Provider Portal. Required fields are indicated in the directions. Choose the Submit Claim Dental (see screen sample below) claim option from the Claims menu to open the form (see screen sample below).

**Oklahoma HealthCare Authority**

My Home Eligibility **Claims** Prior Authorizations Referrals Files Exchange Financial Letters Reports Resources

Search Claims **Submit Claim Dental** Submit Claim Inst | Submit Claim Prof | Submit Claim Pharm | Search Payment History

Claims > Submit Claim Dental Contact Us | Logout

Monday 03/23/2020 01:11 PM CST

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**Submit Dental Claim: Step 1** ?

\* Indicates a required field.

**Provider Information**

This panel contains provider information.

<b>Billing Provider ID</b>	<b>ID Type</b> NPI	<b>Name</b>
<b>Zip Code</b>		<b>SC Provider Number</b>

**Patient Information**

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

\*Member ID

<b>Last Name</b>	<b>First Name</b>	<b>Middle</b>
<b>Birth Date</b>		

**Claim Information**

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

<b>Accident Related</b> <input type="text"/>	<b>Emergency</b> <input type="text"/>
* <b>Place of Treatment</b> 11-Office <input type="text"/>	<b>Patient Account Number</b> <input type="text"/>
<b>Other Insurance</b> None <input type="text"/>	

**Total Charged Amount** \$0.00

**Continue** **Cancel**

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**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			Remove

1    \*ICD Version     \*Diagnosis Code

**Other Insurance Details**

TPL Amount

**Service Details**

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

Svc #	Svc Date	Oral Cavity Area	Tooth Number	Procedure Code	Units	Charge Amount	Action
1							Remove

1    \*Svc Date     Oral Cavity Area     Tooth Number

Tooth Surface                     Prosthesis

Cavity Code                

\*Procedure Code     Modifiers        

Diagnosis Pointers            

\*Units     Charge Amount

Rendering Provider ID     ID Type     Zip Code     SC Provider Number

**Attachments**

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

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

[Go to Top](#)

**DDE Dental Claim Submission Instructions**

<b>Billing Information</b>		
<b>Form Locator</b>	<b>DDE Dental Claim Submission Instructions</b>	<b>Requirement</b>
Billing Provider ID	Your Provider ID Number should appear in the first box. Confirm it is correct; if it is not, you may need to log out and access the correct provider.	Required
<b>Patient Information</b>		
<b>Form Locator</b>	<b>DDE Dental Claim Submission Instructions</b>	<b>Requirement</b>
Member ID	Enter the member's Oklahoma SoonerCare ID number in this field. <i>The patient's last and first name, and birth date will auto-populate if the member ID number entered is found in the system.</i>	Required
<b>Diagnosis Codes</b>		
<b>Form Locator</b>	<b>DDE Dental Claim Submission Instructions</b>	<b>Requirement</b>
ICD Version	Use the drop-down list to select a diagnosis type.	Required, if applicable
Diagnosis Code	Enter at least three (3) characters to begin searching for a diagnosis code.	Required, if applicable
<b>Claim Information</b>		
<b>Form Locator</b>	<b>DDE Dental Claim Submission Instructions</b>	<b>Requirement</b>
Accident Related	Use the drop-down list to further describe the accident.	Required, if applicable
Emergency	Specify whether the claim was an emergency by selecting Yes or No from the drop-down list.	Not Required
Place of Treatment	Select the appropriate place of treatment from the drop-down list.	Required
Patient Account Number	The Patient Account Number will be captured and appear on the remittance advice (RA), if entered in this field.	
Other Insurance	Select the applicable option for other insurance.	
Total Charged Amount	Total charges are automatically populated.	<i>Auto</i>
<b>Other Insurance Details (when Other Insurance-Include is selected)</b>		
<b>Form Locator</b>	<b>DDE Dental Claim Submission Instructions</b>	<b>Requirement</b>
TPL Amount	Enter the TPL amount.	
<b>Service Details</b>		
<b>Form Locator</b>	<b>DDE Dental Claim Submission Instructions</b>	<b>Requirement</b>
Svc Date	Enter the date of service here.	Required
Oral Cavity Area	Use the drop-down list to select the cavity area.	
Tooth Number	Use the drop-down list to select a tooth number.	Required, if applicable
Tooth Surface	Use the drop-down list to select a surface type.	Required, if applicable
Prosthesis	Use the drop-down list to select a prosthesis type.	



Procedure Code	Enter the procedure code.	Required
Modifiers	Enter up to four (4) modifiers.	
Units	Enter the number of units billed.	Required
Charge Amount	Enter the total dollar amount of charges for this line of service. <i>This action will auto-populate the Total Charges field but will not multiply the amount by the number of units.</i>	Required
Rendering Provider ID Number	Enter the NPI of the dentist performing the services. The Rendering Provider field displays for the first service line only.	
ID Type	Use the ID Type drop-down list to select NPI as the Rendering Provider ID type.	Required, if applicable
Zip Code	Enter the ZIP code of the rendering provider.	
SC Provider Number	Enter the Oklahoma SoonerCare provider number.	
If additional items are to be billed on this submission, click Add next to the line item window and repeat process. Click Remove to remove a line entry.		
<b>Attachments</b>		
<b>Form Locator</b>	<b>DDE Dental Claim Submission Instructions</b>	<b>Requirement</b>
Transmission Method	Select from the drop-down list how attachments will be sent.	Required, if applicable
Upload File	Click Browse to locate file being uploaded; available when selecting FT-File Transfer.	Required, if applicable
Attachment Type	Select the type of file from the drop-down list.	Required, if applicable
Description	Enter a description of the attachment.	
HCA-13D	If a hard-copy attachment is to be added, a system-generated HCA-13D paper attachment form will be available to print once the claim has been submitted by selecting BM-By Mail or FX-By Fax from the Transmission Method drop-down list. See Section F in this chapter for instructions on sending form HCA-13D by fax or mail. Unique ACNs (control numbers) are generated once an attachment is added.	Required, if applicable
Submit	When finished, click Submit.	Required

## Section E: Drug/Compound Prescription Drug, Pharmacy, NCPDP

### Drug/Compound Drug Claim Forms

The **Drug/Compound Drug Claim Forms** are used to bill pharmacy services and are available online at <http://www.okhca.org/rxforms/>.



Pharmacy Claim submissions are done through the Drug Claim Form (Pharm-1) and Compound Prescription Drug Claim Form (Pharm-2). These claim forms should be used for every pharmacy paper billing, including the resubmission of a claim that is over one year past date of service. The form locator chart indicates which fields are *optional*, *required* or *required, if applicable*.

### Drug/Compound Drug Claims Mailing Address

Please mail paper claims to:

**Pharmacy**  
DXC Technology  
P.O. Box 18650 -  
Oklahoma City, OK 73154

### Drug Claim Form

## Drug Claim Form

**PLEASE PRINT CLEARLY**

Provider Number (required) 01	Loc (req) 02	Billing NPI (optional) 03	Telephone Number 04		
Patient's Name: Last, First (required) 05	Member ID (Required) 06	Member's Date of Birth (Required) mmddccyy 07	Emergency (Y or N) 08	Pregnancy (Y or N) 09	NH Pt. (Y or N) 10
Prescription Number (Required) 11	Date Prescribed (Required) 12	Date Dispensed (Required) 13	NDC Number (Required) 14	Quantity (required) 15	Days 16
Brand Medically Necessary 17	Refill 18	Individual Prescriber's NPI Number (Required) 19	Individual Prescriber's Name: Last, First (Required) 20		

Provider's Name and Address 25	This is to certify that the foregoing information is true, accurate, and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any falsification of claims, statements, or documents, or concealment of material fact may be prosecuted under applicable Federal or State law.  I, the undersigned, being aware of restricted funds in the Medicaid program, agree to accept as full payment for services enumerated on this claim form, for this Medicaid patient, the allowance determined by the Department or its designee. I further certify that no supplemental charges have been or will be billed to the patient; I further recognize that any difference of opinion concerning the charges and/or allowance for this claim shall be adjudicated as specified in the Provider Manual.  Signature of Provider or Representative (Required) 26
Date Billed (Required) 27	

Charge (Required) 21	Third Party Paid 22	Total Amount Billed (Required) 23	Usual and Customary 24
-------------------------	------------------------	--------------------------------------	---------------------------

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**Mail Completed Claim Form to:**  
 DXC Technology | P.O. Box 18650, Oklahoma City, OK 73154  
 OHCA Revised 12/28/2018


PHARM-1


**Pharmacy Drug Claims Field Descriptions/Instructions**

Field	Form Locator	Prescription Drug (PHARM-1) Field Instructions	Requirement
1	<b>Provider Number</b>	Enter the 9-digit Oklahoma SoonerCare provider number (100000000).	Required
2	<b>Loc (Location Code)</b>	Enter the alpha-character location code from the Oklahoma SoonerCare provider number (A).	Required
3	<b>Billing NPI</b>	Enter the NPI of the billing provider.	Not Required
4	<b>Telephone Number</b>	Telephone number	Not Required
5	<b>Patient's Name</b>	Enter the patient's name. ( <i>Last name, First name</i> )	Required
6	<b>Member ID Number</b>	Enter the member's 9-character Oklahoma SoonerCare identification number.	Required
7	<b>Member's Date of Birth</b>	Enter the member's date of birth. ( <i>MMDDCCYY</i> )	Required
8	<b>Emergency (Y or N)</b>	Enter <b>Y</b> (yes) or <b>N</b> (no) to indicate if the prescription is related to an accident.	Not Required
9	<b>Pregnancy (Y or N)</b>	Enter <b>Y</b> (yes) or <b>N</b> (no) to indicate if the prescription is related to a pregnancy.	Not Required
10	<b>NH Pt.</b>	Enter <b>Y</b> (yes) or <b>N</b> (no) to indicate if the prescription was dispensed to a resident of a nursing home facility.	Not Required
11	<b>Prescription Number</b>	Prescription Number: Enter the pharmacy's prescription number; may include up to seven (7) characters.	Required
12	<b>Date Prescribed</b>	Enter the date the prescription was written; must be on or before receipt date, not a future date.	Required
13	<b>Date Dispensed</b>	Enter the date the prescription was dispensed; must be on or before receipt date, not a future date.	Required
14	<b>NDC Number</b>	Enter the 11-digit National Drug Code (NDC) number of the drug dispensed.	Required
15	<b>Quantity</b>	Enter the metric quantity to three (3) decimal places, up to 11 characters. (e.g., 99999999.999)	Required
16	<b>Days</b>	Enter the number of days' supply dispensed; may be up to three (3) digits	Required
17	<b>Brand Medically Necessary</b>	Enter the appropriate brand name indicator as indicated below: 0—No product selection indicated 1—Substitution not allowed by prescriber—dispense as written	Required, if applicable
18	<b>Refill</b>	Enter two (2) digits to indicate the number of times the prescription has been dispensed. 00—original dispensing, 01 to 99—refill number	Required
19	<b>Individual Prescriber's NPI Number</b>	Enter the 10-digit NPI number of the prescriber.	Required
20	<b>Individual Prescriber's Name</b>	Enter the prescriber's name. ( <i>Last name, First name</i> )	Required

21	<b>Charge</b>	Enter the charge for this prescription.	Required
22	<b>Third Party Paid</b>	Enter the amount paid by the primary insurance (TPL).	Required, if applicable
23	<b>Total Amount Billed</b>	Enter the total amount billed. (e.g., Charge – TPL = Total Amount Billed)	Required
24	<b>Usual and Customary</b>	Enter the usual and customary charge for the quantity and NDC provided.	Required
25	<b>Provider's Name and Address</b>	Enter the billing provider's name, address and telephone number.	Not Required
26	<b>Signature of Provider or Representative</b>	This must be an authorized name of a person indicating the information entered in the face of this bill is in conformance with the certifications listed on the form.  A stamped signature is acceptable; writing Signature on File is <b><i>not</i></b> acceptable.	Required
27	<b>Date Billed</b>	Enter the date the bill is submitted. (MMDDYY)	Required

### Compound Prescription Drug Claim Form





**Compound Prescription Drug Claim Form**

**PLEASE PRINT CLEARLY**

1 Provider Number		Loc	2 Telephone Number									
3 PATIENT'S NAME LAST, FIRST			4 CLIENT NO.		5 PRESCRIBER'S I.D. NUMBER		6 EMERG	7 PREC	8 N.H. PAT	9 BRAND	10 REFILL	
11 PRESCRIPTION NUMBER		12 DATE PRESCRIBED		13 DATE DISPENSED		14 LOCAL USE ONLY		15 DAYS		16 CHARGE		17 3 <sup>RD</sup> PARTY PAID
21 LINE NUMBER	22 NDC NUMBER		23 DESCRIPTION OF INGREDIENT							24 QUANTITY		
1												
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												

18  
Provider's Name and Address ?

This is to certify that the foregoing information is true, accurate, and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any falsification of claims, statements, or documents, or concealment of material fact may be prosecuted under applicable Federal or State law.

I, the undersigned, being aware of restricted funds in the Medicaid program, agree to accept as full payment for services enumerated on this claim form, for this Medicaid patient, the allowance determined by the Department or its designee. I further certify that no supplemental charges have been or will be billed to the patient; I further recognize that any difference of opinion concerning the charges and/or allowance for this claim shall be adjudicated as specified in the Provider Manual.

19  
Signature of Provider or Representative

20  
Date Billed

---

MAIL COMPLETED CLAIM FORM TO:  
 DXC Technology  
 P.O. Box 18650  
 Oklahoma City, OK 73154

OHCA Revised 12/28/2018
PHARM2

**Compound Prescription Drug Claim Form Field Description/Instructions**

Field	Requirement	Compound Drug (PHARM-2) Field Descriptions/Instructions
1	Required	<b>Provider Number:</b> Enter the 9-digit Oklahoma SoonerCare provider number (100000000).
		<b>Loc (Location Code):</b> Enter the alpha-character location code from the Oklahoma SoonerCare provider number (A).
2	Not Required	Telephone Number
3	Required	Patient's Name (Last, First): Enter the member's name.
4	Required	Client No: Enter the member's 9-character Oklahoma SoonerCare identification number.
5	Required	Prescriber's ID Number: Enter the 7-digit Oklahoma Prescriber ID number of the prescribing physician.
6	Not Required	Emerg: Enter Yes or No to indicate if the prescription is related to an emergency.
7	Not Required	Preg: Enter Yes or No to indicate if the prescription is related to a pregnancy.
8	Not Required	N.H. PAT: Enter Yes or No to indicate if the prescription was dispensed to a resident of a nursing home facility.
9	Required, if applicable	Brand: Brand Name Indicator <i>0—No product selection indicated</i> <i>1—Substitution not allowed by prescriber, dispense as written</i>
10	Required	Refill: Refill Indicator; enter two (2) digits to indicate the number of times the prescription has been dispensed. Example: <i>00—original dispensing, 01-99—refill number</i>
11	Required	Prescription Number: Enter the pharmacy's prescription number; may include up to seven (7) characters.
12	Required	Date Prescribed: Enter the date the prescription was written; must be on or before receipt date, not a future date.
13	Required	Date Dispensed: Enter the date the prescription was dispensed; must be on or before receipt date, not a future date.
14	<i>Not Used</i>	<i>Local Use Only</i>
15	Required	Days: Enter the number of days' supply dispensed; may include up to three (3) characters.
16	Not Required	Charge: Enter the total charges for this claim; may include up to nine (9) digits.
17	Required, if applicable	3rd Party Paid (TPL): Enter the amount paid by the primary insurance; may include up to eight (8) digits.
<b>Billing Information</b>		
18	Not Required	Provider's Name and Address: Provider's name, address and telephone number.
19	Required	Signature of Provider or Representative: This must be an authorized name of a person indicating that the information entered in the face of this bill is in conformance with the certifications listed on the form. A stamped signature is acceptable but writing "signature on file" is not acceptable.
20	Required	Date Billed: Enter the date the bill is submitted ( <i>MM/DD/YY</i> )

Service Lines		
Field	Requirement	Compound Drug (PHARM-2) Field Descriptions/Instruction
21, lines 1-15	Required	NDC Number: Enter the 11-digit National Drug Code (NDC) number of each of the drugs dispensed.
22, lines 1-15	Required	Description of Ingredient: List each ingredient with the corresponding NDC.
23, lines 1-15		Quantity: Metric unit quantity (e.g., 9999999.999).

**Direct Data Entry (DDE) Claim Submission – Pharmacy, including compounds**

Use the Pharmacy claim form example and directions below as guides when submitting a claim through DDE the SoonerCare Provider Portal. Choose the Submit Claim Pharm option (see screen sample below) from the Claims drop-down menu to access the form (see screen sample below).

**Oklahoma HealthCare Authority**

My Home Eligibility **Claims** Prior Authorizations Referrals Files Exchange Financial Letters Reports Resources

Search Claims | Submit Claim Dental | Submit Claim Inst | Submit Claim Prof **Submit Claim Pharm** Search Payment History

[Contact Us](#) | [Logout](#)

Claims > Submit Claim Dental Monday 03/23/2020 01:11 PM CST

**Submit Dental Claim: Step 1** ?

\* Indicates a required field.

**Provider Information**

This panel contains provider information.

<b>Billing Provider ID</b>	<b>ID Type</b> NPI	<b>Name</b>
<b>Zip Code</b>		<b>SC Provider Number</b>

**Patient Information**

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

* <b>Member ID</b>	<input type="text"/>		
<b>Last Name</b>		<b>First Name</b>	<b>Middle</b>
<b>Birth Date</b>			

**Claim Information**

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

<b>Accident Related</b>	<input type="text"/>	<b>Emergency</b>	<input type="text"/>
* <b>Place of Treatment</b>	11-Office <input type="text"/>	<b>Patient Account Number</b>	<input type="text"/>
<b>Other Insurance</b>	None <input type="text"/>		

**Total Charged Amount** \$0.00

**Continue** **Cancel**

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**Claim Information**

General Claim Information Instructions

\*Prescriber ID  ID Type NPI \*Last Name

\*Prescription #  \*Fill #  \*Date Written  \*Date of Service

\*Days Supply

Dispense/Written

---

**Compound Information**

General Compound Information Instructions

Ingredient Component Count  
0

**Compound Details**

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

#	Compound NDC	Ingredient Quantity	Action
1			
1	*Compound NDC <input type="text"/>	*Ingredient Quantity <input type="text"/>	

---

**Pricing Information**

General Pricing Information Instructions

\*Total Charges

**DDE Pharmacy Claim Submission Instructions**

<b>Provider Information</b>		
<b>Form Locator</b>	<b>DDE Pharmacy Claim Submission Instructions</b>	<b>Requirement</b>
Service Provider ID	Your Provider ID Number should appear in the first box. Confirm it is correct; if it is not, you may need to log out and access the correct provider.	Required
Rendering Provider NPI	Display only	
Rendering Provider Number	Display only; will default to the service provider.	
<b>Patient and Claim Information</b>		
<b>Form Locator</b>	<b>DDE Pharmacy Claim Submission Instructions</b>	<b>Requirement</b>
Member ID	Enter the member's Oklahoma SoonerCare ID number in the client ID field. <i>The member's last and first name will auto-populate if the member ID number entered is found in the system.</i>	Required
Birth Date	Enter the date of birth of the recipient.	Required
Claim Type	Use the drop-down list to select whether or not the prescription is a regular pharmacy claim or a compound drug pharmacy claim.	Required
Other Coverage Code	Use the drop-down list to determine if other insurance exists or coverage has been denied.	
Pregnancy	Use the drop-down list to select the appropriate response of Yes or No to indicate whether or not the prescription was related to a pregnancy.	Not Required
Emergency	Use the drop-down list to select the appropriate response of Yes or No to indicate whether or not this prescription was related to an emergency.	Not Required
Nursing Facility	Use the drop-down list to select the appropriate response of Yes or No to indicate whether or not this prescription was dispensed to a resident of a nursing home facility.	Not Required
<b>Claim Information</b>		
<b>Form Locator</b>	<b>DDE Pharmacy Claim Submission Instructions</b>	<b>Requirement</b>
Prescriber ID	Enter the Oklahoma Prescriber ID number of the prescribing physician.	Required
ID Type	This field will automatically populate.	Auto
Last Name	Enter the last name of the prescribing physician.	Required
Prescription Number	Enter the pharmacy-assigned prescription number (up to seven digits) for the current prescription.	Required
Fill Number	Enter two (2) digits to indicate the number of times the prescription has been dispensed. <i>00—original dispensing, 01-99—refill number</i>	Required
Date Written	Enter the date the prescription was prescribed by the physician.	Required

Date of Service	Enter the date the prescription was dispensed by the pharmacy.	Required
NDC	Enter the 11-digit National Drug Code (NDC) number of the drug dispensed. Compound will auto-populate to 00000000000.	Required
Quantity Dispensed	Enter the quantity being dispensed for the above NDC within the prescription.	Required
Days' Supply	Enter the number of days the prescription will cover.	Required
DAW Code	Select the most appropriate option from the drop-down list to indicate if the prescription was dispensed as prescribed (dispensed as written) or if a generic medication was substituted.	Required
<b>Compound Details</b>		
<b>Form Locator</b>	<b>DDE Pharmacy Claim Submission Instructions</b>	<b>Requirement</b>
Compound NDC	Enter the 11-digit National Drug Code (NDC) number of the drug dispensed.	Required
Ingredient Quantity	Enter the quantity of the compound.	Required
Ingredient Drug Cost	Enter the cost amount of the ingredient.	Required
Basis of Cost Determination	Use the drop-down list to select the source behind the cost determination.	Not Required
<b>Pricing Information</b>		
<b>Form Locator</b>	<b>DDE Pharmacy Claim Submission Instructions</b>	<b>Requirement</b>
Total Charge	Enter the usual and customary charge.	Required
<b>DUR Overrides</b>		
<b>Form Locator</b>	<b>DDE Pharmacy Claim Submission Instructions</b>	<b>Requirement</b>
Reason for Service	Use the drop-down list to select the appropriate Prospective DUR intervention used to determine outcome of claim.	Required, if applicable
Professional Service	Use the drop-down list to select the appropriate Prospective DUR conflict message.	Required, if applicable
Result of Service	Use the drop-down list to select the appropriate Prospective DUR outcome that was made using the intervention.	Required, if applicable.
<b>Diagnosis Codes</b>		
<b>Form Locator</b>	<b>DDE Pharmacy Claim Submission Instructions</b>	<b>Requirement</b>
Diagnosis Code Type	Use the drop-down list to select a diagnosis type.	Required
Diagnosis Code	Enter at least three (3) characters to begin searching for a diagnosis code.	Required
<b>Other Insurance Details (when Other Coverage Code/Exists is selected)</b>		
<b>Form Locator</b>	<b>DDE Pharmacy Claim Submission Instructions</b>	<b>Requirement</b>
TPL Amount	Enter an amount in dollars and cents.	
Submit	Click Submit when finished.	Required

## Section F: Electronic Claim Attachments

Proper filing of attachments to electronic claims is essential to the successful payment of submitted claims with attachments. An important part of the filing process is accurate entry of provider, member, and ACNs on the electronic claim form and the HCA-13 cover sheet. When submitting attachments, selecting Transmission Method By Mail or By Fax (see screen sample below) will generate an Electronic Claim Paper Attachment Form Cover Sheet button. The provider number, client ID number, claim number and ACN number will be auto populated.

