

# **Provider Billing and Procedures Manual**

**Oklahoma Health Care Authority  
August 2022**



**OKLAHOMA**  
Health Care Authority

# Table of Contents

<b>Table of Contents</b> .....	<b>ii</b>
<b>Chapter 1: General Information</b> .....	<b>1</b>
<b>Chapter 2: Contacts and Resources</b> .....	<b>2</b>
Provider Policies .....	2
Payments .....	2
Provider Contracts .....	3
Provider Contract Maintenance .....	3
Provider Resources .....	4
OHCA Call Tree .....	4
OHCA Public Site .....	5
Provider Inquiries .....	6
Forms.....	7
Call Centers .....	8
Claims .....	8
Eligibility Verification System (EVS) .....	9
Member Inquiries .....	10
SoonerCare Provider Portal .....	10
Provider Training and SoonerCare Education Specialists .....	11
OHCA Provider Webpage .....	13
<b>Chapter 3: SoonerCare Provider Portal</b> .....	<b>14</b>
Introduction .....	14
Important Website Notes.....	14
<b>Section A: Accessing the SoonerCare Provider Portal</b> .....	<b>14</b>
Getting to the SoonerCare Provider Portal.....	15
Registering for a Provider Portal Account .....	15
Types of Web Users .....	16
Forgot Password.....	17
<b>Section B: Web Features</b> .....	<b>17</b>
Broadcast/Global Messages .....	17
Main Page.....	18
My Home.....	18

My Profile .....	18
Manage Accounts.....	18
Eligibility Tab .....	22
Treatment History (Dental).....	23
Treatment History (Medical).....	24
Claims Tab.....	25
Search Claims.....	25
Claim Submission .....	26
Pricing Page .....	27
Prior Authorizations Page.....	29
Additional Information for Successful Use.....	31
Referrals .....	32
Trade Files Page (Batch Submission).....	32
Help Page .....	35
Logout Link.....	35
<b>Chapter 4: Member Eligibility Verification.....</b>	<b>36</b>
Introduction .....	36
Member ID Card.....	36
Section B: Options to Verify Member Eligibility .....	38
EVS/AVR .....	38
Provider Portal .....	39
Electronic Data Interchange (EDI) .....	41
<b>Chapter 5: Claim Completion.....</b>	<b>42</b>
Introduction .....	42
Ordering Paper Claim Forms.....	42
Section A: Paper Claims .....	42
Section B: 1500, Professional, 837P .....	43
The 1500 Health Insurance Claim Form.....	43
1500 Claims Field Descriptions/Instructions .....	45
Direct Data Entry (DDE) Claim Submission – Professional .....	51
DDE Professional Claim Submission Instructions.....	56
Section C: UB-04, Institutional, 837I.....	59
The UB-04 Universal Billing Claim Form.....	59

UB-04 Universal Billing Claim Form .....	60
UB-04 Claim Field Descriptions/Instructions .....	61
Direct Data Entry (DDE) Claim Submission – Institutional .....	66
DDE Institutional Claim Submission Instructions.....	67
Direct Data Entry (DDE) Claim Submission Inpatient/Outpatient Crossovers .....	72
Part A – Crossover Details at the Header Level.....	72
Part B – Crossover Details on each line of service .....	73
<b>Section D: ADA 2012, Dental, 837D.....</b>	<b>74</b>
The ADA 2012 Paper Claim Form .....	74
ADA 2012 Claims Field Descriptions/Instructions.....	76
Direct Data Entry (DDE) Claim Submission – Dental.....	79
DDE Dental Claim Submission Instructions .....	81
<b>Section E: Drug/Compound Prescription Drug, Pharmacy, NCPDP.....</b>	<b>83</b>
Drug/Compound Drug Claim Forms.....	83
Drug Claim Form .....	84
Pharmacy Drug Claims Field Descriptions/Instructions.....	85
Compound Prescription Drug Claim Form .....	87
Compound Prescription Drug Claim Form Field Description/Instructions .	88
Direct Data Entry (DDE) Claim Submission – Pharmacy, including compounds .....	89
DDE Pharmacy Claim Submission Instructions.....	91
<b>Section F: Electronic Claim Attachments.....</b>	<b>93</b>
Helpful Tips.....	94
Attachment Form Cover Sheet (HCA-13).....	95
<b>Section G: Electronic Special Process Claims (HCA-17A) .....</b>	<b>96</b>
Special Process Claims (1500, Institutional, Dental) .....	96
1500 .....	96
Institutional.....	96
Dental .....	97
Attachments.....	97
<b>Chapter 6: Electronic Data Interchange .....</b>	<b>100</b>
Introduction .....	100
EDI Resources .....	101

Section A: Professional Claims (837