The screenshot shows a web form titled "Attachments". At the top, it says "Click the Remove link to remove the entire row." Below this is a table with columns: #, Transmission Method, File, Control #, Attachment Type, and Action. A "Click to collapse" link is visible. A dropdown menu is open for the "Attachment Type" field, showing the following options: AA-Available on Request at Provider Site, BM-By Mail, EM-E-Mail, FT-File Transfer, and FX-By Fax. There are "Add" and "Cancel" buttons at the bottom of the form.

### Claim Attachments Mailing Address

Once completed, fax the form to 405-947-3394 or mail to:

**DXC Technology**  
P.O. Box 18500  
Oklahoma City, OK 73154

### Helpful Tips

An Attachment Form Cover Sheet will be generated for each Transmission Method added once the claim has been submitted.

The screenshot shows a box with the following text: "Click **Attachment Coversheet(s)** to view the claim attachments coversheet(s).", "Click **Print Preview** to view the claim details as they have been saved on the payer's system.", "Click **Edit** to resubmit the claim.", and "Click **View** to view the details of the submitted claim." Below the text are five buttons: Attachment Coversheet(s), Print Preview, Edit, New, and View.

## Attachment Form Cover Sheet (HCA-13)



**Oklahoma Health Care Authority  
Electronic Claim Paper Attachment Form  
Cover Sheet**

*The three fields below are required and must match claim.*

<b>1. Provider Number</b>	
<b>2. Client ID Number</b>	
<b>3. Attachment Control Number</b>	

**Purpose:**

This form is to be used when a claim requiring a paper attachment is being submitted electronically. Submission of this completed form along with the required attachment and electronically submitted claim will allow the appropriate review process to be conducted by the OHCA.

**Instructions:**

1. In box 1, fill in the pay to Provider Number used for filing the electronic claim.
2. In box 2, fill in the 9-digit client identification number submitted on the electronic claim.
3. In box 3, fill in the Attachment Control Number (ACN) used for filing the electronic claim. The ACN on this form must be the same number entered in the control number field of the direct data entry (DDE) screen (Medicaid on the Web) or the PWK segment of the 837 transaction. Make sure the ACN is clear and legible on the HCA-13. Illegible information could delay or stop the attachment process. Numbers are the only characters that should be used in the ACN section. Do not use dashes or spaces in the ACN section.
4. Place this completed form on top of the attachment(s) for each electronic claim. (DO NOT INCLUDE ADDITIONAL COVER SHEET)
5. Mail to: DXC Technology  
P.O. Box 18500, OKC, OK 73154  
Fax: 405-947-3394

**NOTE: Do not place another fax cover sheet on top of this form.**

**\*This form is for use with electronically filed claims requiring attachments.**

Sender's Name:  Phone Number:

This fax contains confidential information and is intended only for the individual named. If you are not the named addressee you should not disseminate, distribute or copy this fax. Please notify the sender immediately by phone if you have received this e-fax by mistake and destroy the fax you received. Fax transmissions cannot be guaranteed to be secure or error-free as information could be intercepted, corrupted, lost, destroyed, arrive late or incomplete. The sender therefore does not accept liability for any errors or omissions in the contents of this message, which arise as a result of fax transmission.

## Section G: Medicare-Medicaid Crossover Invoice

### HCA-28: Medicare-Medicaid Crossover Invoice Form - Inpatient Claims Special Batch Processing ONLY


The **Medicare-Medicaid Crossover Invoice** form (**HCA-28**) should be used when submitting **Inpatient crossover** claims for Special Processing **ONLY**. Use this form as a supplement to the Medicare Explanation of Benefit (EOB) statement attachment previously required on paper crossover claims. The form was created due to multiple versions of the Medicare (EOB) statements being printed from the different software formats currently available. The information to be keyed from the Medicare EOB to process crossover claims no longer appears in a standard format when printed. This means the necessary information to be keyed appears differently and is marked with different headers on each printed electronic Medicare EOB, making crossover claim processing challenging. The Medicare-Medicaid Crossover Invoice form will allow these claim types to be keyed more quickly and accurately.

1. You must write CROSSOVER at the top of every claim.
2. Use this form for Inpatient claims when filing a special process claim, using the HCA 17 Claim Inquiry Response Form.
3. Use one Medicare-Medicaid Crossover invoice for each claim.
4. Mail the completed form to: DXC

Technology  
P.O. Box 18506  
Oklahoma City, OK 73154

#### 1.1.11



**Medicare-to-Medicaid Crossover Invoice Form (HCA-28)**



## Medicare-to-Medicaid Crossover Invoice

(As of February 1, 2017, OHCA no longer accepts paper crossover claims.)

Inpatient Only

Please check one:	
<input type="checkbox"/> Medicare only	<input type="checkbox"/> Medicare supplemental claims
<input type="checkbox"/> Medicare replacement	
SoonerCare Provider ID: _____	
Member ID: _____	Member Name
	First: _____ Last: _____
Patient Control Number: _____	
Medicare HIC Number: _____	
From DOS: _____	To DOS: _____
Total Billed: \$ _____	
Date Paid: _____	
Coinsurance: \$ _____	
Deductible: \$ _____	
Blood Deductible: \$ _____	
Total Allowed: \$ _____	
Medicare Remark Code : _____	
Amount Paid: \$ _____	
	
Provider Signature	
Date	

This form should only be used for appeals with an HCA-17 which requires a red and white claim form.

*Important:* By submitting this form to OHCA, the provider attests that the information included in the form matches the EOB. If the information on this crossover claim type form does not exactly match the information on the EOB, the claim may be denied or returned.

OKHCA Revised 03/2018
HCA-28 Form

**HCA-28 Form Field Descriptions/Instructions – Inpatient Claims**

<b>Form Locator</b>	<b>HCA-28 Field Descriptions/Instructions</b>	<b>Requirement</b>
SoonerCare Provider ID	Enter the SoonerCare Provider ID number. This consists of nine (9) numeric characters and one (1) alpha character, or 10-character ID number.	Required
Member ID	Enter the member's 9-character Oklahoma SoonerCare identification number.	Required
Member Name (First, Last)	Enter the member's name. <i>(first name, last name)</i>	Required
Patient Control Number	Enter the internal patient account number; this number will appear on the remittance advice (RA).	Required
Medicare HIC Number	Enter the member's Medicare HIC number; the Medicare HIC number should be the same number as submitted on the claim.	Required
From DOS/To DOS	Enter the From and To Dates of Service as indicated on the Medicare EOB for the indicated claim. <i>(MM/DD/CCYY)</i>	Required
Total Billed	Enter the total amount billed for all detail lines from the Medicare EOB.	Required
Date Paid	Enter the date the claim was paid by Medicare. <i>(MM/DD/CCYY)</i>	Required
Coinsurance/ Medicare Remark Code	Enter the amount of coinsurance for the total Medicare claim and the corresponding Medicare Remark Code(s).	Required, if applicable
Deductible/ Medicare Remark Code	Enter the amount of the deductible for the total Medicare claim and the corresponding Medicare Remark Code(s).	Required, if applicable.
Blood Deductible	Enter the amount of the indicated Blood Deductibles on the Medicare claim.	Required, if applicable
Total Allowed	Enter total allowed amount for the entire Medicare claim and the corresponding Medicare Remark Code(s).	Required, if applicable
Amount Paid	Enter the Amount Paid from the Medicare EOB and the corresponding Medicare Remark Code(s).	Required, if applicable
Provider Signature	Signature of Physician or Supplier; the name of the authorized person designated by the agency or organization.	Required
Date Signed	Enter date the claim was signed. <i>(MM/DD/CCYY)</i>	Required



**HCA-28B: Medicare-Medicaid Crossover Invoice Form Outpatient and HCFA 1500 Claims****Special Batch Processing ONLY**

The **Medicare-Medicaid Crossover Invoice** form (**HCA-28B**) should be used when submitting **Outpatient** claims and **HCFA 1500** claims for Special Processing only. Use this form as a supplement to the Medicare Explanation of Benefit (EOB) statement attachment previously required on paper crossover claims. The form was created due to multiple versions of the Medicare (EOB) statements being printed from the different software formats currently available. The information to be keyed from the Medicare EOB to process crossover claims no longer appears in a standard format when printed. This means the necessary information to be keyed appears differently and is marked with different headers on each printed electronic Medicare EOB, making crossover claim processing challenging. The Medicare-Medicaid Crossover Invoice form will allow these claim types to be keyed more quickly and accurately.

1. You must write CROSSOVER at the top of every claim.
2. Use this form for Outpatient claims and HCFA 1500 claims when filing a special process claim, using the HCA 17 Claim Inquiry Response Form.
3. Use one Medicare-Medicaid Crossover Invoice for each claim.
4. Mail the completed form to:

DXC Technology  
P.P. Box 18506  
Oklahoma City, OK 73154

### Medicare to Medicaid Crossover Invoice Form (HCA 28B)



## Medicare to Medicaid Crossover Invoice

(As of February 1, 2017 OHCA no longer accepts paper crossover claims.)  
Outpatient and HCFA 1500 only

Page  of

HCA-28B

1 Please check one: <input type="checkbox"/> Medicare only <input type="checkbox"/> Medicare supplement claims <input type="checkbox"/> Medicare replacement											
2 SoonerCare Provider ID				3 Member ID							
4 Member Last Name				4a Member First Name							
5 Patient Control Number				6 Medicare HIC Number							
7 Detail(s) Information											
Dtl #	a. From DOS	b. To DOS	c. Procedure Code	d. Charges	e. Allow Amt	f. Ded	g. Coins	h. Blood Ded	i. Paid	j. Paid Date	k. Medicare Reason Code
1											
2											
3											
4											
5											
6											
8 Totals Information				a. Charges	b. Allow	c. Ded	d. Coins	e. Blood Ded	f. Paid	g. Total Pages	

9 Provider Signature  10 Date

This form should only be used for appeals with an HCA-17 which requires a red and white claim form.

*Important:* By submitting this form to OHCA, the provider attests that the information included in the form matches the EOB. If the information on this crossover claim type form does not exactly match the information on the EOB, the claim may be denied or returned.

Revised 03/12/2018

**HCA-28B Form Field Descriptions/Instructions for Outpatient and HCFA 1500 Claims**

	<b>Form Locator</b>	<b>HCA-28B Field Description/Instructions</b>	<b>Requirement</b>
1	Check One	Check the box for the appropriate form (claim type) to be submitted.	
2	SoonerCare Provider ID	Enter the 10-character Oklahoma SoonerCare provider number of the Billing Provider.	Required
3	Member ID	Enter the member's 9-digit SoonerCare identification number. Must be nine digits.	Required
4	Member Last Name	Enter the member's last name.	
4a	Member First Name	Enter the member's first name.	
5	Patient Control Number	Patient's Account Number – Enter your internal patient tracking number. The tracking number should be the same as the submitted claim.	Not required
6	Medicare HIC Number	Enter the Patient's Medicare HIC Number. The Medicare HIC Number should be the same number as submitted on the claim.	Required
7	<b>Detail Lines</b>		
7a	From DOS	Enter the From date of service. (MM/DD/YYYY)	Required
7b	To DOS	Enter the To date of service. (MM/DD/YYYY)	Required
7c	CPT	Enter the appropriate Current Procedural Terminology (CPT) procedure code for each procedure/service listed.	
7d	Charges	Enter the Medicare charges (billed amount) listed on the MAP EOB for each detail.	Required
7e	Allow Amt	Enter the Medicare Allowed amount listed on the EOB for each detail.	Required, if applicable
7f	Ded	Enter the Medicare deductible amount listed on the EOB for each detail.	
7g	Coins	Enter the Medicare Coinsurance amount listed on the MAP EOB for each detail.	Required, if applicable
7h	Blood Ded	Enter the Blood Deductible listed on the EOB, if applicable.	Required, if applicable
7i	Paid	Enter the Medicare Paid amount listed on the EOB for each detail.	Required, if applicable
7j	Date Paid	Enter in the Date Paid. (MM/DD/YYYY)	Required
7k	Medicare Reason Code	Enter Medicare's reason code listed on the MAP EOB for each detail.	Required, if applicable
8	<b>Totals Information</b>	Enter the Medicare total charges (billed amount) listed on the EOB. <b>Note:</b> A provider may attach additional template forms (pages) as necessary. The combined total charges for all pages should be listed on the last page. All other forms must indicate "Continue" in this block.	

8a	Charges	Enter the total Charges amount listed on the EOB.	
8b	Allow	Enter the Medicare total Allowed amount listed on the EOB.	
8c	Ded	Enter the Medicare total Deductible amount listed on the EOB.	
8d	Coins	Enter the Medicare total Coinsurance amount listed on the EOB.	
8 e	Blood Ded	Enter the Medicare total Blood Deductible amount listed on the EOB.	
8f	Paid	Enter the Medicare total Paid amount listed on the EOB.	
8g	Total Pages	Enter the total number of pages that are submitted, for more than one page. If the crossover claim contains more than 7 detail line items, use multiple pages to identify up to the detail line items for the claim (as necessary).	
9	Provider Signature	Signature of Physician or Supplier– The name of the authorized person, someone designated by the agency or organization.	Required
10	Date	Enter date the claim was signed. (MM/DD/YYYY)	Required

## Section H: Special Batch Process Claims (HCA-17)

### HCA-17 Form Claim Appeal and Review Cover Sheet

Special batch process claims are primarily the claims that are accepted on paper.

- HCA-17 form is on top, then the claim form, then attachments.
- These claims are required to be submitted on an original claim with applicable documentation:
  - 1500 and UB-04 must be standard size red and white claims forms.
  - Dental claim must be the current ADA 2012 form.
- All paper claims require a SoonerCare Legacy number (200123456A).
- Must have SoonerCare Legacy number in field 57 on UB04 and 24J (if applicable) and 33B on 1500.
- Only one-page claims accepted.
- No more than 999 total pages.
- Paper crossover claims are only accepted as a special batch process and must include the HCA Medicare Crossover Invoice.

#### Special Batch Process Mailing Address:

Oklahoma Health Care Authority  
PO Box 18506  
Oklahoma City, OK 73154

**Claim Appeal and Review Cover Sheet Form (HCA-17)**

**HCA 17 Form**  
**STATE OF OKLAHOMA**  
**OKLAHOMA HEALTH CARE AUTHORITY**  
**CLAIM APPEAL AND REVIEW COVER SHEET**

---

Attach a red & white, one-page claim form and any applicable documentation. If you have previously sent a claim for review, please be sure to include additional documentation not previously sent to support your request along with this cover sheet. Please include detailed processing instructions in the Inquiry field. A completed cover sheet, claim form and documentation is required for each appeal.

**SEND COMPLETED COVER SHEET AND CLAIM FORM TO:**  
**Attn: Provider Services**  
 Oklahoma Health Care Authority  
 PO Box 18506, Oklahoma City, OK 73154

**COVER SHEET MUST BE PLACED ON TOP OF CLAIM FORM**

**PROVIDER INFORMATION**

Name & Address:	Provider Number: _____ Group Number (if applicable): _____ Telephone: _____ Contact Name: _____ <p style="text-align: right; font-size: small;">Please print.</p>
-----------------	---

**CLAIM INFORMATION**

Member Name	Member ID Number	Date of Service	Related ICN
<p><b>INQUIRY:</b> (Please list specific reasons why claim needs/requires special processing.)</p>			

Printed Name: _____	Date: _____
Signature: _____	

For Internal Use Only

**COVER SHEET MUST BE PLACED ON TOP OF CLAIM FORM**

OKLA HCA Revised: 3/12/18

HCA-17

**Claim Appeal and Review Cover Sheet Sample Form (HCA-17)**

**HCA 17 Form**  
**STATE OF OKLAHOMA**  
**OKLAHOMA HEALTH CARE AUTHORITY**  
**CLAIM APPEAL AND REVIEW COVER SHEET**

---

Attach a red & white, one-page claim form and any applicable documentation. If you have previously sent a claim for review, please be sure to include additional documentation not previously sent to support your request along with this cover sheet. Please include detailed processing instructions in the Inquiry field. A completed cover sheet, claim form and documentation is required for each appeal.

**SEND COMPLETED COVER SHEET AND CLAIM FORM TO:**  
**Attn: Provider Services**  
 Oklahoma Health Care Authority  
 PO Box 18506, Oklahoma City, OK 73154

**COVER SHEET MUST BE PLACED ON TOP OF CLAIM FORM**

**PROVIDER INFORMATION**

<p><b>Name &amp; Address:</b>                  XYZ Medical                  123 Main Street                  Anywhere, OK 11111</p>	<p><b>Provider Number:</b> 100000000X  <b>Group Number (if applicable):</b>  <b>Telephone:</b> 405-599-1234  <b>Contact Name:</b> Jane Smith  <small>Please print.</small></p>
---	--

**CLAIM INFORMATION**

Member Name	Member ID Number	Date of Service	Related ICN
Jimmy Johns	000000000	01/31/2020	1020001456456

**INQUIRY:** (Please list specific reasons why claim needs/requires special processing.)

2 office visits on the same day. 2 different physicians, 2 different provider specialties. Documentation attached. Please review for payment.

<p><b>Printed Name:</b> Jane Smith  <b>Signature:</b> _____</p>	<p><b>Date:</b> 7/13/2020</p>
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For Internal Use Only

**COVER SHEET MUST BE PLACED ON TOP OF CLAIM FORM**

OKLA HCA Revised: 3/12/18

HCA-17

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# Chapter 6: Electronic Data Interchange

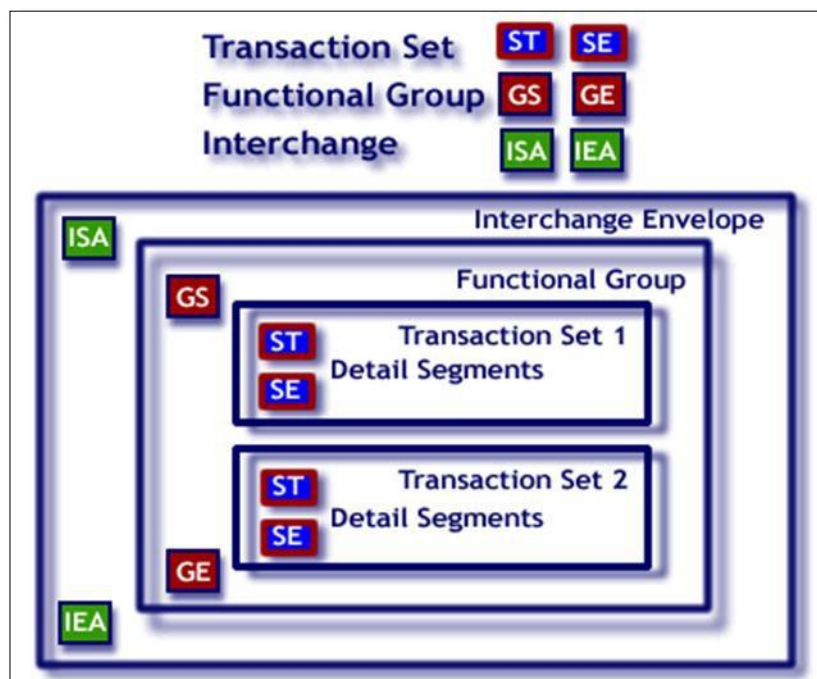
## Introduction

Electronic Data Interchange (EDI) is the most efficient method of submitting and receiving large amounts of information within the Oklahoma Medicaid Management Information System (OKMMIS).

Some benefits of EDI include:

- Improved accuracy.
- Low operating costs.
- Increased cash flow.
- Shorter payment turnaround time.
- Ability to check claims status electronically.
- Increased accounts receivable timeliness and functionality.

In addition, there is no charge to providers for EDI submission. EDI transactions are sent in envelope information structures as detailed below:



The first step to becoming an electronic claims submitter is to complete an EDI application form. The form is found on the OHCA website at [www.okhca.org](http://www.okhca.org) or by contacting the EDI Help Desk.

Providers may take advantage of the EDI process by using a billing agency, clearinghouse or VAN/third party vendor approved by the fiscal agent.

DXC promotes the use of electronic claims submissions through EDI. The EDI team is available to provide direction, answer questions and assist providers or billing agents with the submission of electronic transactions.

## EDI Resources

OKMMIS-specific companion guides and National Council of Prescription Drug Programs (NCPDP) payer sheets are available on the OHCA public website at: [www.okhca.org](http://www.okhca.org).

Implementation Guides are available from the Washington Publishing Company at [www.wpc-edi.com](http://www.wpc-edi.com).

The EDI Help Desk can be reached by phone at 800-522-0114 or 405-522-6205 *Option 2, 2*.

Email correspondence can be sent to [okxixEDI@dxc.com](mailto:okxixEDI@dxc.com). Written correspondence for the EDI Help Desk can be sent to:

**DXC Technology – EDI Help Desk** 2401  
NW 23<sup>rd</sup> Street, Suite 11 Oklahoma City, OK  
73107

## Section A: Professional Claims (837 Professional)

### 837 Professional Transaction

The ASC X12N 837 Professional transaction is the electronic equivalent for the 1500 paper claim form.

#### Key Notes

- No more than 50 service lines are allowed per claim.
- Typical Providers must use the 10-digit NPI as the billing/pay-to, referring and rendering provider ID.
- For atypical providers that are not eligible for an NPI, the REF segment (Bill-to Provider's Secondary ID #) in Loop 2010AA must be included and must have the "EI" field qualifier and the provider's Tax Identification Number. The Provider's Legacy Id Number must be in the Ref\*G2 segment in loop 2010BB.

- The PAT segment, Loop 2000C and 2010CA is no longer needed. All SoonerCare subscribers have their own SoonerCare ID number. When the subscriber and the patient are the same person, omit the PAT information in Loop 2000C and 2010CA.
- SoonerCare numbers sent on all claims:
  - Atypical Providers must use Identification.
  - Typical Providers must use NPI# as primary identification. (Please refer to the companion documents for further information regarding loops and segments).
  - Subscribers – 123456789 (nine digits).
- No more than 5,000 claims per transaction set are allowed.

## Section B: Institutional Claims (837 Institutional)

### 837 Institutional Transaction

The ASC X12N 837 Institutional transaction is the electronic equivalent of the UB-92 paper claim form. All hospitals and institutional facilities must use the 837 Institutional transaction to bill electronically for services covered under the SoonerCare program.

#### Key Notes:

- The 837 Institutional transaction must be used for inpatient claims.
- Providers must use their 10-digit NPI number as the billing/pay-to provider ID. (See companion documents for loops and segments.)
- Limit each transaction set to 5,000 claims.
- Limit each claim to a maximum of 50 service lines.
- For attending, operating and other physicians, please use only the physician's 10-digit NPI number as the primary identifier in the appropriate NM1 segment.
- The physician's taxonomy code is not used for operating physicians or physicians classified as "other."

- Do not use revenue code 001 as a total for all service lines included on the claim.
- Unit rate is required if revenue code is 100-219 (SV02-06).

## Section C: Dental Claims (837 Dental)

### 837 Dental Transaction

The ASC X12 837 Dental transaction is the electronic equivalent of the ADA 2012 paper claim form.

#### Key Notes:

- No more than 50 service lines are allowed per claim.
- Providers must use the 10-digit NPI as the billing/pay- to, referral, and rendering provider ID.
- The PAT segment, Loop 2000C and 2010CA, is no longer needed unless billing a claim for a newborn. Every SoonerCare subscriber, except newborns, have their own SoonerCare ID number. When the subscriber and the patient are the same person, omit the PAT information in Loop 2000C and 2010CA.
- The SoonerCare numbers to be sent on claims should follow this format:
  - Providers – 100000000A (nine digits with one alpha character at the end for a total of 10 characters)
  - Subscribers – 123456789 (nine digits)
- The tooth quadrant in field SV30401 must be listed.
- The TOO segment must be populated indicating tooth number and surface code.
- No more than 5,000 claims per transaction.

## Section D: Pharmacy Claims

### Pharmacy Claims

All interactive electronic pharmacy claims should be submitted using the NCPDP version 5.1 standard. All pharmacy claims submitted electronically in batch must be in NCPDP version 1.1 standard.

**Key Notes:**

- To obtain NCPDP payer sheets, go to [www.okhca.org](http://www.okhca.org) and select the Provider link. Under Claims Tools, select the HIPAA Companion Documents for Electronic Transaction link, then scroll down the page and select the NCPDP link.
- 3C version is no longer accepted.
- If a pharmacy is sending a compound claim, a 2 needs to be entered in field 406-D6 in the claim segment.
- If a 2 is entered in 406-D6, the compound details must be with the claim. Each NDC number must be listed.
- To send test files, the pharmacy must check with their van/switch and have them send the test to the DXC test port.

## Section E: Claim Inquiries/Responses

### Claim Inquiry Transaction (Batch)

The 276 Transaction Set is used to transmit health care claim status request/response inquiries from health care providers, clearinghouses and other health care claims adjudication processors. The 276 Transaction Set can be used to make an inquiry about a claim or claims for specific SoonerCare members. It is mandatory under HIPAA that the OKMMIS can accept this transaction set to create health care claim status responses.

**Key Notes:**

- The 276 should be limited to 5,000 inquiries per transaction set (ST-SE envelope).
- In order to return valid claim data on the 277, the data in the 276 must match the data on the claim.
- The hierarchy of the search criteria in the EDI system is:
  - NPI/Provider ID
  - Recipient ID
  - Recipient ID and Name must match
  - ICN

- Amount Billed
- Date of Service

### **Claim Inquiry Response Transaction (Batch)**

The 277 Transaction Set is used to transmit health care claim status inquiry responses to any health care provider, clearinghouse or other health care claims adjudication processors that have submitted a 276 to the OKMMIS.

#### **Key Notes:**

The 277 is used solely as a response to a 276 request. The 277-Unsolicited (version 3050) is not the same thing. Refer to Section H for more information on RAs and the 277-Unsolicited.

## **Section F: Eligibility Inquiries/Responses**

### **Eligibility Inquiry Transaction (Batch)**

The ASC X12N 270 Eligibility Inquiry Transaction set is used to transmit health care eligibility benefit inquiries from health care providers, clearinghouses and other health care adjudication processors.

#### **Key Notes:**

The 13-Month Rule – The only time to get 13 months of retrospective eligibility is at the beginning of a month. Checking at the end of the month allows you to review the past 12 months in addition to the upcoming month. Eligibility is updated toward the end of the month.

#### **Inquiry Types:**

- Type of insurance plan.
- Type of service performed.
- Where the service is performed.
- Where the inquiry is initiated.
- Where the inquiry is sent.

When identifying a recipient/subscriber based on the information on a 270 request, the following combinations of data are valid:

- Recipient ID only
- SSN and DOB

- SSN and name
- DOB and name
- No more than 99 inquiries per ST-SE transaction set

### Eligibility Inquiry Transaction

The ASC X12N 271 Eligibility Response Transaction set is used to respond to health care eligibility benefit inquiries as the appropriate mechanism.

#### Key Notes:

- The eligibility information returned is not a guarantee of claims payment.
- A value of 1 will be returned in the 271 response for a member with active coverage. This is indicated in loop 2110C-EB01.

## Section G: Remittance Advice (RA)

### 835 Remittance Advice

The 835 Transaction Set will only be used to send an Explanation of Benefits (EOB) RA. For SoonerCare, payment is separate from the EOB RA and will therefore not be affected by changes to how the provider receives payment – via paper or electronically. The 835 transaction will be available to OHCA providers and contracted clearinghouses requesting electronic remittance advice (ERA).

The 835 Transaction does not accommodate notification of a claim status of pending/suspended/under review. SoonerCare provides a supplemental transaction that provides claim status information on pending claims. This transaction is the 277 Health Care Payer Unsolicited Claim Status (X12 version 3050) and is available to every OHCA provider and contracted clearinghouse requesting ERA.

#### Key Notes:

- Requests for changes in the delivery of an RA must be made in writing to the EDI team.
- ERAs may be combined and/or sent to a designated receiver via the provider's secure Internet account.

## Section H: Electronic Claims/PAs with Paper Attachments

An attachment cover sheet, form HCA-13, is available for every attachment to be submitted with electronic claims or electronic PA requests. HCA-13 allows claims or PA request submitters to continue billing their claims or PA requests electronically, even if an attachment needs to be sent with the claim or PA request.

To ensure proper handling of attachments:

- The Attachment Control Number (ACN) in the PWK segment in the electronic claim or the Control field of the direct data entry page on SoonerCare Provider Portal must be identical to the ACN field on HCA-13. (See Section F of the Claims Completion chapter in this manual.)
- The provider and recipient numbers on the claim must match the provider and recipient numbers on form HCA-13.
- Each submission of a claim must have a new ACN. If resubmission of a claim occurs, a counter after the original number is suggested.
- All ACNs must be unique.
- The number must be clear and legible on the HCA-13. Please do not mark out information on the form; use a new form if a mistake is made.
- When creating ACNs, avoid using:
  - Dashes, spaces or any other special characters.
  - ICN (claim number).
  - Phone numbers.
  - Patient's date of birth.
  - Patient's SSN/FEIN.
- Copies of the Attachment Cover Sheet can be obtained:
  - In the Forms Chapter of this manual.
  - On the OHCA website at [www.okhca.org](http://www.okhca.org).
  - By calling the DXC Call Center at 405-522-6205 or toll-free at 800-522-0114



## Section I: Electronic Media Types

EDI transactions can be submitted to DXC via:

- OHCA SoonerCare Provider Portal.
- Batch upload process.

### EDI Batched Electronic Transactions

Batch transactions/files sent to DXC via the OHCA SoonerCare Provider Portal or the RAs are immediately placed in the OKMMIS for processing.

## Section J: HIPAA Transaction and Code Set Requirements

The Health Insurance Portability and Accountability Act (HIPAA) is a national effort driven by the Department of Health and Human Services (DHHS) and the Centers for Medicare and Medicaid Services (CMS) geared toward administrative simplification and electronic submission standardization. The HIPAA influences the way protected health information (PHI) is transferred and sets specific guidelines for protection of PHI used for treatment, payment and business operations.

On August 14, 2000, the DHHS issued a Final Rule for Standards for Electronic Transmissions as part of the Administrative Simplification portion of the HIPAA. Find the Final Rule at <http://aspe.hhs.gov/admsimp/final/txfin00.htm>. In October 2002, DHHS issued an addendum to the Final Rule, which was accepted in December 2002 and published in February 2003. This is the most current HIPAA compliant formatting standard for the Transaction Code Set (TCS) rule.

The OKMMIS follows the HIPAA-mandated TCS standards as set forth by DHHS and CMS.

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# Chapter 7: Claims Resolution Process

## Introduction

This chapter is designed to outline the process a claim goes through from submission to completion. By understanding this process, providers should have a better idea of how to evaluate their denied claims and how to get those claims corrected.

## Section A: Claim Creation

When paper claims are received, they are first sorted into groups related to the claim type (i.e., outpatient, inpatient, dental, physician).

Once the claims are sorted by claim type, they are scanned into the Oklahoma Medicaid Management Information System (OKMMIS). The scanners translate the information into the OKMMIS by optical character recognition (OCR). This reduces the amount of human error by allowing the system to read the claims directly.

When claims are scanned into the OKMMIS, they are assigned an Internal Control Number (ICN). This number has information regarding the claim and assists providers and OHCA when researching a claim. An example of the ICN coding orientation is found below, followed by the coding description.

### Coding Orientation: R R Y Y J J J I I I I I

Code	Description
R R	These first two digits of the ICN refer to the region code assigned to a particular type of claim. Region codes are explained later in this chapter.
Y Y	These two digits of the ICN refer to the calendar year the claim was received. For example, all claims received in calendar year 2019 would have 19 in this field.
J J J	These 3 digits of the ICN refer to the Julian date the claim was received. Julian dates are shown on many calendars as days elapsed since January 1. There are 365 days in a year, 366 in a leap year. A claim received on March 4, 2020, a leap year, would have a Julian date of 064, which indicates that March 4, 2020, is the 64 <sup>th</sup> day.
I I I I I I	The final six digits of the ICN refer to the claim number, which is assigned when the claim comes into the DXC mailroom.

Based on this information, an ICN number of 1006032123456 indicates that the claim was received on paper (region code 10), in the year 2006 (06), on February 1<sup>st</sup> (032). The remaining 6 digits

are assigned as a batch sequence number by the OKMMIS and illustrate the order in which the claim was received.

Region codes indicate the claim submission method used. More frequently used region codes are:

<b>Code</b>	<b>Description</b>
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
25	Point of service claims
26	Point of service claims with attachments
40	Claims converted from old OKMMIS
45	Adjustments converted from old OKMMIS
47	Converted history – only adjustments
49	Recipient linking claims
50	Adjustments – non-check related (recoupment/payout)
51	Adjustments – check related (refund)
52	Mass adjustments – non-check related
53	Mass adjustments – check related
54	Mass adjustments – void transaction
55	Mass adjustments – provider rates
56	Adjustments – void non-check related (recoupment)
57	Adjustments – void check related (refund)
58	Adjustments – processed by DXC SE
59	Provider reversals/voids
60	Adjustments – history only
61	Mass adjustments – history only
62	Mass adjustments – void non-check related
63	Mass adjustments – void check related
64	HMO Copay adjustments – non-check related (w/ refund)
65	HMO Copay adjustments – check related (w/out refund)
80	Claims reprocessed by DXC systems engineers
90	Special projects
91	Batches requiring manual review
92	HMO Copays – paper
94	Web HMO Copays – with attachment
99	Converted claim with duplicate ICN

## Section B: Data Entry

Once claims are scanned into the OKMMIS and assigned an ICN, the OKMMIS sends the claim to the data entry department. There, the required fields are keyed manually to verify that the information necessary to process the claim is complete and accurate. Once the claim data are entered, the OKMMIS will attempt to automatically adjudicate the claim. The claim will run through two different types of edits.

Please note that the following information regarding edits is very general and should not be considered a full and comprehensive list of all the edits used by the OKMMIS system.

### MMIS Edits

OKMMIS edits are wide-ranging edits that review the claim and details from a very general perspective. OKMMIS edits will review the claims data for accuracy and compare the claim to the member's file to check for eligibility and programs. The system will then compare the claim to the provider's file for contract effective dates and check the provider's file to ensure the provider type is eligible to receive payment for the type of services provided. Lastly, the system will check the service lines to ensure that the services being provided are covered under Oklahoma SoonerCare, as well as checking for any policy limitations regarding units allowed, prior authorizations or age restrictions.

### ClaimCheck Edits

ClaimCheck edits evaluate claims for coding accuracy. ClaimCheck employs logic from three edits: Rebundling, Incidental, and Mutually Exclusive. The Rebundling edit checks are for procedure unbundling. This occurs when two or more procedure codes are used to report a service when a single and more comprehensive procedure code exists. Incidental edits check for certain procedures performed at the same time as a more complex primary procedure and are clinically integral to the successful outcome of the primary procedure. Mutually Exclusive edits check for procedures that represent overlapping services, or different techniques or approaches that accomplish the same result.

## Section C: Resolutions

Once a claim has adjudicated, it is assigned one of four statuses by the OKMMIS system. The claim is paid, denied, suspended, or given a status of resubmit.

## **Paid Claims**

Paid claims are claims that contain services which are covered by Oklahoma SoonerCare; however, they do not always result in a payment being issued. For example, if a claim is submitted which has a primary insurance payment of \$100.00, and a SoonerCare allowable of \$75.00, the claim will be marked paid since the charges are eligible for coverage. No payment would be made under this circumstance. Additionally, if ANY lines on the claim are covered, the claim will be marked paid, even though one or more of the service lines may have denied.

Once a claim is assigned a paid status, the payment will be issued on the following financial cycle (usually on Wednesdays) and will be listed on the Paid Claims page of the provider's remittance advice (RA).

## **Denied Claims**

Denied claims are claims that have been determined not covered by Oklahoma SoonerCare. These denials may be issued for various reasons including: non-covered services, inaccurate information submitted on the claim, member's eligibility, or the provider's contract information.

Claims denied for non-covered service could be due to program restrictions or policy limitations. Providers can contact the OHCA call center for details on these denial types.

Claims denied for inaccurate information, including incorrect member's SoonerCare identification number, can be corrected by the provider and resubmitted for consideration.

Claims may be denied based on the member coverage being inactive for claim date(s) of service. Eligibility is determined by the Oklahoma Department of Human Services (OKDHS). Eligibility disputes should be directed to the member's local county OKDHS office.

In some instances, a claim may deny because of information listed on the provider's contract. The provider's contract period may have terminated, or the provider's contract type may not be eligible to bill for the service provided (for example: a family practitioner billing for dental services).

## **Suspended Claims**

Suspended claims are claims that are currently still in process. Claims suspend when they cannot be automatically adjudicated or require additional review. Suspended claims are forwarded to a resolutions department for manual review. For example, if a claim

has a primary insurance payment, the claim and attached documentation are reviewed. Remember: claims in a suspended status are still being processed and do not need to be resubmitted.

### **Resubmit Status**

Once a suspended claim has been reviewed, the resolutions department will resubmit the claim so the OKMMIS can rerun the editing process. The claims system cycles every six hours. Subsequently, a claim in resubmit status will normally adjudicate in no more than six hours. It is important to note that claims in resubmit status require no action from the provider.

### **Working Denied Claims**

Claims can be denied at either the header or detail levels. The header level contains information about the member and provider, but not about the services performed. This is where the OKMMIS will verify member's eligibility and provider's contract information. Denials at this level will cause the entire claim to be denied.

The detail level of the claim contains information specific to the services performed. The detail level verifies coverage of services, policy limitations or program restrictions. Denials at this level will deny specific service lines and not the entire claim.

Once a claim has been denied, providers have two ways to research their denials: via the SoonerCare Provider Portal or the RA.

### **RA Research**

When researching using the RA, locate the denied claims section. Once you have found a denied claim, view the header information. Any edits applying to the header information will be listed as Header EOBs. These codes are the HIPAA Adjustment Codes and contain general information about the claim. For further description of these codes, see the EOB Code Descriptions page of the RA. You may find several edits listed. Please note that not every edit listed is a denial edit. If there are no header denials, look at each detail line for edits specific to that service. These edits will be listed at the end of each detail line as Detail EOBs.

If the denial reason is still unclear, providers may contact the OHCA call center for assistance or log onto the SoonerCare Provider Portal at [www.okhca.org](http://www.okhca.org) and do additional research.

### **SoonerCare Provider Portal Research**

To research denied claims on the SoonerCare Provider Portal, go to the claim inquiry page. For information on how to get to this section, see the Web/RAs Usage chapter of this manual. On the claim inquiry screen, you may search by the denied ICN or the member ID and date of service. Once the claim has been accessed, scroll down to open the section of the claim marked “Adjudication Errors” to view the header and detail denials. The HIPAA Adjustment Code will be listed here along with a HIPAA Adjustment Remark Code, which provides more detailed information. If the denial reason is still unclear, you may select the HIPAA Adjustment Code number to view the MMIS EOB description. The MMIS EOB provides the most detailed information about the denial.

Once the reason for the denial has been determined, any inaccurate or incomplete information can be corrected, and the claim can be resubmitted for processing. If all information is accurate and complete, the claim may have been denied due to policy limitations or program restrictions.



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# Chapter 8: Paid Claim Adjustment Procedures

## Introduction

This section explains the business processes of how claim-specific adjustments and non-claim specific adjustments flow through the Oklahoma Medicaid Management Information System (OKMMIS). It is the responsibility of the adjustment department to process in a timely manner all claim-specific and non-claim-specific financial transactions. When a claim is adjusted, it is reprocessed as a new claim. When the adjustment claim processes, it may be affected by system changes made since the original claim was processed.

## Section A: Adjustment Categories

Adjustments are classified in two categories – check-related (refund) or non-check related. Check-related adjustments are classified as either full or partial. An explanation of the claim adjustment types is provided below. Adjustments are made to paid detail lines only on paid claims.

### 1.1.12 Non-Check Related Adjustments

#### Underpayment Adjustments

The provider is seeking additional reimbursement for a paid claim. The net payment to the provider is the difference between the original claim amount and the adjusted claim amount, when the adjusted claim amount is more than the original claim amount.

#### Overpayment Full Offset

The provider or the OHCA has recognized that a full overpayment for a claim occurred, and the provider or the OHCA has requested that the overpayment amount be deducted from future claim payments to the provider. After the adjustment void processes, the claim is systematically adjusted to zero and an account receivable is established for the entire amount of the claim.

#### Overpayment Partial Offset

The provider or the OHCA has recognized that a partial overpayment for a specific claim occurred and the provider has requested that the overpayment amount be deducted from future

claim payments. The historical data for the claim are adjusted and an account receivable is established for the overpayment amount.

## **Check-Related Adjustments**

### **Full Claim Refund**

The provider or the OHCA has recognized that a full overpayment for a claim occurred and the provider issues a refund check for the entire claim payment. During the claim adjustment process, the refund amount is applied to the claim and the original claim is systematically adjusted to zero.

### **Partial Claim Refund**

The provider or the OHCA has recognized that a partial overpayment for a specific claim occurred and the provider issues a refund check for the overpayment. The refund amount is applied to the adjustment claim during processing and the historical data for the claim are adjusted.

## **Negative Adjustment Amounts (Overpayments)**

If a claim is incorrectly adjudicated and the provider receives an overpayment, the provider is required to immediately take action with one (1) of the following options:

- 1) Mail a check in the amount of the overpayment along with a completed adjustment request form (HCA-14 for UB-04 and IP/OP Crossover, or HCA-15 for CMS 1500, Dental and Crossover Part B).

Please send check to:

**OHCA – Finance**

P.O. Box 18299

Oklahoma City, OK 73154; or

- 2) Void the claim on the SoonerCare Provider Portal to set up a recoupment; or
- 3) Complete an adjustment request form (HCA-14 or HCA-15) and submit it according to the instructions provided on the form.

In addition to completing one of the options listed above, include a copy of the paid remittance advice (RA) and a copy of the corrected claim, which applicable; a copy of the

Medicare EOMB; and/or a copy of the insurance EOB.  
Please send correspondence to:

**OHCA – Adjustment Unit**  
4345 N. Lincoln Blvd.  
Oklahoma City, OK 73154-0299

If the payment is not received, recoupment procedures will be initiated by the OHCA.

When a claim has resulted in a recoupment, the amount of the overpayment will appear on your remittance advice as NET OVERPAYMENT (AR) and the amount of the overpayment will be listed. This amount will be deducted from the current remittance net payment. If the AR amount is larger than the net payment, it will carry over to future remittances until satisfied. A summary of the recoupment activity is reported on the financial transactions page of the RA as well as the summary page.

### **Positive Adjustments (Underpayments)**

If a claim is incorrectly adjudicated and the provider receives an underpayment, the OHCA will initiate procedures to generate a payment adjustment to the submitted claim.

If the provider identifies an underpayment error to a paid claim, the provider may request a payment adjustment by submitting:

1. A completed adjustment request form (HCA-14 for UB, Inpatient/Outpatient crossover, or HCA-15 for 1500, Dental or Crossover Part B) for each claim requested for adjustment.
2. A copy of the paid RA or detailed explanation of the paid information and a copy of the corrected claim. If applicable, a copy of the Medicare EOMB and/or copy of the insurance EOB.
3. Any additional documentation – including sterilization consent form, hysterectomy acknowledgment, abortion certification or patient certification for Medicaid funded abortion. These documents must be attached to the adjustment request in order to assist the OHCA in making proper determination

All documentation is mailed to:

**OHCA – Adjustment Unit**  
4345 N. Lincoln Blvd.  
Oklahoma City, OK 73154-0299

## **OHCA Review**

Each adjustment request is reviewed for proper documentation and OHCA policy and procedural compliance. Requests failing to meet these requirements will be returned to the provider for the missing information.

## **Section B: Adjustment Types and Workflow**

Adjustments are typically initiated by the provider but may also be requested by the OHCA. The provider completes an adjustment request form and forwards it to the specified adjustment address on the form.

### **Non-Check Related Adjustments (regions 50 and 56)**

Non-check-related adjustments are defined as provider requests for additional payment, which are referred to as:

- An underpayment adjustment, or
- Provider requests for an overpayment amount to be deducted from future claim payments (referred to as an offset adjustment).

Offset adjustments are further categorized as full-claim offsets or partial-claim offsets. Non-check-related adjustments are processed through the OKMMIS.

### **Check-Related Adjustments (regions 51 and 57)**

Check-related adjustment requests are cash receipts received and dispositioned as claim-specific refunds to the OHCA. The refunded dollar amount is posted to the specific claim as the adjustment is processed in the OKMMIS. A reason code, indicating the source of the refund, is typed in the adjustment record. This allows the system to categorize the refunds into provider, SURS and TPL recoveries for cash management reporting. Check-related adjustments are processed through the OKMMIS.

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# Chapter 9: Third Party Liability

## Introduction

Private insurance coverage generally does not exclude an individual from receiving Oklahoma SoonerCare benefits. Many SoonerCare members have other insurance in addition to SoonerCare. Insurance may be a commercial group plan through the member's employer, an individually purchased plan, Medicare, or insurance available as a result of an accident or injury. For most Oklahoma members, SoonerCare supplements other available coverages and is primarily responsible for paying the uncovered medical expenses.

To ensure that the OHCA does not pay expenses covered by other sources, federal regulation (*42 CFR 433.139*) established the OHCA as the payer of last resort. This means that if an OHCA member has any other resource available to help pay for the cost of his or her medical care, that resource must be used prior to the OHCA. Other resources include, but are not limited to

- Commercial health insurance policies, both group and individual.
- Medicare.
- TRICARE, formerly known as CHAMPUS.
- Indemnity policies that pay a fixed per diem for hospital or nursing home services.
- Auto insurance.
- Homeowner's insurance.
- Worker's compensation.
- Other liability insurance.

In Oklahoma, the Victim Compensation Act and Indian Health Services are the only resources that do not have to be used prior to the OHCA.

## **OHCA Third Party Liability Program**

The OHCA Third Party Liability (TPL) program is charged with ensuring compliance with federal and state TPL regulations. The program has two primary responsibilities:

1. To identify OHCA members who have third party resources available.
2. To ensure that those resources pay prior to the OHCA.

The OHCA has full authority to fulfill these responsibilities. The OHCA member must sign an assignment of rights form, which allows the third-party payment be made directly to the OHCA. This is one of the eligibility conditions to OHCA membership. Each member must further agree to cooperate with the OHCA to obtain payment from those resources, including authorization of providers and insurers to release necessary information to pursue third party payment. TPL requirements are the same, regardless of the type of third-party resource. The TPL program fulfills its responsibilities based on whether the other resource falls under the general category of health insurance. These may include commercial policies, Medicare, and liability insurance such as auto and homeowner.

The TPL program has four primary sources of information for identifying members who have other health insurance: caseworkers, providers, data matches and discrepancy letters.

### **Caseworkers**

When a member applies for SoonerCare, the caseworker asks if the member has other insurance coverage. If so, the caseworker obtains all available information about the other policy and updates the member's file, which will update the OKMMIS with that information.

### **Providers**

During the OHCA member's medical appointment, providers must ask if the member has other insurance coverage. If so, the provider obtains information about the other policy and provides it to the OHCA by written notice, phone call or inclusion on a claim form. Providers should request that the OHCA member sign an assignment of benefits authorization form. This form should state that the member authorizes the insurance carrier to reimburse the provider directly.



### **Data Matches**

The OHCA uses private vendors, Health Management Systems (HMS) and DXC Technology (DXC) to perform regular data matches between OHCA members and commercial insurance eligibility files. Data matches are performed with all major insurers, including Blue Cross and Blue Shield, Aetna, Cigna, HealthChoice and others.

### **Discrepancy Letter**

The discrepancy letter is used to update the OHCA member's file. This letter will be mailed to a provider when there is a TPL payment indicated on a paid claim, but no TPL is shown in the DXC system. The completed discrepancy letter can be faxed or mailed to the TPL unit. The unit verifies the information prior to updating the system. This form can be downloaded from the OHCA website. It is in the Forms section under TPL forms. Regardless of the source, all TPL coverage information is stored in the DXC system and available to providers through the Eligibility Verification System (EVS).

## **Section A: Services Exempt from Third Party**

### **Liability/Cost Avoidance Requirements**

To increase overall savings to the OHCA, the Centers for Medicare and SoonerCare Services (CMS) encourage three types of medical services:

1. Pregnancy care.
2. Prenatal care.
3. Preventive pediatric care, including Early Periodic Screening Diagnosis and Testing (EPSDT).

To help ensure that providers are not deterred from providing these services, federal regulations exempt claims for these types of care from the cost-avoidance requirement. Providers that render any of these exempted services are still permitted, but are not required, to bill available third-party resources. Claims for these services, identified by the diagnosis codes, bypass the normal cost-avoidance process.

### **Cost Avoidance**

When a provider determines that a member has an available TPL resource, the provider is required to bill that resource prior to billing the OHCA. If the EVS indicates TPL resource information and the

provider submits a claim to the OHCA without documentation that the third-party resource was billed, federal regulations (with a few exceptions as described in Section B of this chapter) require that the claim be denied. This process is known as cost avoidance. When a claim is cost avoided, the provider must bill the appropriate third party. If that resource denies payment or pays less than the OHCA would have paid, the provider can rebill the OHCA. Providers must be fully aware of and comply with the procedures outlined in this chapter to prevent claims from being erroneously cost avoided.

### **Liability Insurance**

Unlike health insurance, liability insurance is generally available only under certain circumstances. For example, an auto insurance liability policy covers medical expenses only if expenses are the direct result of an auto crash and the policy's insured is liable. However, if there is medical payments coverage under the auto policy of the vehicle in which the member was injured, the member must only establish that the injuries are accident related. He or she does not have to establish liability to pursue a medical payments' claim. Under homeowner's and other property-based liability insurances, the at-fault party's liability generally must be established before an injured member is reimbursed for medical expenses related to the injury, unless there is a separate medical payments coverage available under the policy. In that case, to obtain medical payment benefits, the member would typically only have to establish they were injured on the property. Because of the circumstantial nature of this coverage, the OHCA does not cost avoid claims based on liability insurance.

If a provider is aware that a member has been in an accident, the provider can bill the OHCA or pursue payment from the liable party. If the OHCA is billed, the provider must note that claims are for accident-related services by marking the appropriate box in field 10 on form 1500, listing the appropriate occurrence code on form UB-04; or entering the appropriate Related Causes Code in data element 1362 on form 837 Professional (837P) or 837 Institutional (837I) electronic transaction. Providers that choose to initially pursue payment from the liable third party must remember that claims submitted to the OHCA after the one-year timely filing limit are denied.

When the OHCA pays claims for accident-related services, the TPL program performs post-payment research, based on trauma diagnosis codes, to identify cases with potential liable third parties. When third parties are identified, the OHCA presents all paid claims associated with the accident to the responsible third party for

reimbursement. Providers are not normally involved in this post-payment process and are not usually aware that the OHCA has pursued recoveries. Providers may contact the TPL unit with questions about TPL case procedures and are encouraged to report all identified third party liability cases to the TPL unit. For example, if a provider receives a record's request from an attorney regarding a third-party liability case, providers are encouraged to notify the TPL unit of these requests.

## Section B: TPL Claim Processing Requirements

This section outlines provider responsibilities for supporting cost containment through timely identification and billing of primary insurers. Providers are required to bill all other insurance carriers prior to billing the OHCA, except for programs that are secondary to the OHCA. The TPL Unit is available to assist with determining other insurance resources and maintaining the most current member TPL files.

### Documentation Requirements

The OHCA must deny claims if there is evidence that TPL exists and documentation indicating that the third party was billed is not submitted with the claim. To prevent claims from being denied, providers must be aware of responsibilities concerning third parties and comply with the procedures described in this chapter.

### Third Party Liability Identification

Prior to rendering a service, the provider must verify that the member is eligible. Use the EVS described in the Member Eligibility chapter of this manual to check eligibility status for all members. Additionally, the EVS should be used to verify TPL information so providers can determine if another insurer is liable for all or part of the bill. EVS has the member's most current TPL information, including, the insurance carrier, benefit coverage and policy numbers. In some cases, it is not possible to determine by the EVS if a specific service is covered. If a specific service does not appear to be covered by the stated TPL resource, providers must still bill that resource to receive a possible denial or payment. For example, some insurance carriers cover optical and vision services under a medical or major medical plan. Medical services that are covered by a primary insurer must be billed first to the primary insurer. If there is no other insurer indicated on the EVS and the member reports no additional coverage, bill the service to the OHCA as the primary payer.

When the EVS shows a member is a qualified Medicare beneficiary (QMB) only or a specified low-income Medicare beneficiary (SLMB)

only, the provider should contact Medicare to confirm medical coverage. Failure to confirm medical coverage with Medicare could result in claim denial because the Medicare benefits may have been discontinued or recently denied. The OHCA pays the Medicare premiums for SLMB only and QMB only members but does not provide medical coverage. The coinsurance and deductible are covered for members with Medicare entitlement.

### **Prior Authorization**

A service requiring OHCA's prior authorization (PA) must be satisfied to receive payment from the OHCA, even if a third party paid a portion of the charge. The only exception is when the third-party payer is Medicare Parts A or B and Medicare allows in whole or in part for the service.

### **Billing Procedures**

When submitting all claims, the amount paid by a third party must be entered in the appropriate field on the claim form or electronic transaction.

If a third-party payer made payment, an explanation of payment (EOP), explanation of benefits (EOB), or remittance advice (RA) is not required for electronically submitted claims.

When a member has other insurance and the primary insurer denies payment for any reason, a copy of the denial such as an EOP, EOB or RA must be attached to the OHCA claim or the claim will be denied.

If an EOP, EOB or RA cannot be obtained, attach to the claim a statement copy or correspondence from the third-party carrier.

When billing the OHCA for the difference between the amount billed and the primary insurer's payment, the OHCA pays the provider the difference, up to the OHCA allowable charge. If the primary insurer payment is equal to or greater than the allowable charge, no payment is made by the OHCA. In this instance, the provider is not required to send the claim to the OHCA for processing. Providers cannot bill members for any balance.

### **Non-Covered Services or Lifetime Maximum Exceeded**

When a service that is repeatedly furnished to a member and repeatedly billed to the OHCA is not covered by the third-party insurance policy, a provider can submit photocopies of the original denial for up to one year from the date of the original denial. The provider should write Non-Covered Service on the insurance denial when submitting copies for billing purposes. For example, if an

insurer denies a claim for skilled nursing care because the policy limits are exhausted for the calendar year, that same denial could be used for subsequent skilled nursing care related claims for the duration of that calendar year. The denial reason must relate to the specific services and timeframes of the new claim.

### **Subsequent Third-Party Liability Payment**

TPL payments received by providers for claims paid by the OHCA cannot be used to supplement the OHCA allowable charges. If the OHCA paid the provider for services rendered and the provider subsequently receives payment from any other source for the same services, the OHCA payment must be refunded within 30 days. The refund should not exceed the OHCA payment to the provider. Checks must be made payable to the OHCA and mailed to:

**OHCA Finance Unit**  
P.O. Box 18299  
Oklahoma City, OK 73154

### **Remittance Advice Information**

If a claim denies for TPL reasons, Electronic RAs identify this information with the adjustment reason and adjustment remark codes. If the provider has information that corrects or updates the TPL information provided on the RA, follow the procedures for updating TPL information. For additional information, refer to the Member Third Party Liability Update Procedures section in this chapter.

### **Insurance Carrier Reimburses OHCA Member**

Providers with proof that an OHCA member received reimbursement from an insurance carrier should follow these steps:

1. Contact the insurance carrier and advise them that payment was made to the member in error. Request that a correction and reimbursement be made to the provider.
2. If unsuccessful, the provider must bill the member for the services. In future visits with the OHCA member, the provider should request that the OHCA member sign an assignment of benefits authorization form. The form states the member authorizes the insurance carrier to reimburse the provider. This process might result in reimbursement to the provider.

## Section C: Coordination with Commercial Plans

Specific guidelines must be followed to receive payment from the OHCA when submitting claims for a member enrolled in private preferred provider organization (PPO) or private health maintenance organization (HMO) plans.

### HMO Billing OHCA

The OHCA reimburses providers for copayments and services not covered by commercial plans incurred by OHCA members under a capped arrangement.

#### Copayment Billing

In 2001, the OHCA implemented a procedure for providers to bill the OHCA for HMO copays on eligible SoonerCare recipients enrolled in private health plans and Medicare Replacement HMOs.

The appropriate claim form (UB-04 or 1500) should be used. At the top of the paper claim form, print in large letters: "HMO copay." Use the appropriate procedure code. However, provide only the desired copay reimbursement amount due in box 24F and 29 on the 1500 claim form and box 47, the TOTALS box, and box 55B on the UB-04.

The paper claim forms should be mailed to:

**DXC Technology**  
P.O. Box 18500  
Oklahoma City, OK 73154

HMO copay claims can also be billed on the SoonerCare Provider Portal. When submitting a claim on the portal, select "yes" on the drop-down box labeled "HMO COPAY." These claims must be billed with the desired copay reimbursement amount and an EOB must be attached. Do not bill total charges or the claim will be denied.

Claims will be subject to all other applicable regulations. If you have any questions, please call the OHCA at 405-522-6205 or 800-522-0114.

#### Covered and Non-covered Services Billing

When billing for services not covered under the member's plan, the provider bills the OHCA and indicates carrier denied in the TPL amount on forms 1500 or 837P. The provider must attach a copy of the statement from the capped plan that indicates the service is not covered. The OHCA requires that a member follow the rules of his or her primary insurance carrier. Therefore, if the primary insurance

carrier requires the member to be seen by in-network providers only or payment will be denied, the OHCA does not reimburse for claims denied by the primary carrier because the member received out-of-network services. However, if the primary carrier pays for out-of-network services at the same rate as in-network services or at a reduced rate, the provider may submit the bill to the OHCA. Also, if the primary insurance carrier pays for out-of-network services but does not pay a particular bill in full due to a deductible or copayment, the provider may still submit the bill to the OHCA. If no payment or a partial payment was made by the primary carrier, this should be indicated on the claim form, and documentation from the carrier noting the deductible or copayment amount must be attached to the claim.

## Section D: Medicare-OHCA Related Reimbursement

Many OHCA members are eligible for SoonerCare and Medicare. These individuals are called dually eligible. According to TPL regulations, Medicare is treated just as any other available resource. Thus, when an OHCA member is also enrolled in Medicare, providers must bill Medicare prior to submitting a claim to the OHCA for reimbursement. For an OHCA provider to receive reimbursement from Medicare, the provider must be enrolled in the Medicare program. Providers can be enrolled in Medicare as participating or nonparticipating. Medicare participating providers receive payment directly from Medicare. Medicare benefits for nonparticipating providers are paid directly to the OHCA member.

In either scenario, the OHCA pays the coinsurance and deductibles. If a provider is not enrolled in Medicare, either as participating or nonparticipating, the member should be referred to a Medicare/SoonerCare dually enrolled provider. OHCA reimbursement is not available to a non-Medicare enrolled OHCA provider who renders service to a Medicare/SoonerCare dually eligible member.

### Medicare Enrolled Participating Provider Reimbursement Process

When a provider is enrolled with Medicare, the Medicare payment is made directly to the provider. The provider accepts Medicare's allowable amount and the patient is not responsible for the disallowed amount. The OHCA is only responsible for the deductible and coinsurance. For example, the charge is \$150, the allowable amount is \$100, \$50 is disallowed, the deductible is \$25 and coinsurance is \$15. Medicare pays \$60; the provider absorbs \$50. The OHCA pays \$40. The member is not responsible for any charges.

## Medicare Enrolled Non-participating Provider Reimbursement Process

When a nonparticipating provider is enrolled with Medicare, the Medicare payment is made to the member. The member is responsible for the complete charge, as the provider does not accept assignment. For example, the charge is \$150, the allowable amount is \$100, the disallowed amount is \$50, the deductible is \$25 and the coinsurance is \$15. The patient is billed for \$150. Medicare reimburses the patient \$60 and the patient is responsible for paying the remaining \$50.

The OHCA SoonerCare member must be referred to a Medicare/OHCA SoonerCare provider to receive the best benefit.

## Crossover Claims

It is important to remember that providers must include the correct Medicare identification number for a claim to crossover automatically. The following information concerns crossover claims:

- If a provider does not receive the OHCA payment within 60 days of the Medicare payment, claims that did not crossover should be submitted electronically.
- If the member has a Medicare supplement policy, proof of filing with the Medicare supplement carrier as well as Medicare must be submitted with the OHCA claim or the claim will deny.
- If the member has a Medicare supplement policy, the claim is filed with Medicare and automatically crosses over to the Medicare supplement carrier rather than the OHCA for payment of coinsurance and deductible. After the provider receives all EOBs, the provider must submit the claim and EOBs to OHCA.
- **NOTE:** If the TPL benefit code has been entered incorrectly as a hospitalization (A) or medical (C) versus Medicare Supplemental Part A (O) or Medicare Supplemental Part B (P) for the supplemental policy, the claim crosses directly to the OHCA and may be paid without proof of filing with the Medicare supplement carrier. These situations generally result in OHCA overpayments that must be refunded immediately. To prevent overpayment, a provider that identifies enrollees with a Medicare supplemental policy conveyed as an A or B on EVS can request a TPL file update by sending a copy of the enrollee's Medicare supplemental insurance card to the TPL Unit.



Providers whose claims are not crossing over automatically should contact Provider Enrollment to verify that OHCA has your Medicare provider number correctly in the system.

### **Prior Authorization**

Prior authorization is not required for members with Medicare Part A and Part B coverage if the services are covered by Medicare and Medicare pays for the services in whole or in part. Services not covered by Medicare are subject to normal prior OHCA authorization requirement restrictions, referral and prior authorization requirements of SoonerCare.

### **Medicare Non-Covered or Denied Services**

Claims for services not covered by Medicare will crossover to OHCA and be denied. The claim must be resubmitted to the OHCA's P.O. Box 18506, Oklahoma City, OK 73154 address, with a copy of the Medicare RA and the HCA-17 form attached. These claims are treated as any other TPL claim. Certain services are excluded and never covered by Medicare; therefore, the OHCA can be billed first for these services, bypassing the requirement to bill Medicare first. This applies to Medicare supplements as well. Otherwise, OHCA benefits can only be paid to the provider of services after Medicare payment or denial of payment occurs.

### **Other TPL Resources**

If the member has other insurance on file that covers those services not covered by Medicare, the other insurance resources must be billed before the OHCA.

## **Section E: Member TPL Update Procedures**

Other insurance information is entered into the DHS system by the caseworker when a member is enrolled in the OHCA. The information is transmitted electronically via real-time transaction to the OHCA. The county office and the OHCA TPL Unit update TPL information. The TPL Unit is the primary entity for maintaining TPL information about the member. Providers who receive information about OHCA members from insurance carriers that is different from what is listed on EVS can forward the information to the TPL Unit. Information about additional insurance coverage or changes in insurance coverage must be relayed to the TPL Unit as soon as possible to keep member files current and to assist in accurate provider claim processing.

## **Automated Recovery, Resource Data Request Letters and Questionnaires**

Automated discrepancy letters and questionnaires are sent to insurance carriers, members, and providers when recoveries are initiated or TPL resource data are requested. When the TPL data are verified, the system is updated accordingly. As a result, providers have access to the most current insurance billing information through the eligibility verification system (EVS) applications or the automated voice response (AVR) system. When a discrepancy letter is received, providers must thoroughly complete the form and return it to the TPL Unit via fax or mail. The address is indicated on the form.

Providers may access and use the discrepancy letter, and TPL Accident/Injury Questionnaire on the OHCA website. When a questionnaire is completed, the provider can fax or mail it to the DXC TPL Unit. The TPL Unit verifies and investigates the information prior to updating the system.

## **General Update Procedures**

When forwarding update information to the TPL Unit, indicate the member identification (RID) number and any other pertinent member or carrier data on all correspondence. Copies of letters, RA, EOB or EOP information from other insurance carriers are important for maintaining member TPL file information. Carrier letters, RAs, EOPs or EOBs that document coverage must substantiate any requested changes. Mail the above information concerning other insurance coverage to:

### **TPL Unit**

Third Party Liability Update  
4345 N Lincoln Blvd.  
Oklahoma City, OK 73105

The TPL discrepancy letter can be downloaded from the OHCA website. When completed, providers should fax or mail it to the address indicated on the letter.

The TPL Unit can be reached by phone at 800-522-0114 and selecting option 3 then 2.

The TPL Unit reviews and verifies the OHCA member insurance information, coordinates with the carrier, if required, and makes necessary changes to the TPL file in the OHCA system to accurately reflect member TPL coverage. Providers can confirm the update with EVS or by calling the TPL Unit. Allow 10 business days from the date of receipt for the OHCA member's file to be updated.

## Telephone Inquiry Procedures

To discuss other insurance issues, providers should contact the TPL Unit using the telephone numbers below from 8 a.m. to 5 p.m. Monday through Friday, excluding holidays:

### **Third Party Liability Unit**

800-522-0114 *Option 3, 2*

Fax: 405-530-3478

When calling the TPL Unit, have the member's identification number available. This telephone inquiry function is limited to TPL issues. Direct general provider inquiries to the OHCA Call Center.

**NOTE:** *OHCA cannot provide information about benefits covered under each coverage type. Providers should contact the insurance carrier for this information.*

## Written Inquiry Procedures

Documentation must substantiate each change made to a member's TPL file. If changes to member files are necessary, providers must forward copies of information from other insurers that document the member's TPL information to be updated.

When forwarding update information to the TPL Unit, indicate the member's name; RID number; copy of EOB, RA, member's third party insurance card, letter from carrier and any other correspondence that will help maintain the member's TPL file. The TPL Unit verifies all TPL information submitted with the respective insurance carrier. Mail information about other insurance coverage to:

### **OHCA TPL Unit**

Third Party Liability Update

4345 N Lincoln Blvd.

Oklahoma City, OK 73105

## Summary

The following is a summary of the steps used to revise member TPL:

- When a policy is terminated, a patient was never covered, or the insurance carrier has a different billing address than on the TPL resource file, the provider sends the updated TPL information to the TPL Unit.
- If the provider sends documentation from the insurance carrier, the member's TPL file is updated with the corrected information within 10 business days from the date of receipt by the OHCA.

- If the provider sends in documentation that is not from the insurance carrier (discrepancy letter, copy of insurance card, handwritten note, etc.), the TPL unit will contact the insurance carrier to verify the other insurance information and if appropriate, update the system within 10 business days of receipt.
- The provider does not need to delay filing a claim; however, notifying the TPL Unit of updated TPL data will make subsequent billing easier.
- The provider can download the TPL questionnaire and discrepancy letter form from the OHCA website.
- Do not send TPL-related claims to the TPL unit for processing.

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# Chapter 10: Prior Authorization

## Introduction

Under the Oklahoma SoonerCare program, there are services that require prior authorization (PA) by the Oklahoma Health Care Authority (OHCA). To obtain additional information on PAs and a list of services that require PA, go to the OHCA website at [www.okhca.org](http://www.okhca.org).

All services requiring PA will be authorized based on the service procedure code. The OHCA authorization file will reflect the service codes authorized. A PA number will be assigned, and a notice generated to the medical provider. The notice of authorization will contain the PA number, the service/procedure code authorized, and the number of units or dollar amount allotted. Notices will be provided online for providers using Web services or by email for all other providers.

## Section A: Prior Authorization Requests

### Medical and DME Requests

Requests processed by the Medical Authorization Unit (MAU) such as durable medical equipment (DME), high tech imaging, medical procedures and supplies, or occupational/physical/speech must be submitted electronically thru the SoonerCare Provider Portal. All appropriate forms, if applicable, and supporting medical documentation should be uploaded at the time of the initial Prior Authorization submission.

### Dental Requests

Dental prior authorization requests (PAR) may be submitted electronically through the SoonerCare Provider Portal or by mail.

#### Provider Portal PA Submission:

How to submit [Dental Basics and Beyond](#).

#### Mail/Paper Dental PA Submission:

Submit paper/mailed requests for dental prior authorization requests (PAR) to:

**DXC/Dental Authorization**  
P.O. Box 548804  
Oklahoma City, OK 73154

All prior authorization requests must demonstrate medical necessity. Providers have seven (7) days to submit additional

information for any PAR that was placed in a pending status for additional documentation requirements. After seven (7) days, the PAR will “system cancel” and the provider must submit a new PAR with all necessary documentation.

### **Dental PAR Requirements:**

Minimum required records to be submitted include *all* the following:

- Comprehensive treatment plan.
- Right and left identified bitewing X-rays or panoramic X-ray.
- Periapical film(s) of tooth/teeth involved or the edentulous areas (if not visible in bitewings), tooth number identified and dated; all images must be of diagnostic quality.
- Requests for **scaling and root planning** must include periodontal charting, in addition to the records listed above.

**Comprehensive orthodontic requests** must include the following:

- Caries Risk Assessment.
- Completed HLLD form.
- Referral letter from the member’s general dentist.
- Cephalometric X-ray with tracing.
- Panoramic X-ray.
- 3-D model images or study models (images preferred).
- Detailed description of any oral maxillofacial anomaly; if diagnosed as a surgical case, submit an oral surgeon’s written opinion that orthognathic surgery is indicated and the surgeon is willing to provide this service.
- Estimated length of treatment.
- Intraoral photographs showing teeth in centric occlusion and/or photographs of trimmed anatomically occluded diagnostic casts; a lingual view of casts may be included to verify impinging overbites.

**NOTE—RECORDS WILL NOT BE RETURNED. We are unable to accept faxed PAR submissions.**

## Pharmacy Requests

Requests for PA for prescription medication should be submitted on the appropriate pharmacy PA forms. These forms are available on the OHCA website at [www.okhca.org](http://www.okhca.org). The University of Oklahoma's College of Pharmacy, Medication Coverage Authorization Unit (MCAU), approves or disapproves each medication authorization request on behalf of the OHCA.

### Fax Pharmacy Prior Authorization Request Forms to:

Toll Free: 800-224-4014  
Metro Area: 405-271-4014

### OHCA Pharmacy Help Desk:

Toll Free: 800-522-0114, *option 4*  
Metro Area: 405-522-6205, *option 4*

### Pharmacy PA Forms:

<http://www.okhca.org/rxforms>

### Pharmacy PA Criteria:

<http://www.okhca.org/rxPA/>

## Outpatient Rehabilitative Behavioral Health, Licensed Behavioral Health Professionals and Psychologist Services

Public and private outpatient behavioral health agencies, and private independent licensed practitioners must complete the Customer Data Core (CDC) Form and submit to the OHCA designated behavioral health utilization management and quality improvement organization. Currently this information must be submitted via the PI Client Information System (PICIS) found at <https://ww4.odmhsas.org/cdc/>. The information provided for pre-admission is brief and is primarily used to track the utilization of various services.

Preadmission services do not require clinical review and will be approved unless the member has exhausted the benefit, or another provider has requested prior authorization for additional services.

## Inpatient Behavioral Health, Detoxification, Group Home and Therapeutic Foster Care Services

Inpatient psychiatric services for SoonerCare members under the age of 21 must be prior authorized before the service is provided. Telephonic initial and concurrent reviews to determine Medical Necessity Criteria are required for the following services:

- [Acute Inpatient Care](#)
- Psychiatric Residential Treatment Facility (PRTF) Services



- Residential Behavior Management Services in Therapeutic Foster Care (TFC) Settings
- Residential Crisis Stabilization

Please contact the OHCA Inpatient Review Request Line for telephonic review contact (800) 522-0114. Please have your Provider ID number ready. Select:

- Option 1 for Provider
- Option 6 for Prior Authorizations
- Option 2 for Behavioral Health

### **Requests for Services to Illegal/Ineligible Aliens/Sooner To Be Sooners**

Illegal aliens are only eligible for emergency medical services. Requests for alien services should be submitted to the local county OKDHS office with a notification of needed medical services form, along with the history/physical and discharge summary. The county OKDHS office staff will complete the appropriate paperwork and forward all information to the OHCA Level of Care Evaluation Unit (LOCEU). LOCEU will create a new case in MEDATS and forward the documents to medical Professional Services where an Administrative Assistant (AA) checks the time between the date of service and application date for needed medical services (the time span must not exceed 20 days. The AA forwards the documents to a Medical Director who reviews the case, notes their decision on the cover sheet and returns it to the AA. The AA records the decision in MEDATS, prints the screen and a cover sheet to send to DXC for scanning. The scanned copies are returned to the AA who securely trashes the documents. MEDATS will notify the county OKDHS office of the decision(s) (the approval or denial) of the requested services. The OKDHS county office staff members are responsible for notifying the applicant and the provider of the decision.

## **Section B: Prior Authorization Process**

The OHCA staff will issue a determination for each requested medical/dental service requiring a PA. A computer-generated PA request decision form showing OHCA determination of the service is mailed to the member. The request decision form is not a confirmation of the individual's eligibility for SoonerCare, and the approved clinical period for services may extend beyond the actual period of the member's eligibility. The request decision form serves as notification of the status of a request for PA or a notice of change for the listed services.

Prior authorization represents a clinical decision regarding medical necessity but is not a guarantee of member eligibility or SoonerCare payment. It is the responsibility of the provider to verify not only SoonerCare eligibility, but also to verify program eligibility and benefit plan (example: TXIX, Insure Oklahoma) at the time of service. Factors that affect payment are correct claim completion, appropriate referral (if required), provider contract, timely filing and member eligibility.

### **Retroactive Authorization**

Medical Authorization should be requested prior to providing a service. If this is not possible due to urgent or emergency situations, the provider must request authorization within 30 days of the initial date of service. Requests received after 30 days of initial date of service will not be processed. The following conditions must be met for a retroactive medical authorization request to be approved:

1. The services rendered must be covered under the SoonerCare program.
2. The services must be verifiable and meet OHCA medical necessity criteria.

See the Forms chapter of this manual for an example of the Medical and Dental Prior Authorization request forms.

**Note:** Retro authorizations do not apply to all services, such as high-tech imaging and occupational/physical/speech therapy. It is the provider's responsibility to confirm retro limitations prior to providing services. See the MAU public webpage at [www.okhca.org/mau](http://www.okhca.org/mau) for information

## **Section C: Reconsideration and Appeal Procedures**

### **Level 1—Reconsideration**

All denial reconsiderations for medical/DME and behavioral health must be submitted as a new authorization request (see Section A). The same 30-day retroactive authorization limit applies to all reconsideration requests (i.e. the resubmitted request must be received within 30 days of the initial date of service).

The MAU will accept reconsiderations submitted via the SoonerCare Provider Portal.

Pharmacy mail or fax the new authorization request to the address below:

## Pharmacy

### University of Oklahoma College of Pharmacy

Pharmacy Management Consultants  
Medication Coverage Authorization Unit  
P.O. Box 26901  
ORI W-4403  
Oklahoma City, OK 73190  
Fax: 800-224-4014 or 405-271-4014

## Level 2—Appeal

Dissatisfaction with the results of a review may be disputed by the member only through a formal appeal by returning a completed OHCA LD-2 Form to the OHCA Legal Division within 20 days of Notice of Prior Authorization receipt. Individuals may represent themselves, have another party represent them or have an attorney represent them. An LD-2 form may be obtained from the OHCA website at [www.okhca.org](http://www.okhca.org), by contacting the Legal Division of the OHCA at 405-522-7217 or by sending a request to:

### OHCA Legal Division Docket Clerk

P.O. Box 18497  
Oklahoma City, OK, 73154-0497

In the appeal explain what's being appealed and the reason(s) for the appeal.

## Section D: Home & Community-Based Services (HCBS) §1915(c) WAIVER Prior Authorizations

Medicaid State Plan services are provided to waiver members. Services that are covered as an integral part of the specific waivers must be prior authorized by the entity or agency that administers the waiver under which the member receives services.

### ADvantage Waiver

6138 E. 38<sup>th</sup> Pl, 3<sup>rd</sup> Floor  
Tulsa, OK 74120

or

P.O. Box 35900  
Tulsa, OK 74153  
918-933-4900

<http://www.okdhs.org/services/aging/Pages/ADvantageservices.aspx> or  
<http://www.okhca.org/individuals.aspx?id=8143>

**Community Waiver, In-Home Supports Waiver for Adults, In- Home Supports Waiver for Children and the Homeward Bound Waiver:**

**OKDHS/Developmental Disabilities Services Division (DDSD)**

405-521-6267

<http://www.okdhs.org/services/dd/Pages/default.aspx>

**Personal Care Services:**

OKDHS – Personal care services are prior authorized by the OKDHS. Inquiries should be directed to:

**OKDHS**

Claims Unit

P. O. Box 50550

Tulsa, OK 74150 918-

933-4900

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# Chapter 11: Financial Services

## Introduction

Financial Services ensure that all funds are appropriately disbursed for claim payments and all post-payment transactions are applied correctly. The financial processing function includes generation of payments to providers and production of a remittance advice (RA) for providers that claims were adjudicated and/or financial transactions were processed. Payments are issued via electronic funds transfer (EFT). The only exceptions are personal care, individual rehab, aides, respite care and foster care.

The Financial Processing function maintains the following information:

- Payment information (checks and EFTs).
- RA reporting.
- 1099 and W-2 IRS reporting.
- Void, stop payments, re-issuance of payments.

## Section A: Payment Information

### Payments

The provider has two (2) primary methods of receiving payment from SoonerCare: system-generated checks and electronic funds transfer (EFT). These payments, along with the remittance advice, are produced during the financial cycle. The remittance advice, which details each provider's claims and financial transaction activity during the period, is made available to the billing provider through an electronic format to allow verification of billing and payments.

Checks or EFT notices are printed and sent/mailed separately from the electronic remittance advice.

### Electronic Funds Transfers (EFT)

Providers use the EFT payment option to expedite funds directly to their designated bank account. EFTs will be the default payment disbursement option for all providers unless it is proven that a provider cannot receive an EFT transaction. Those who cannot receive an EFT will receive their payment by paper check.

## Manual Payments

A less common method for provider payment receipt is the paper warrant issuance (check).

## State Agency Funds Transfers

For all state agencies participating in the Oklahoma Medicaid program, payments will be disbursed via state agency funds transfers. Since the Oklahoma Medicaid program is operated by a state agency, the funds are transferred to the corresponding state agency participating in the Oklahoma Medicaid program.

## Section B: Remittance Advice (RA)

OHCA providers receive a weekly remittance advice (RA) for any claims submitted the previous week. The RA identifies claims that are paid, denied, in process or adjusted. The RA includes the client ID number, the provider number, the Internal Control Number (ICN) of the claim processed, the date(s) of service and paid amount. The RA also details any reductions to the paid amount, for reasons such as TPL and/or client copayment. Each claim detail might have an explanation of benefit (EOB) code explaining the reason for payment, denial, adjustment or in-process statuses. RAs are tailored to individual claim form types—1500, UB-04, Dental and Pharmacy. When applicable, RAs include additional information, including procedure codes, revenue codes or admission and discharge dates for providers billing on the UB-04 claim form.

The RA has several document types in this order:

- 1 Check or EFT advice (if applicable).
- 2 Address page.
- 3 Banner messages (if applicable).
- 4 Claims activity/status reports (if applicable).
  - a. Ordered by claim type (Physician, Institutional, Dental, Pharmacy).
  - b. Ordered by claim status (paid, denied, in process, adjusted).
- 5 Financial transactions.
  - a. Expenditures (system generated only).
  - b. Cash receipts.
  - c. Accounts receivable.
- 6 TPL information (if applicable).
- 7 EOB descriptions (if applicable).
- 8 Summary report.

The RA is generated in each claim payment cycle. A provider will receive an RA if the provider has activity during the claim cycle or outstanding accounts receivable.

### **Remittance Advice Section Descriptions**

The RA contains the following information:

#### **Medicare Crossover Paid**

Claims with a paid status are shown in this RA series, including claims paid at zero.

#### **Medicare Crossover Denied**

These claims have been denied payment.

#### **Medicare Crossover in Process**

Claims in the processing cycle not finalized are listed in this RA series. Claims found here include:

- with attachments;
- past the filing limit;
- suspended;
- requiring manual pricing; and
- with adjustments that have not been finalized.

**These claims have not been denied.** Claims reflected as In Process are ultimately shown as paid, denied or adjusted on subsequent RAs. Claims in process must be monitored to final resolution.

#### **Claims Paid**

Claims with a paid status are shown in this RA series, including claims paid at zero.

#### **Claims Denied**

These claims have been denied payment.



## Claims in Process

Claims in the processing cycle that have not been finalized are listed in this RA series. Claims found here include:

- with attachments;
- past the filing limit;
- suspended;
- requiring manual pricing; and
- with adjustments that have not been finalized.

These claims have not been denied. Claims reflected as In Process are ultimately shown as paid, denied, or adjusted on subsequent RAs. Claims in process must be monitored to final resolution.

**NOTE:** *Each claim in process lists the EOB message that corresponds to the reason it has been suspended.*

## Claims Adjustments

Adjusted claims are listed in this RA series. Two header lines are shown for each adjusted claim. The first header line is for the original or *mother* claim, while the second header line is for the adjusted or *daughter* claim.

## Financial Transactions

Non-claim-specific payouts, refunds, and accounts receivable (A/R) transactions are listed in this series of the RA. A transaction number is used to uniquely identify each financial transaction. If a financial transaction is associated to a cash receipt, the cash control number (CCN) is also displayed for informational purposes. Examples of miscellaneous financial transactions tabulated in this RA section include:

1. Non claims specific payouts to a provider.
2. Refunds made to the OHCA by a provider not associated with a single claim.
3. Amounts scheduled for recoupment, which the A/R section tracks repayment of to determine amount to be recouped.

## EOB Code Descriptions

Explanation of Benefits (EOB) codes applied to submitted claims are listed along with the respective code narrative. These codes and corresponding narratives describe the reasons submitted claims were suspended, denied or not paid in full.

## Summary

Data from the entire RA series are reflected on this page. This section summarizes all claim and financial activity for each weekly cycle and reports year-to-date totals.

## Remittance Advice Sorting Sequence

Claims are shown on the RA by type and according to the following priority sequence:

### 1500

1. Alphabetically by member name.
2. Alphanumerically by patient number assigned by the provider.
3. Numerically by ICN.

### UB-04

1. Alphabetically by member name.
2. Alphanumerically by patient number assigned by the provider.
3. Numerically by ICN.

### Drug

1. Alphanumerically by prescription number.
2. Alphabetically by member name.
3. Numerically by ICN.

### Dental

1. Alphabetically by member name.
2. Numerically by ICN.

## EOB Codes

EOB codes are provided with each RA. These codes and the corresponding details describe the reason submitted claims were suspended, denied, or not paid in full. Because the claim can have edits and audits at both the header and detail levels, EOB codes are listed for both header and detail information. A maximum of 20 EOBs are listed for the header, and a maximum of 20 EOBs are listed for each detail line. Exceptions are suspended claims, which have a maximum of two EOBs per header and detail. **These are not denial codes, but rather the reason the claim is being reviewed.** EOB data are listed immediately following the claim header and detail information beside the caption of

the EOB. EOB 00 lists header codes, EOB 01 lists line one of the claim's codes, and EOB 02 lists line two of the claim's codes. If there are no EOBs posted for a particular EOB XX line, the line is not printed. Explanation of benefits and denial information are provided in HIPAA compliant formats.

For more detailed EOB and denial information, providers are encouraged to use the OHCA SoonerCare Provider Portal available at [www.okhca.org](http://www.okhca.org). Once there, use the claim inquiry option. An additional resource for this information can be found by calling 800-522-0114 and selecting option 1, for claim status.

For more information about HIPAA, please visit: [www.cms.hhs.gov](http://www.cms.hhs.gov)

For a detailed listing of these new HIPAA codes, visit: [www.wpc-edi.com/ClaimAdjustment\\_40.asp](http://www.wpc-edi.com/ClaimAdjustment_40.asp)

### Remittance Advice Examples

The following pages display examples of the OHCA RA and detailed information regarding the statements. The illustrative samples give examples of where the data are found on the RA document. Examples that follow the illustrative samples include claims adjudication pages for each claim type. The examples are a representative sample of what a provider might see on an RA. This is not a comprehensive listing for each claim type.

Field	Description	Field Type	
Additional Payment	Provides the additional payment amount when the adjustment results in a positive paid amount.	Number	9
Address	Payee's address.	Character	31
Admit Date	The date member was admitted to hospital.	Character	6
Allowed (Compound Drug ADJ)	Computed detail-level dollar amount allowable for dispensed drug under the medical assistance program being billed.	Number	9
Allowed Amount (Compound Drug)	The computed detail level allowed amount for dispensed drug under the Medical assistance program being billed.	Number	9
Allowed Amount (Home Health)	The computed detail level amount allowable for the services rendered under the Medical assistance program being billed. Adding all the allowable amounts for all the services described on the detail lines arrives at this amount.	Number	9
Allowed Amount (Dental)	The computed dollar amount allowable for services rendered on each detail line under the Medical Assistance Program being billed. May occur 12 times depending on the number of detail lines billed.	Number	9
Allowed Amount (Compound Drug)	The computed dollar amount for the dispensed drug under the Medical Assistance Program being billed. This amount is determined by totaling prices of all ingredients used to formulate the compound.	Number	9
Allowed Amount (LTC ADJ)	This is the computed allowable amount for the services billed. The data displayed pertain to the adjusted claim.	Number	9

Field	Description	Field Type	
Allowed Amount (CMS-1500 ADJ)	The computed dollar amount allowable for the services rendered under the Medical Assistance Program being billed. Adding all the allowable amounts on all the detail lines arrives at this. The first amount (credit) displayed is for the original claim. The amount for the adjusted claim is displayed under the amount for the original claim. These numbers may vary.	Number	9
Attending Prov	Number used to identify provider performing the service.	Number	10
Billed Amount	Dollar amount billed by provider for the claim.	Number	9
Billed Amount (LTC Denied)	Dollar amount requested by the provider for the service billed on each detail line. May occur 23 times depending on number of detail lines billed.	Number	9
Billed Amount (Dental)	Dollar amount requested by the provider for the service billed on each detail line. May occur 12 times depending on number of detail lines billed.	Number	9
Billed Amount (CMS-1500 ADJ)	The total dollar amount requested by the provider for the services billed on all the detail lines. Adding all the billed amounts on all the detailed lines will arrive at this amount. The first amount (credit) displayed is for the original claim. The amount for the adjusted claim is displayed under the amount for the original claim.	Number	9
Billed Amount (LTC ADJ)	Dollar amount requested by the provider for the service billed on each detail line. May occur 23 times depending on number of detail lines billed. The data displayed pertain to the adjusted claim.	Number	9
Billed Amount (CMS-1500 Denied)	The total dollar amount requested by the provider for the services billed on all the detail lines. Adding all the billed amounts on all the detailed lines will arrive at this amount.	Number	9
Billed Amount (Compound Drug)	Dollar amount requested by the provider for dispensed drug.	Number	9
Blood Deductible (MCR)	Amount of money paid toward the blood deductible on a Medicare claim.	Number	8
City	City in which payee resides.	Character	15
Client Number	Client's Medicaid identification number.	Character	12
Client Number (Inpatient In-Process)	Client's Medicaid identification number. Unique identifier of the client.	Character	12
Client Name	Client's name.	Character	29
Copay AMT (MCR)	The dollar amount of member liability on a claim that is to be collected by the provider at the time the service is rendered. It is the patient's liability for a medical bill.	Number	8
Copay Amount	The dollar amount member should pay and is deducted from the allowed amount to arrive at paid amount.	Number	8
Copay Amount (CMS-1500 ADJ)	The dollar amount member should pay and is deducted from the allowed amount to arrive at paid amount. The first amount (credit) displayed is for the original claim. The amount for the adjusted claim is displayed under the amount for the original claim. These numbers may vary.	Number	8
Copay Amount (Compound Drug)	The dollar amount member should pay and is deducted from the allowed amount to arrive at paid amount. The copay amount that is deducted depends on the type of drug dispensed.	Number	8
Copay Amount (MCR Part B ADJ)	The dollar amount of member liability on a claim that is to be collected by the provider at the time the service is rendered. It is the patient's liability for a medical bill.	Number	8

Field	Description	Field Type	
Copay (MCR Part A ADJ)	The dollar amount of member liability on a claim that is to be collected by the provider at the time the service is rendered. It is the patient's liability for a medical bill. For example, some pharmacy programs require that the patient pay a specific amount toward each prescription filled. The fee will not be charged for the following members: individuals under 21, or members in nursing facilities and intermediate care facilities for the mentally retarded.	Number	8
Date SVC PERF (Dental)	Date service was actually performed. May occur 12 times depending on number of detail lines billed.	Character	6
Days	Total days member was in hospital/nursing home	Number	3
EOBs/Detail EOBs	These are the detail EOB codes that apply to the detail on the claim form. There could be a maximum of 20 EOB codes per claim detail. See HIPAA Reason Code for detailed information on EOBs.	Number	4
Dispense Date (Compound Drug)	The date drug was dispensed to member. This serves as the service date for drug claims.	Character	6
EOB Codes	The detail EOB codes that apply to the detail on the compound drug claim form. There can be a maximum of 20 EOB codes per detail. See HIPAA reason code for detailed information on EOBs.	Number	4
EOB Sequence Code/Number	This is the sequential line number of the EOB code line.	Number	2
HCPCS/Rate	These are the HCPCS procedure codes that correspond to the revenue codes on each of the detail lines being billed. These codes are used to compute the allowable amount for the services rendered. This might occur 23 times depending on the number of detail lines billed.	Character	8
Header EOBS	The EOB codes that apply to the header on the claim form. There can be a maximum of 20 EOB codes per claim. See HIPAA Reason Code for detailed information on EOBs.	Number	4
Header EOBS (CMS-1500 Denied)	The EOB codes that apply to the header on the claim form. These codes are used to explain how the claim was processed or priced. There can be a maximum of 20 EOB codes per claim. See HIPAA Reason Code for detailed information on EOBs.	Number	4
ICN	This is a unique number used to identify and track a claim processed through the system.	Character	13
ICN (ADJ)	This is a unique number used to identify and track a claim processed through the system. The first number displayed is the ICN of the original claim. The ICN of the adjusted claim is displayed under the ICN of the original claim.	Character	13
Issue Date	Date check/payment was issued.	Character	10
LVL Care	This field indicates the level of care rendered for patient.	Character	3
Medicaid Billed Amount	This is the dollar amount billed by the provider.	Number	9
Medicaid Paid Amount	This is the dollar amount that is payable.	Number	9
Medicaid Reimbursement Amount	The full amount payable on claim prior to deducting state share. The paid amount is the amount after state share is deducted from reimbursement amount.	Number	9
Medicaid TPL Amount	Indicates the payments made by sources outside of the state medical assistance programs. This amount is deducted from the allowed amount to arrive at the paid amount.	Number	9
Medicare Coinsurance Amount	This is the dollar amount that the member should pay and is deducted from the allowed amount to arrive at the Medicare paid amount.	Number	8

Field	Description	Field Type	
Medicare Deductible Amount	Indicates the dollar amount that the member is responsible for paying. The Medicare deductible amount includes the Medicare deductible and blood deductible dollar amounts. This dollar amount will crossover and be paid by Medicaid.	Number	8
Modifiers	This column shows the modifiers used to further describe the service rendered. Up to four modifiers may be entered on each detail line.	Character	2
NDC	National Drug Codes correspond to the ingredients used. A maximum of 15 ingredients can be entered on one claim.	Character	11
Net Overpayment/(AR)	Provides the Net Overpayment amount when the adjustment results in a negative paid amount and an accounts receivable (setup)	Number	9
Paid Amount	The dollar amount that is payable for the claim.	Number	9
Paid Amount (Dental)	The dollar amount that is payable for the claim. Computing allowable amount for the services and deducting the TPL amount determine this.	Number	9
Paid Amount (Home Health)	The dollar amount that is payable for the claim/services rendered. This represents the allowable amount plus the overhead amount, minus the TPL and deductible amounts.	Number	9
Paid Amount (CMS-1500 ADJ)	This is the dollar amount paid for the services rendered. This is arrived at by computing the allowable amount for the services and deducting the TPL amount. The first amount (credit) displayed is for the original claim. The amount for the adjusted claim is displayed under the amount for the original claim. These numbers may vary.	Number	9
Paid Amount (Compound Drug)	Dollar amount paid for drug. This is determined by computing allowable amount for drug and deducting TPL, and/or copay amounts.	Number	9
Patient Account Number/PAT NO	This is a unique number assigned by the provider. This is usually used for filing or tracking purposes	Character	30
Patient Number (ADJ)	This is a unique number assigned by the provider. This is usually used for filing or tracking purposes. This is the same for both the original and adjusted claims.	Number	30
Patient Liability	This is the patient liability amount the member is responsible for paying. This amount is subtracted from the allowed amount to arrive at the paid amount.	Number	9
Payee Number	Provider number for provider receiving payment and RA.	Number	9
Payment Number	Check number corresponding to a check or the control number of an EFT transaction	Number	9
PL SERV (Dental)	This column shows the place of service code(s) indicating where the services were actually rendered. May occur 12 times depending on the	Character	2
PL SERV (CMS-1500)	This column shows the place of service code(s) indicating where the services were actually rendered. May occur 6 times depending on the number of detail lines billed.	Character	2
PROC CD (Dental)	This column shows the American Dental Association (ADA) procedure code used to indicate what services were actually rendered to the member by the provider. May occur 12 times depending on the number of detail lines billed.	Character	5
PROC CD (CMS-1500)	This column shows the HCPCS procedure code used to indicate what services were actually rendered to the member by the provider. May occur 6 times depending on the number of detail lines billed.	Character	5
Provider Name	Payee's name.	Character	50
RX NO.	Prescription number on the prescription used to dispense the drug.	Character	7
Refund Amount Applied	Provides the Refund Amount Applied when the adjustment results in a negative paid amount and cash is applied in the payment cycle.	Number	9
Reimbursement Amount	The full amount payable on claim prior to deducting state share. The paid amount is the amount after state share is deducted from reimbursement amount.	Number	9

Field	Description	Field Type	
Rendering Provider Number	Number used to identify provider performing the service.	Number	9
REV CD	Revenue code pertaining to the service billed on the detail line. This might occur 23 times depending on the number of detail lines billed.	Number	3
Service Dates From	Earliest date of service on detail lines.	Character	6
Service Dates Thru	Latest date of service or discharge date on the detail lines.	Character	6
Service Dates From (ADJ)	Earliest date of service on detail lines. The dates pertaining to the original claim are displayed first. The dates pertaining to the adjusted claim are displayed under the dates for the original claim.	Character	6
Service Dates Thru (ADJ)	Latest date of service on the detail lines. The dates pertaining to the original claim are displayed first. The dates pertaining to the adjusted claim are displayed under the dates for the original claim.	Character	6
Service Location Code	One-byte alphabetic code used to indicate billing provider location.	Character	1
Spenddown Amount	This field is not currently being used for Oklahoma Medicaid billing.	Number	8
SRV Date	These are the dates the services were actually rendered. Each detail line will have a date on which the service billed on that line was rendered to the member. These might occur 23 times depending on the number of detail lines billed.	Character	6
SRV Date (LTC Denied)	If other services or supplies are billed aside from the patient stay (accommodation code), then the service date is entered and displayed. The occurrence of this field depends on the number of detail lines used to bill other than accommodation codes.	Character	6
SRV Date (LTC ADJ)	If other services or supplies are billed aside from the patient stay (accommodation code), then the service date is entered and displayed. The occurrence of this field depends on the number of detail lines used to bill other than accommodation codes. The data displayed pertain to the adjusted claim.	Character	6
State	State where payee resides.	Character	2
Surface (Dental)	This column shows the surface code pertaining to the part of the tooth that was worked on. May occur 12 times depending on the number of detail lines billed.	Number	5
Tooth (Dental)	This column shows the tooth number of the tooth or the tooth quadrant that was worked on.	Number	2
TPL Amount	Dollar amount paid by any source outside of the state medical assistance program that is being billed. If present, this amount is subtracted from allowed amount to arrive at the paid amount.	Number	9
TPL Amount (ADJ)	Payments made by sources outside of the state medical assistance programs. This amount is deducted from the allowed amount to arrive at the paid amount. The first amount (credit) displayed is for the original claim. The amount for the adjusted claim is displayed under the amount for the original claim. These numbers may vary.	Number	9
Total Claims Paid - Allowed Amt	Total amount allowed for payee claims.	Number	10
Total Claims Paid - Billed	Total billed amount for payee's claims	Number	10
Total Claims Paid - Blood Deductible Amt	This amount reflects the total of all blood deductible amounts for the claims.	Number	9
Total Claims Paid - Coinsurance Amt	This amount reflects the total of all coinsurance amounts for the claims.	Number	9
Total Claims Paid - Copay	Total amount of copay for payee's claims.	Number	9
Total Claims Paid - Deductible Amt	This amount reflects the total of all deductible amounts for the claims.	Number	9

Field	Description	Field Type	
Total Claims Paid - Paid	Total amount paid for payee's claims.	Number	10
Total Claims - Patient Liability	The total of Patient Liability amounts for all the claims.	Number	9
Total Claims Paid - Reimbursement	This amount reflects the total of all reimbursement amounts for the claims.	Number	10
Total Claims Paid - Spenddown	This field is not currently being used for Oklahoma Medicaid billing.	Number	9
Total Claims Paid - TPL	This amount reflects the total of all TPL amounts for the claims.	Number	10
Total No. Adj	This is the total number of all claims adjusted for the current financial cycle.	Number	6
Units (CMS-1500)	This shows the units of service being billed on each detail line. May occur six times depending on the number of detail lines billed. On adjusted claims, the data displayed pertain to the adjusted claim.	Number	6
Units (LTC)	This is the number of units of service.	Number	8
Units (Compound Drug)	Quantity of ingredient(s) used.	Number	6
Units (Inpatient/Outpatient)	This shows the units of service rendered. This might occur 23 times depending on the number of detail lines billed.	Decimal	8
Zip Code	Payee's zip code. It may contain zip code plus four-digit geographic indicator.	Character	10

## Section C: Electronic Remittance Advice

An electronic RA is available by using the X12 835 transaction as mandated under HIPAA. The 835 transaction is available to all OHCA providers and contracted trading partners that have requested electronic RAs. The 835 is a financial transaction that functions as an electronic means of posting accounts receivable.

The 835 Transaction is available from the Web or Remote Access Server (RAS) in a downloadable file.

The 835 Transaction does not accommodate notification of a claim status of pending/suspended/under review. Oklahoma Medicaid will be providing a supplemental transaction that will provide claim status information on pended claims. This transaction is the 277pc Health Care Payer Unsolicited Claim Status.

## Section D: 1099 & W-2s

Annual earnings, based on the unique Tax Identification Number (TIN), are reported on IRS Form 1099 and submitted to each provider and the Internal Revenue Service. All money earned by TIN is reported on the Form 1099, based on an untaxed basis. It is then the responsibility of the provider to file and pay the appropriate taxes. These taxes can be owed to federal, state and local governments.



Additionally, an IRS Form W-2 is generated to report earnings and FICA contributions to the OCHA's Individual Personal Care Services providers. All money earned and FICA withholdings for each of these providers is reported on the Form W-2. It is then the responsibility of the provider to file and pay the appropriate taxes. These taxes can be owed to federal, state and local governments.

## Section E: Stop Payments, Voids, Re-issuance

### Stop Payments

Stop Payments occur when a provider indicates a check was not received. If the provider has not received a check, a stop payment request is necessary so that a replacement check can be issued. If a check is incorrectly issued, the stop payment request is necessary to prevent the funds from being disbursed in error.

A provider may call to request that a stop payment be placed on a check that was not received. In order for a payment to be reissued, the original check must first be stopped in the OKMMIS, and the OHCA manually reissues the provider a system-generated replacement check. The check can be resubmitted anytime and will be printed in the next manual check print run.

### Check Void

There are two types of voids that can occur within the OKMMIS: regular check voids and check void/reissue.

#### Regular Check Voids

The first type, a regular void, occurs for any of the following reasons:

- The individual receiving treatment, listed on the RA, is not a patient of the provider who received the check.
- A payment was received by the wrong provider, and the check is returned to the OHCA with "void" or "not ours" written on the face of the check.
- A check was paid to a provider who does not belong to the group or has left the group.
- The payment was inappropriately made payable to the wrong location or provider identification number.
- The check is cancelled by statute and the OHCA directs that a void can be completed.

In the above situations, the checks would be voided within the OKMMIS and all claims associated with the dollars identified to this check will become denied claims. In order to receive payment for any of the now voided claims, it will be necessary for the provider to resubmit the claims.

### **Check Void/Reissue**

The second type of voided check is a Void/Reissue. Void/Reissue items are a result of a check being mutilated or destroyed and a subsequent reissued check being manually prepared.

## **Section F: Electronic Care Coordination Payments**

The 820 Transaction Set is the HIPAA compliant financial transaction used to transmit care coordination payments. The 820 Transaction Set is generated by the Oklahoma OKMMIS and is distributed to primary care providers/case managers (PCP/CMs) who request electronic capitation reports and participate in the SoonerCare Choice program.

The 820 Care Coordination Payment is combined with the last financial cycle of the month. This transaction is used for the Premium Payment Remittance Information (PPRI). Total payment amount noted in the BPR02 segment of the 820 Transaction may or may not equal the actual payment amount. This is due to the integration of the premium payment with fee-for-service claims payment in the same weekly financial cycle.

The 820 Transaction is only available by download via the Web or RAS. The PCP/CMs must contact DXC to make other arrangements if other media is required

### **Appendices**

- Banner Page
- CMS-1500 Claims Paid Page
- CMS-1500 Claims Denied Page
- CMS-1500 Claims In Process Page
- CMS-1500 Claim Adjustments Page
- Provider Remittance Advice Summary
- Explanation of Benefit Codes

### Provider Remittance Advice Banner Messages Example

```

REPORT: CRA-0000-W          STATE OF OKLAHOMA          DATE: MMDDYY
PROCESS: FNIO3011         MEDICAID MANAGEMENT INFORMATION SYSTEM    PAGE:  9,999
LOCATION: FINJW201          PROVIDER REMITTANCE ADVICE
                           PROVIDER BANNER MESSAGES

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXX 999999-9999

PAYEE NUMBER 999999999 X
ISSUE DATE   MMDDYY

THIS IS A TEST OF RA BANNER MAINTENANCE BY CLAIM TYPE.
TEXT REGARDING PROVIDER SPECIFIC INFORMATION COULD BE FOUND IN THIS AREA.
    
```

### Provider Remittance Advice CMS-1500 Claims Paid Example

```

REPORT: CRA-0113-W          STATE OF OKLAHOMA          DATE: MMDDYY
PROCESS: FNIO3011         MEDICAID MANAGEMENT INFORMATION SYSTEM    PAGE:  9,999
LOCATION: FINJW201          PROVIDER REMITTANCE ADVICE
                           CMS-1500 CLAIMS PAID

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXX 999999-9999

PAYEE NUMBER 999999999 X
PAYMENT NUMBER 999999999
ISSUE DATE   MMDDYY

-ICN-      SERVICE DATES      BILLED  ALLOWED  TPL  SPENDDOWN  COPAY  REIMB. PAID
-PATIENT NUMBER- FROM  THRU    AMOUNT  AMOUNT  AMOUNT  AMOUNT  AMOUNT  AMOUNT  AMOUNT  AMOUNT

CLIENT NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX CLIENT NO.: XXXXXXXXXXXXXXXX
RYYJJBBSSS      MMDDYY MMDDYY  9,999,999.99  9,999,999.99  999,999.99  9,999,999.99
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
          9,999,999.99  9,999,999.99  999,999.99  9,999,999.99

HEADER EOBS: 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999

          SERVICE DATES RENDERING  BILLED  ALLOWED
PL SERV PROC CD MODIFIERS UNITS FROM THRU PROVIDER AMOUNT  AMOUNT  DETAIL EOBS
XX  XXXXXX XX.XX.XX.XX 9999.99  MMDDYY MMDDYY XXXXXXXXXXXX 9,999,999.99  9,999,999.99  9999 9999 9999 9999 9999 9999 9999 9999
          9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
XX  XXXXXX XX.XX.XX.XX 9999.99  MMDDYY MMDDYY XXXXXXXXXXXX 9,999,999.99  9,999,999.99  9999 9999 9999 9999 9999 9999 9999 9999
          9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
XX  XXXXXX XX.XX.XX.XX 9999.99  MMDDYY MMDDYY XXXXXXXXXXXX 9,999,999.99  9,999,999.99  9999 9999 9999 9999 9999 9999 9999 9999
          9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
XX  XXXXXX XX.XX.XX.XX 9999.99  MMDDYY MMDDYY XXXXXXXXXXXX 9,999,999.99  9,999,999.99  9999 9999 9999 9999 9999 9999 9999 9999
          9999 9999 9999 9999 9999 9999 9999 9999 9999 9999

TOTAL CMS-1500 CLAIMS PAID:  99,999,999.99  99,999,999.99  9,999,999.99  99,999,999.99
          99,999,999.99  9,999,999.99  99,999,999.99
    
```









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# Chapter 12: SoonerCare Choice

## Introduction

SoonerCare Choice is a managed care model in which each member is linked to a Primary Care Provider/Case Manager (PCP/CM) who serves as the “medical home”. PCP/CMs manage the basic health care needs, including after-hours care and specialty referral of the members on their panel. The level of medical home determines the care coordination payment the PCP receives. All other services are paid based on the OHCA current FFS payment methodology. PCPs may also qualify for SoonerExcel incentive payments based on individual performance. Physicians (M.D./D.O.), nurse practitioners and physician assistants in primary care specialties can contract as PCP/CMs.

### Quality Assurance

The OHCA is committed to ensuring that high quality health care is always available to its members. SoonerCare Choice providers agree to cooperate with external review organizations, internal reviews and other quality assurance efforts.

#### CAHPS Report Card

Annual telephone and mail surveys of SoonerCare Choice members are conducted by an external review organization, which measures health care satisfaction, including care provided by their PCP/CM.

#### After-hours Surveys

Telephone surveys are conducted by the OHCA or one of its agents to ensure that PCP/CMs provide information concerning after-hours access to medical information or a medical professional.

#### Member Reports

Member calls to the SoonerCare Helpline for issues regarding quality of care or access to care needs are documented and forwarded to the OHCA for research and/or resolution.

#### On-site Audits

On-site audits are conducted by OHCA Quality Assurance/Quality Improvement staff.

### Encounter Data Reviews

Data reflecting medical care use rates, preventive care services and referral patterns are reviewed and analyzed. This information is used in determining use patterns, referral patterns, rate setting and other reporting purposes.

### Emergency Room Utilization Profiling

OHCA Quality Assurance/Quality Improvement staff perform quarterly analysis of PCP/CM office encounter claims submission versus emergency room claim submission. The results of these reports are forwarded to the PCP/CMs as well as SoonerCare Provider Services. The goal of this project is to reduce inappropriate use of emergency rooms.

## Covered Members

OHCA determines eligibility for most SoonerCare members using [MySoonerCare.org](https://mysooner.org). This system is a secure web-based application process that provides real-time eligibility for members who have internet access. The Oklahoma Department of Human Services (OKDHS) continues to determine eligibility for some SoonerCare programs. Members must meet financial, residency, disability status and other requirements before they can become eligible for **SoonerCare**.

**SoonerCare Choice** covers members who qualify for medical services through the Temporary Aid to Needy Families (TANF) program or those who qualify due to age or disability. Members may also include women who have been diagnosed with breast or cervical cancer under Oklahoma Cares or children with disabilities who qualify under the Tax Equity and Fiscal Responsibility Act (TEFRA).

### Native Americans

Native Americans who are eligible for **SoonerCare Choice** must enroll with a Primary Care/Case Manager. They may choose a traditional **SoonerCare Choice** provider or enroll with an Indian Health Service, Tribal, or Urban Indian (I/T/U) clinic provider that participates in the program. All Native American members have the option to self-refer to any I/T/U facility for services that can be provided at these facilities.

### SoonerCare Choice Exempt

Most members who are eligible for **SoonerCare** benefits will be enrolled in the **SoonerCare Choice** program. Individuals exempt from this mandate are:

- Eligible for Medicare and SoonerCare Traditional.

- Enrolled in a waiver program (ADvantage waiver, Home/Community waiver, etc.).
- Residing in a long-term care center or institution.
- Individuals with other forms of credible health insurance coverage.
- Subsidized adoption.
- State or Tribal custody.

## Access to Care

**SoonerCare Choice** PCP/CMs are required to maintain access to primary and preventive care services in accordance to the contract. The following standards apply:

1. PCP/CMs must maintain 24-hour, seven day per week telephone coverage, which will either page an on-call medical professional or provide alternative information to members concerning whom they can contact to obtain medical advice.
2. PCP/CMs must offer hours of operation that are no fewer than the hours of operation offered to commercial patients or SoonerCare Traditional members.
3. PCP/CMs must provide medical evaluation and treatment within 24 hours for urgent medical conditions. Generally, urgent care is for sudden illnesses or injuries where there is no immediate danger of death or permanent disability.
4. PCP/CMs can charge the appropriate copayment to Choice members ages 21 and over. PCP/CMs may not deny services based on the member's inability to pay the appropriate copayment.

### Emergency Care

PCP/CMs are not required to provide emergency care either in office or in an emergency room. PCP/CMs that do provide emergency care in the emergency room will be reimbursed based on current OHCA policy.

PCP/CMs should not refer members to an emergency room for non-emergency services. Providers should interact with their assigned members to discourage inappropriate emergency room use. PCP/CMs should manage follow-up care from the emergency room, as needed.

## Member Enrollment/Disenrollment

### SoonerCare Choice Enrollment

SoonerCare member benefits start when eligibility for SoonerCare is determined.

The effective date of SoonerCare Choice member benefits depends on the certification date. Always check the Eligibility Verification System (EVS) either by calling the toll-free EVS line, through the swipe machine or on the SoonerCare Provider Portal.

**NOTE:** *Medical care during the time a member is eligible for SoonerCare Traditional, but not yet effective in SoonerCare Choice, will be covered under the SoonerCare Traditional fee-for-service program.*

Continuing eligibility for SoonerCare benefits must be recertified periodically. The recertification intervals vary according to the type of assistance members receive. SoonerCare members are notified in writing by DHS prior to expiration of benefits.

Breaks in eligibility may result in a disruption in the continuity of care. If the PCP/CM's capacity is limited in comparison to demand, the member may not be able to regain his or her place on that PCP/CM's panel.

Members may re-enroll with a PCP/CM by calling the SoonerCare Helpline if they have a break in eligibility and are being recertified. Members who lose and regain eligibility within 365 days are assigned to their most recent PCP/CM, if the PCP/CM has available capacity and if the member's age is within the PCP/CM's scope of practice.

### Choosing a PCP/CM

OHCA offers all members the opportunity to choose a PCP/CM from the provider directory. If a member does not choose a PCP/CM, OHCA will contact the member to assist them in choosing a medical home. If a member seeks care prior to choosing a medical home the provider seeing the member will become the medical home.

Families with more than one eligible member can choose a different PCP/CM for each eligible member.

Enrollment with a PCP/CM takes effect on the day the selection is made. Prior to the first day of each month, the OHCA provides the PCP/CM with a SoonerCare Choice eligibility listing of new enrollees and continuing members.

### Capacity (Number of Members requested per PCP/CM)

The PCP/CM specifies the maximum number of members he or she is willing to accept. The maximum number is 2,500 members for each physician PCP/CM. The maximum capacity for physician assistants and nurse practitioners serving as PCP/CMs is 1,250. The PCP/CM must agree to a minimum panel of 50 members. The OHCA cannot guarantee the number of members a PCP/CM receives.

A PCP/CM may request a change in its capacity by submitting a written request to the Provider Enrollment division of OHCA or by utilizing the Update Provider File link through the provider portal. If approved, OHCA will implement the change on the first day of the month with sufficient notice.

If a PCP/CM requests a lower capacity – within program standards and approved by the OHCA – the reduction in members will come through members changing PCP/CMs or losing eligibility. Members will not be disenrolled to achieve a lower capacity.

### Changing PCP/CMs

The OHCA or the SoonerCare Helpline may change a member from one PCP/CM to another PCP/CM for the following reasons:

- Member can request change without cause.
- When a PCP/CM terminates his or her participation in the **SoonerCare Choice** program.

### Disenrollment at the Request of the PCP/CM

The OHCA may also change a member from the assigned PCP/CM to another PCP/CM for good cause and upon electronic request of the assigned PCP/CM. If the request is a good cause change, the OHCA will act upon the request within 30 days of receipt from the OHCA SoonerCare Choice division.

Good cause is defined as:

- Non-compliance with PCP/CM's direction.
- Abuse of PCP/CM and/or staff (includes disruptive behavior).
- Deterioration of PCP/CM-member relationship.
- Excessive no-show appointments above the PCP/CM office policy limit.

The dismissal request should be done on the provider portal where supporting documentation should be uploaded electronically. Members may not be notified by the PCP/CM until approval for disenrollment is granted by the OHCA.

Either party has the right to appeal the decision to the administrative law judge, pursuant to OAC 317:2-1-2 (Authority's Grievance Procedure).

## Referrals

### **SoonerCare Choice** referrals:

- Are made based on medical necessity as determined by the PCP.
- Are required prior to receiving the referred service, except for retrospective referrals as deemed appropriate by the PCP/CM.
- Must have the correct individual referring provider number to ensure payment to the referred to provider (provider/referral numbers are site specific).

Referrals must be created by the PCP/CM or a designee within the PCP/CM's office who is authorized to create referrals for the provider.

Some services may also require prior authorization. It is up to the referred to provider, or provider ordering services, to obtain prior authorization as needed. Prior authorization for services is obtained through the Medical Authorization Unit (MAU) at OHCA or one of its agents.

**SoonerCare Choice** referrals must be made if the member requests a second opinion when surgery is recommended. Following the second opinion, any treatment received by the member is to be rendered by the PCP or through a referral made by the PCP/CM.

**SoonerCare Choice** referrals may be made to another PCP/CM for services equal to those of a specialist. Examples of this include: a family practitioner referring to another family practitioner who performs a surgical procedure or a general practitioner referring to an internist who manages complicated diabetic patients.

SoonerCare Choice referrals may be made to a provider for ongoing treatment for time specified by the PCP/CM but limited to 12 months. For the duration of the referral, the referred-to provider will not be required to receive further referrals to provide treatment for the specific illness indicated on the referral.

### **SoonerCare Choice** referrals are not required for:

- Child physical/sexual abuse exams.
- Services provided by a PCP/CM for members enrolled or assigned to the PCP/CM.
- Emergency room care.

- Obstetrical care.
- Vision screenings for members younger than 21 years.
- Basic dental for members younger than 21 years (benefit is limited to emergency extractions for members older than 21 years).
- Behavioral/mental health.
- Family planning.
- Inpatient hospital services.
- Routine laboratory and X-ray.
- Services provided to Native Americans in a tribal, IHS or Urban Indian Clinic facility.

Referrals can be submitted using the SC-10 form. This form can be found by clicking on providers then forms on the okcha.org website. Alternative referral methods can also be used and should include at a minimum:

- Member's name, ID number and telephone number.
- Primary care provider's (PCP's) name and telephone/fax number.
- Referring provider's name, SoonerCare ID number and NPI.
- Referring providers original or electronic signature.
- Reason for referral.
- Referral start and end date.
- Specialty provider's name, address and telephone/fax number.

### **Payment for Referred Services**

Payment for referred services is subject to coverage limitations under the current SoonerCare reimbursement policies. Payment for referred services is limited to four specialty visits per month for adults older than 20 years of age. Visits to the PCP/CM are excluded from this limitation. To ensure payment, PCP/CMs must refer only to SoonerCare providers who have an active SoonerCare Traditional contract.

## Documenting the Medical File

Documentation in the medical record should include a copy of each referral to another health care provider and any additional referrals made by the referred-to provider when this information is known. An example might be ancillary services.

Documentation in the medical record should include a medical report from the referred-to provider. The referred-to provider should report their findings to the referring PCP/CM within two weeks of the member's appointment. In the event a medical report is not received within a reasonable time, the PCP/CM should contact the referred-to health care provider to obtain this information.

## Early and Periodic Screening Diagnosis and Treatment (EPSDT)

Early and Periodic Screening Diagnosis and Treatment (EPSDT) is a federally mandated program and is one of the highest priorities of the SoonerCare Choice program. EPSDT is designed to provide a comprehensive program of preventive screening examinations, dental, vision, hearing and immunization services to SoonerCare Choice members age 20 or younger.

### Schedule of EPSDT Services

As a minimum, the following schedule for EPSDT screening is required:

- Six visits during the first year of life.
- Two visits in the second year of life.
- One visit yearly for ages 2 through 5.
- One visit every other year for ages 6 through 20.
- Metabolic lead screen at ages 1 and 2; or at 6 years old if not done by age 2. *This is mandatory.*

### Additional Requirements

The OHCA requires contractors to:

- Conduct and document follow-up appointments with all members younger than 21 years who miss appointments.
- Administer outreach, including telephone calls or printed notification mailed to a member when a health care screen is indicated or missed. This ensures that all members age 20 or younger are current.
- Educate families of members age 20 or younger about the importance of early periodic screening, diagnosis and treatment.



## EPSDT Bonus Payment

The OHCA offers bonuses to be paid to PCP/CMs who demonstrate a specified screening rate.

To qualify for the EPSDT bonus, verifiable encounter claim data must be submitted in a timely manner as set forth in the SoonerCare Choice contract and for any following contract addendums.

The OHCA may conduct on-site chart audits.

See the Reimbursement section below for further bonus payment details.

## Reporting Requirements

Data, information and reports collected or prepared by PCP/CMs in the course of performing duties and obligations as a PCP/CM are owned by the state of Oklahoma. The OHCA and other appropriate entities reserve the right to examine this information upon request. This information includes medical and financial records, accounting practices, and other items relevant to the provider's contract.

The PCP/CM is required to report to the OHCA in writing and within a timely manner any changes to its SoonerCare Choice contract. The report must include demographic, financial and group composition information as reported in their contract.

Claims submitted by the PCP/CM should be submitted in the same manner and on the same claim forms used to submit claims for SoonerCare Traditional members. Encounter Claims must be submitted within 60 days from the date of services. Denied claims must be corrected and resubmitted within 60 days of adjudication.

## Reimbursement

### Care Coordination

SoonerCare Choice PCP/CMs are paid a monthly Care Coordination fee for panel members who have established a visit within the last 15 months.

Care Coordination payments vary according to the type of members the PCP services and their level of medical home status.

Care Coordination payments are made by the 10<sup>th</sup> working day of each month for all eligible members enrolled with the PCP/CM on the first day of each month. A single monthly payment is generated and accompanies the Care Coordination Listing or is deposited directly.

## Claims

PCP/CMs are required to file a claim with the OHCA each time a service is provided to a member. Claims filed will be paid subject to the current SoonerCare Traditional fee schedule and reimbursement policies.

Claims are to be submitted on the appropriate claim form within 60 days of the date of services.

## Immunization Incentive Payment

Immunization Incentive Payments are available when the PCP/CM provides written notice that it has administered the fourth dose of DPT/DTAP to a member prior to the member's second birthday.

## Care Management

The Care Management Department is comprised of registered nurses and licensed practical nurses. These medical professionals assist in facilitating medical services for SoonerCare members with complex medical conditions.

### Population Care Management Services

- Help members access care and services.
- Assist providers with coordination of discharge planning.
- Resolve issues and concerns with providers as related to medical care.
- Help obtain approvals for medicines and medical services.
- Provide patient education to identified groups.
- Assist with coordinating community support and social service systems.
- Offer out-of-state referrals if no comparable in-state services are offered or in cases of urgent care needs.
- Complex medical conditions include:
  - High-risk OB cases.
  - Transplant cases.
  - Catastrophic illness or injury.
  - Women enrolled in the Breast and Cervical Cancer (BCC) program.
  - Children who receive in-home Private Duty Nursing services (includes periodic home visits to evaluate and certify medically necessary services).

Provide support to SoonerCare providers for issues with:

- Care Management Referral forms.
- High service utilization.
- Medical regimen noncompliance.
- Inappropriate ER visits.
- Multiple providers/pharmacies.
- Scheduled medication requests.
- Refusing alternative treatments/prescriptions.
- Refusing pain management referrals.
- Drug-seeking behaviors.

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# Chapter 13: Insure Oklahoma

## Introduction

Insure Oklahoma was founded in 2005 in an effort to help provide health coverage to uninsured, working Oklahomans.

Insure Oklahoma is a program under the SoonerCare umbrella and administered by the OHCA. This program consists of two benefits branches.

Insure Oklahoma consists of two (2) benefit branches:

- 1) Insure Oklahoma Employer Sponsored Insurance (ESI):
  - Geared to small businesses with no more than 250 employees. Nonprofit no more than 500 employees.
  - Offers premium subsidy assistance for qualified group health care plans for eligible employees.
- 2) Insure Oklahoma Individual Plan (IP):
  - Designed as an option for people who cannot access Insure Oklahoma through their employer.

Member eligibility for both programs requires candidates to:

- Have valid Oklahoma residency.
- Be a U.S. citizen or a legal alien not currently receiving Medicaid or Medicare services.
- Be between 19 and 64 years old.

The ESI program requires candidates to have a household income not exceeding 200 percent of the federal poverty level (FPL). The IP program requires that candidates have a household income not exceeding 100 percent of the FPL.

## Section A: What is the Insure Oklahoma Individual Plan?

The individual plan is a limited health coverage option for qualified Oklahomans. As an Insure Oklahoma individual plan member, you can choose an Insure Oklahoma provider for yourself and your spouse if eligible.

Members of the Insure Oklahoma Individual Plan must choose an Insure Oklahoma Primary Care provider for themselves, and if eligible, their spouse (dependents do not qualify).

This plan provides coverage to eligible:

- Self-employed individuals.
- Workers unable to access Insure Oklahoma through their employer.



**New Version:**

 <a href="http://www.okhca.org">www.okhca.org</a> This card does not guarantee coverage. Copay may apply.	For emergencies, call 911 or your local rescue unit.
<b>Member Name:</b> <b>Member ID:</b> <b>Member DOB:</b> <b>Date Issued:</b>	<b>This card does not guarantee coverage.</b> Visit our websites or call our toll-free numbers to verify benefits, view claims or find a provider: <b>SoonerCare™</b> <a href="http://www.okhca.org">www.okhca.org</a> 1-800-987-7767 TDD Line (Hearing Impaired) 711 <b>Insure Oklahoma™</b> <a href="http://www.insureoklahoma.org">www.insureoklahoma.org</a> 1-888-365-3742 TDD Line (Hearing Impaired) 711
	<b>Provider EVS:</b> (405) 840-0650 or 1-800-767-3949 <b>Other inquiries:</b> (405) 522-6205 or 1-800-522-0114
	

## Section B: Insure Oklahoma Individual Plan Billing Procedures

Billing procedures for the Insure Oklahoma IP are the same as SoonerCare billing procedures. Please refer to the Claim Completion chapter of this manual for details. The Insure Oklahoma IP uses the same mailing addresses as SoonerCare.

Claims are subject to a copayment. The provider reimbursement will be based on the Medicaid allowable plus the copayment. Providers who choose to be primary care physicians will be eligible to be chosen by members. Primary care referrals will follow the same guidelines as SoonerCare.

### PCP Payments

Insure Oklahoma PCPs will receive a \$3 monthly case management fee per recipient.

### Changes to Primary Care Physician Panels

If the provider's panel is closed, yet there is a patient the provider is willing to add to its panel, the Provider Action form (SC-13) should be completed and faxed to 405-917-7374.

## **Eligibility**

Checking eligibility for IP will follow the same process as SoonerCare. A magnetic strip on the back of the card is used by the swipe machines to read member information. Eligibility is also accessible on the Web or through the Automated Voice Response (AVR) system. When viewing eligibility for those enrolled in the Insure Oklahoma IP, the system will reflect the program for Public Product (PUB).

## **Prior Authorization**

The OHCA will handle the IP Prior Authorization (PA) process.

## **Adjustments**

Insure Oklahoma IP adjustments follow the same guidelines as SoonerCare.



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# Chapter 14: Pharmacy

## Introduction

The purpose of the pharmacy division is to manage the Medicaid Pharmacy program in the most efficient and comprehensive manner possible by researching, designing and implementing mechanisms to ensure appropriate, cost-effective and quality therapy.

### Pharmacy Policy (Rules)

Listed below is a brief overview of Pharmacy rules\*:

- Dispensing limitation: 34-day supply or a 90 days supply if on maintenance list.
- Covered Drugs: Must have a Federal Drug Rebate Agreement.
- Excluded Categories: Fertility, cosmetic, weight loss/gain, nutritional supplements.
- Beginning January 2017, OHCA will use Actual Acquisition Cost (AAC) to price brand and generic drugs:
  - The AAC will be set using the lower of Wholesale Acquisition Cost (WAC), National Average Drug Acquisition Cost (NADAC), or State Maximum Allowable Cost (SMAC).
- Professional Dispensing Fee: \$11.41
- Indian Health Services/Tribal/Urban Indian Clinic pharmacies will be reimbursed at the federal OMB encounter rate. The OMB rate will be paid based on a per-member/per-facility/per-day payment.
- Copays:
  - There will be a \$4.00 copay for most SoonerCare members.
  - For SoonerCare members in home and community-based waiver programs, copays are as follows;
    - Zero (\$0) on preferred generics
    - \$0.65 for \$0.01 to \$10.00
    - \$1.20 for \$10.01 to \$25.00
    - \$2.40 for \$25.01 to \$50.00
    - \$3.50 for \$50.01 and greater
  - Copayment is not required of:
    - members younger than 21 years old
    - members in nursing facilities and intermediate care facilities for the developmentally disabled
      - pregnant women
  - Copayment is not required for family planning services, Including all contraceptives and services rendered.

\*Pharmacy program rules change frequently. For the most up-to-date SoonerCare Pharmacy program rules, visit the OHCA website at [www.okhca.org/rx](http://www.okhca.org/rx).

### **Prescription Drug Benefit**

- Adults: Six (6) prescriptions per month with two (2) brand name drug limit.
- Prescriptions that don't count toward prescription limit are HIV antiretrovirals, chemotherapy, contraceptives, hemophilia factor, medication assisted treatments, naloxone, prenatal vitamins, smoking cessation agents, and certain prescriptions that require frequent monitoring.
- Residents of long-term care facilities: no limit.
- Members younger than 21 years old: no limit.
- Waiver Advantage members.

One (1) additional brand name prescription

Seven (7) additional generic prescriptions

Therapy Management, if additional prescriptions are needed

### **Product Based Prior Authorization (PBPA)**

There are multiple Prior Authorization types used to manage the pharmacy benefit.

#### **Product Based Prior Authorization (PBPA)**

This program divides certain therapeutic categories of drugs into two or more levels called Tiers. Tier 1 medications are preferred as the first step for treating a member's health condition. They are cost effective and are available without prior authorization (PA) from the OHCA in most cases. Members who do not achieve clinical success with Tier 1 medications may obtain a Tier 2 or higher medication. Providers with members having clinical exceptions may request a PA to skip the step therapy process and immediately receive a medication from a higher tier. For additional information, please review the OHCA website at [www.okhca.org/pa](http://www.okhca.org/pa).

#### **Scope and Utilization-Based Prior Authorization**

Many drugs are included under the scope or utilization-based prior authorization program. That means the drugs are restricted for certain diagnoses and/or should only be used at a specific dose or for a specific time period. See the link provided above for additional information.

## Pharmacy Lock-In Program

When it is decided that a member meets specific criteria and should be placed in the Pharmacy Lock-in Program, a pharmacy and prescriber are assigned to that member and their eligibility file is updated to only pay claims for controlled substance medications at that pharmacy and from that prescriber. Referrals are made to the Lock-In unit by several sources, including physicians, pharmacies, caseworkers and OHCA staff. Referrals can be made by phone, online or in writing.

### Lock-In Decision Process

Once a member is referred to the Lock-in program, the following information is verified and reviewed for each case:

1. Eligibility (members not eligible are not reviewed)
2. Medicare eligibility (not eligible if dual eligible )
3. Paid pharmacy claims for past year
4. Hospital claims for past year
5. History of diagnostic information
6. Number of prescribers and their specialties

The lock-in process is started if the review shows that the member meets the required criteria based on this information.

Cases that look questionable but do not fully meet the criteria generally result in monitoring of those members or a warning letter sent to the member. Warning letters are sent to members explaining they are being monitored due to a high number of visits to different pharmacies. Cases that receive warnings are reviewed again in six months. If there is no improvement, the members are entered into the Lock-in program. If the behavior improves, the cases are closed. If a decision is made to monitor without a warning, the case is reviewed again in three months and a new decision is made based on behavior pattern.

### Safety Concerns Criteria List:

- Number of ER visits (3)
- Number of different pharmacies (3)
- Number of different prescribers/physicians (5) (combined)
- Number of days' supply of controlled substances
- Diagnosis of drug dependency/other diagnosis.

- Number of hospital discharges (3)
- Other information from past reviews
- Safety concerns

**Who to Call:**

OHCA Main number: 800-522-0114 or 405-522-6205

Pharmacy Help Desk, option 4:

Monday-Friday (8:30 am-7:00 pm)

Saturday (9:00 am-5:00 pm)

Sunday (11:00 am-5:00 pm)

**Durable Medical Equipment (DME)**

The general guidelines concerning the documentation necessary to obtain a prior authorization for DME supplies is located at [www.okhca.org/providers/dme/paguidelines](http://www.okhca.org/providers/dme/paguidelines). Please be sure you use your DME provider number, not your pharmacy provider number, when billing DME claims. With the exception of diabetic supplies, DME claims will not process through the pharmacy point-of-sale system. For a list of DME billing providers, go to [www.okhca.org/providers/dme/dmeproviders](http://www.okhca.org/providers/dme/dmeproviders).

**Diabetic Supplies and Continuous Glucose Monitors**

Pharmacies should submit claims for diabetic testing supplies through their regular pharmacy point-of-sale system. Covered brands include OneTouch, FreeStyle, and Precision test strips and meters; any other brands of strips and/or meters are not covered. Lancets, syringes, pen needles and control solutions will also be covered in the pharmacy claims system. Supplies for insulin pumps will remain DME claims.

The continuous glucose monitor (CGM) systems will require prior authorization (PA). The prior authorization form can be found on the OHCA website at [www.okhca.org/rxforms](http://www.okhca.org/rxforms)

For a list of covered products, please visit [www.okhca.org/bgsupplies](http://www.okhca.org/bgsupplies). Diabetic supplies are zero copay and do not count against the monthly prescription limit.

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# Chapter 15: LTC Nursing Facilities

## Introduction

SoonerCare provides members with coverage for Long-Term Care (LTC) Nursing Facilities and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID). SoonerCare reimburses providers with a set lump-sum payment for each member under their care. Items covered by the reimbursement include: dietary needs, room and board, personal hygiene items and most over-the-counter drugs.

## Section A: LTC Nursing Facility Provider Eligibility

Long-Term Care (LTC) Nursing Facilities may receive payment for the provision of nursing care under the SoonerCare Title XIX program only when they are properly licensed and certified by the Oklahoma Department of Health, meet state and federal requirements, and hold a valid written agreement with the OHCA.

To obtain additional information, go to [www.okhca.org](http://www.okhca.org), select the Providers tab, select Policies & Rules link on the left side of the page, scroll down on the page under Rules & Codes select Oklahoma Health Care Authority Medicaid Rules, select Chapter 30.

## Section B: PASRR

Preadmission Screening and Resident Review (PASRR) is a federal requirement to help ensure individuals are not inappropriately placed in nursing home for long-term care. PASRR requires all members entering SoonerCare-certified nursing facilities be screened for possible mental illness, intellectual disabilities or related conditions prior to admission.

Nursing facilities are required to complete form LTC-300R for all members entering the facility, regardless of pay source. Providers may also submit the LTC-300R electronically using the OHCA SoonerCare Provider Portal.

For additional information, go to [www.okhca.org](http://www.okhca.org), select the Providers tab, select Policies & Rules link on the left side of the page, scroll down on the page under Rules & Codes select Oklahoma Health Care Authority Medicaid Rules, select Chapter 30.

## Section C: ICF/IID Process

Pre-approval and final approval for medical eligibility of SoonerCare-certified members entering public and private ICF/IID are made by the Level of Care Evaluation Unit at OHCA. ICF/IID facilities are required to complete form LTC-300, as well as provide evidence of an intellectual disability or related condition and additional documentation of active treatment needs.

For additional information, go to [www.okhca.org](http://www.okhca.org), select the Providers tab, select Policies & Rules link on the left side of the page, scroll down on the page under Rules & Codes select Oklahoma Health Care Authority Medicaid Rules, select Chapter 30.

## Section D: Member Level of Care Appeals Process

By law, any member who feels adversely affected by any Preadmission Screening and Resident Review (PASRR) determination made by the OHCA regarding a preadmission screening or an annual resident review may request a fair hearing within 30 days from the date of notice of the PASRR result. The member or authorized agent may contact the county DHS office to request a fair hearing Form H-1 to initiate the appeals process.

Providers or physicians who would like to appeal a level-of-care decision may request the OHCA form LD-2 by contacting the OHCA Grievance Docket Clerk Legal Division at 405-522-7217.

For additional information on documentation standards, go to [www.okhca.org](http://www.okhca.org), select the Providers tab, select Policies & Rules link on the left side of the page, scroll down on the page under Rules & Codes select Oklahoma Health Care Authority Medicaid Rules, select Chapter 30.

## Section E: Billing Considerations

Individuals requesting billing information regarding nursing facilities should refer to the Electronic Data Interchange and Billing Instructions chapters of this manual. Nursing facilities will use the UB-92 paper form, 837-I for electronic batch submission and/or Direct Data Entry through the OHCA SoonerCare Provider Portal for claim submission.

Verifying member eligibility and program eligibility is very important. Members in nursing facilities are excluded from enrollment in SoonerCare Choice. If a member is enrolled in SoonerCare Choice, they must be disenrolled from managed care after admission to a nursing facility or ICF-IID.



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# Chapter 16: Indian Health Services

## Introduction

In Oklahoma there are three (3) types of Indian Health facilities: Indian Health Service (IHS), Tribes and Urban Indian clinics. IHS is the federal agency responsible for providing health services to most American Indians and Alaska natives. Unlike SoonerCare, IHS is not an entitlement program. Instead, this provision of health care to American Indians and Alaska natives falls under the federal trust responsibility that recognizes the debt owed to Indian tribal governments. Eligibility for care at IHS, Urban Indian and Tribal facilities is usually determined under federal statute and regulation and depends largely (but not exclusively) on membership in a federally recognized tribe.

## Section A: SoonerCare Eligibility

As a matter of law, American Indians who meet SoonerCare eligibility standards are entitled to SoonerCare coverage. This applies to American Indians as it does to other American citizens. SoonerCare reimburses Indian Health providers for covered services provided to American Indian SoonerCare members. Indian Health is always the payer of last resort when an American Indian SoonerCare member is eligible for services through multiple payers such as Medicare, Medicaid and Indian Health.

## Section B: Contract Health Services

Most IHS, Tribal and Urban Indian facilities provide basic health care services. When specialty services are needed, an Indian Health facility may authorize payment for contract health services. Contract health services are defined by IHS as “services not available directly from IHS or tribes that are purchased under contract from community hospitals and practitioners.” It is important to note that contract health services are usually purchased through a prior authorization arrangement. Since Indian Health is not an insurance company, it is not obligated to pay for health care services unauthorized by the facility.

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## Chapter 17: Utilization Review

Utilization review activities required by the OHCA are accomplished through a series of monitoring systems developed to ensure that services are reasonable, medically necessary and of optimum quality and quantity. Members and providers are subject to utilization review. Utilization control procedures safeguard against:

- Unnecessary care and services.
- Inappropriate services and quality of care.
- Inappropriate payment.

### Utilization Review Focus

Utilization review activities ensure the efficient and cost-effective administration of the OHCA by monitoring:

- Billing and coding practices.
- Medical necessity.
- Level of care validations.
- Quality of care.
- Documentation.
- Misuse.
- Overuse.
- Reasonableness of prior authorization (PA).
- Other administrative findings.

### Federal Regulations

Title XIX of the Social Security Act, Sections 1902 and 1903, and regulations found in 42 CFR 456 mandate that utilization review of the OHCA services provide methods and procedures to safeguard against unnecessary use of care and services.

These federal regulations also require that the OHCA be able to identify and, if warranted, refer cases of suspected fraud or abuse to the Medicaid Fraud Control Unit of the Office of the Oklahoma Attorney General for investigation and prosecution. Utilization review guards against unnecessary medical care and services and ensures that payments are appropriate according to the coverage policies established by the OHCA.

## Utilization Review Monitoring

### DXC Program Integrity System

The Program Integrity Subsystem of the Oklahoma interChange (iCE) MMIS provides the OHCA Program Integrity Unit with a comprehensive solution for identifying and tracking fraud and abuse within the Medicaid program.

### J-SURS

The IBM Watson Health Analytics, Surveillance and Utilization Review System (J-SURS) is used to help identify patterns of inappropriate care and services. Use of this system enables the OHCA to develop a comprehensive profile of any unusual pattern of practice and reveals suspected instances of fraud or abuse in the SoonerCare (Medicaid) program. The Utilization Review program is a useful tool in detecting the existence of any potential defects in the level of care or services provided under the SoonerCare program.

### PI Case Tracker

The PI Case Tracker provides the ability to document and monitor all OHCA audits. This component allows the user to create multiple types of cases, create and track documentation throughout the review process, from initial audit to appeal, and finally financial recoupment of any outstanding monies owed back to the state.

## Section A: Provider Utilization Review

### Fraud Defined

Fraud is an intentional deception or misrepresentation made by the provider or member, which could result in an unauthorized benefit such as an improper payment to a SoonerCare provider. Some examples of fraud are:

- Altering a member's medical records to generate fraudulent payments
- Billing for services or supplies not rendered or provided
- Soliciting, offering or receiving a kickback, bribe or rebate
- Submitting claim forms inappropriately altered to obtain higher reimbursement

## Abuse Defined

The term abuse describes incidents or practices of the OHCA providers that, although not usually considered fraudulent, are inconsistent with accepted sound medical, business or fiscal practices. These practices can result in unnecessary costs to the OHCA, improper payment, or payment for services that fail to meet recognized standards of care or are medically unnecessary. Some examples of abuse are:

- Billing and receiving payment from an OHCA member for the difference between the provider charge and the OHCA reimbursement for the service
- Submitting claims for services not medically necessary in relation to a member's diagnosis
- Excessive charges for services or supplies
- Violation of any of the provisions of the provider agreement

## Record Retention

For more information on record retention, go to [www.okhca.org](http://www.okhca.org), select the Policy link from the Providers section (see screen sample below), and then select the OHCA Rules link under Policies & Rules at left. Select the Chapter 30 link once the page opens, and then scroll down to Sections 317:30-3-4.1 and 317:30-3-15. Specific provider policy sections may be referenced for any additional requests.

The screenshot shows the Oklahoma Health Care Authority website. The header includes the logo and navigation links: about us | individuals | providers | research | policy | contact us | search. The main content area is titled 'Providers' and features a sidebar with a menu: Types, Claim Tools, Forms, Secure Sites, Policies & Rules (highlighted), Training, Updates, and Help. Under 'Policies and Rules', there is a 'WebAlerts' section with an envelope icon and a paragraph explaining the online proposed change site. Below that is a 'Public Meeting Comments' section with instructions on how to sign up for public comment at OHCA Board or MAC meetings. At the bottom, there is a 'Proposed Changes' section with instructions on how to view or make comments.

**OKLAHOMA**  
Health Care Authority

about us | individuals | providers | research | policy | contact us | search

Providers

Home > Providers > Policies and Rules

**OHCA Policies and Rules**

Search Entire Policy  
OHCA Policies and Rules Main Page

Browse chapters by clicking on the plus sign to the right of each chapter below.

**Chapters**

Chapter 1	ADMINISTRATIVE OPERATIONS	+
Chapter 2	GRIEVANCE PROCEDURES AND PROCESS	+
Chapter 10	PURCHASING	+
Chapter 25	SOONERCARE	+
Chapter 30	MEDICAL PROVIDERS-FEE FOR SERVICE	+
Chapter 35	MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY	+
Chapter 40	DEVELOPMENTAL DISABILITIES SERVICES	+
Chapter 45	INSURE OKLAHOMA	+
Chapter 50	HOME AND COMMUNITY BASED SERVICES WAIVERS	+

**Disclaimer.** The OHCA rules found on this Web site are unofficial. The official rules are published by the Oklahoma Secretary of State Office of Administrative Rules as Title 317 of the Oklahoma Administrative Code. To order an official copy of these rules, contact the Office of Administrative Rules at (405) 521-4911.

## Section B: Member Utilization Review

When member utilization review identifies a member, who might be using SoonerCare services more extensively than his/her peers, the member can be placed on a Lock-In/Restricted Services Program. Visit [www.okhca.org](http://www.okhca.org), select the More Options link in the Individual section, and then select Policies and Rules. Select the link under OHCA Rules in the center section. Select the Chapter 30 link once the page opens, and then scroll down to Section 317:30-3-14 to obtain more information on member lock-in.

### Identification of Lock-In Members

Restricted data are available from the following areas:

- Eligibility Verification System (EVS)/Automated Voice Response (AVR) at 800-767-3949 or 405-840-0650
- Swipe card device
- The SoonerCare Provider Portal

If the member is restricted, the EVS/AVR, SoonerCare Provider Portal or swipe-card device will list those restrictions. In addition to the restricted program guidelines, all other OHCA guidelines, such as prior authorization (PA) requirements, must be followed.

For questions about the Lock-In program, please contact the pharmacy help desk at 800 522-0114, *option 4*. The PHARM-16 (Pharmacy Lock-In Referral form) is located on the Pharmacy Forms page at [www.okhca.org/provider/types/pharmacy/pharmacy\\_forms.asp](http://www.okhca.org/provider/types/pharmacy/pharmacy_forms.asp)

## Section C: Utilization Review Trends

Fraud and abuse of the SoonerCare system costs taxpayers millions of dollars each year. Responsible Oklahomans need to work together to prevent fraud and abuse, and to ensure that the SoonerCare funds available are directed to those who truly deserve them.

The state relies on the health care provider community to be active participants in detecting and deterring SoonerCare abuse and fraud. If abusive or fraudulent activities are suspected, providers are encouraged to contact one of the following offices:

### **Member Fraud**

Department of Health and Human Services  
The Office of Inspector General  
Oklahoma City HOTLINE 800-784-5887  
Tulsa HOTLINE 800-797-1780

### **Office of Inspector General (OIG) National Hotline**

1-800-HHS-TIPS (800-447-8477)

### **Office of Inspector General**

Department of Health and Human Services  
Medicaid Fraud Control Unit  
Attn: HOTLINE  
330 Independence Ave., SW  
Washington, DC 20201

### **Provider Fraud**

Office of Attorney General  
2300 North Lincoln Blvd., Suite 112  
Oklahoma City, OK 73105  
Phone: 405-521-4274  
Tulsa Office: 918-581-2885

### **Program Integrity & Accountability**

Oklahoma Health Care Authority  
4345 North Lincoln Blvd.  
Oklahoma City, OK 73154-0299  
Phone: 405-522-7421  
FAX: 405-530-3246



## Section D: Administration Review and Appeal Process

### Criminal Penalties

Section 1909 of the Social Security Act provides criminal penalties for providers or members who make false statements or representations or intentionally conceal facts in order to receive payments or benefits. These penalties apply to kickbacks, bribes and rebates to refer or induce purchase of SoonerCare compensable services. The penalties also apply to individuals who knowingly and willfully charge members the difference between billed amounts and the amount allowed by SoonerCare.

### Basis for Sanctions

The OHCA may sanction a medical provider who has an agreement with the OHCA. To obtain more information on sanctions, go to [www.okhca.org](http://www.okhca.org), select the Policy link under the Providers section, and then scroll down and select the OHCA Rules link under Policies & Rules at left. Select the Chapter 30 link once the page opens, and then scroll down to sections 317:30-3-18, and 317:30-3-19 (REVOKED).

### Appeals Procedures (excluding nursing homes and hospitals)

To obtain more information on appeals, go to [www.okhca.org](http://www.okhca.org), select the Policy link in the Providers section, and then scroll down and select the OHCA Rules link under Policies & Rules at left. Select the Chapter 30 link once the page opens, and then scroll down to Section 317:30-3-20; 317:2-1-2.2 (Members appeals) (REVOKED); 317:2-1-2.3 (other grievances) (REVOKED).

### Appeals Procedures for Long-Term Care Nursing Facilities

To obtain more information on long term care facility appeals, go to [www.okhca.org](http://www.okhca.org), select the Policy link in the Providers section, and then scroll down and the OHCA Rules link under Policies and Rules at left. Select the Chapter 30 link once the page opens, and then scroll down to Section 317:30-3-21.

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# Chapter 18: Quality Assurance and Improvement

## Introduction

The Quality Assurance and Improvement Department of the Oklahoma Health Care Authority (OHCA) coordinates the quality assurance evaluation and improvement processes for all OHCA medical programs. These functions are accomplished through ongoing monitoring and evaluation of SoonerCare services and implementation of improvement initiatives to help ensure that SoonerCare beneficiaries receive appropriate and quality health care. This unit also coordinates the activities of the agency Quality Assurance Committee and provides technical support in developing and reporting federally required quality assurance/improvement activities of the agency.

The Quality Assurance and Improvement requirements of OHCA are completed through a variety of monitoring and evaluation activities to ensure the health care services provided to SoonerCare members meet quality standards as well as program requirements.

Quality Assurance and Improvement activities include:

- monitoring of utilization for the various SoonerCare programs;
- on-site provider audits for the evaluation of contract compliance;
- investigation of member and provider complaints; and development and monitoring of quality improvement studies

## Section A: Provider Utilization Review

State Medicaid agencies are required by federal regulations to provide methods and procedures to safeguard against unnecessary utilization of care and services, and to assure efficiency, economy and quality of care. To meet the requirements of the federal regulations, the OHCA contracts with a Quality Improvement Organization (QIO) to conduct medical and utilization reviews. Telligen serves as the contracted QIO for the OHCA. The Quality Assurance and Improvement department provides oversight of the QIO contract and works with the contracted QIO.

Federal regulations and OHCA rules state that some Medicaid services are subject to utilization review by an external organization under contract with the OHCA. The QIO conducts a medical hospital random sample review on services provided to SoonerCare beneficiaries in the SoonerCare Traditional fee-for-service program. The purpose of the

inpatient hospital utilization review program is to safeguard against unnecessary and inappropriate medical care rendered to SoonerCare beneficiaries. Federal regulations require medical services and/or records to be reviewed for medical necessity, quality of care, appropriateness of place of service and length of stay by the contracted organization. In addition to inpatient review, the QIO conducts a random sample review of hospital outpatient observation services to ensure the services meet specified guidelines.

OHCA rules state that the QIO conducts the administrative process for the providers it reviews. The process conducted by the QIO is the only administrative remedy available to providers and the decision issued by the QIO is considered by OHCA to be a final administrative decision. The final determination is not appealable to OHCA for any further administrative review. Following the final determination on a utilization review, OHCA will recoup the monies paid to the provider(s) associated with the review.

All inpatient and outpatient observation services are subject to QIO post-payment utilization review. These reviews are based on illness severity and treatment intensity. Hospitals and providers have the opportunity to present any and all documentation available to support the medical necessity of the provided services. If a denial determination is made by the QIO, a notice is issued to the facility and attending physician advising them of the decision and the time frame for submitting a reconsideration request. Additional information submitted with the reconsideration request will be reviewed by the QIO and a final decision on the reconsideration will be made by the QIO within the specified time frame. The provider(s) will be notified of that decision. Once the process is finalized, the QIO notifies OHCA of the decision. If the initial decision is upheld, the claim is processed for recoupment. If the review is denied and a refund from the hospital and physician is required, the SoonerCare member may not be billed for the denied services.

## Section B: On-Site Provider Audits

The OHCA Quality Assurance and Improvement department conducts on-site provider audits on a routine basis for all SoonerCare Choice primary care providers. The purpose of these reviews is to assess contract compliance and provide education to providers on the SoonerCare program, contract requirements, EPSDT requirements, chart documentation and other topics. The unit staff provides information related to current performance improvement initiatives of the organization and referral assistance to other departments within the agency. It is the role of the Compliance Review Nurse to monitor the contract requirements. Prior to the review, a departmental staff member notifies the office staff and provider of the upcoming review. Once a review date is scheduled, the QA/QI staff sends a copy of the audit tool to the provider, including

information about the documents requested for the review. The randomly-selected medical records list is sent in part to the provider prior to the on-site audit; the remaining records list is provided at the time of arrival to the on-site audit. Following the on-site review, the provider receives a written audit report detailing the findings and any required follow-up action. If a non-compliant area is identified, the QA/QI compliance team will work in partnership with the contracted provider and additional OHCA staff to establish an effective process to meet contract requirements.

## Section C: Member or Provider Complaints

Quality Assurance and Improvement staff members conduct reviews and follow-ups for potential quality of care issues. These cases are identified by OHCA staff and are referred to the Quality Assurance and Improvement department for review. When a referral is received, it is often necessary to request records from the provider(s) identified in the referral or through an analysis of claims related to the complaint.

Cases may also be identified by the contracted QIO through completion of activities associated with contract requirements. Medical records and/or additional information from the identified provider are requested to complete the review of potential issues. OHCA staff may also refer potential quality-of-care cases to the QIO for review and follow-up.

## Section D: Quality Improvement Studies/Projects

OHCA conducts ongoing Quality Improvement studies. Some of these studies are ad hoc in nature and developed in response to an identified area of focus for improvement.

The completion of some studies requires review of the medical records associated with the SoonerCare members selected in the sample. For those studies, a request for a copy of each medical record needed for review will be made by staff from the contracted QIO and/or by OHCA staff. Providers are required to send requested records within the specified time frame of the request. The Quality Assurance and Improvement Department encourages any questions concerning the medical record requests.

The Quality Assurance and Improvement Department participates as support staff in various initiatives, such as prescription drug related deaths of SoonerCare members.

The department has updated the medical home compliance review scoring guide to improve preventive service measures and behavioral health screening and treatment for the child and adult population.

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## Chapter 19: Forms

Updated versions of forms are located under the **Forms** subheading of the **Providers** section on the OHCA website ([www.okhca.org](http://www.okhca.org)) or at [www.okhca.org/providers.aspx?id=120](http://www.okhca.org/providers.aspx?id=120).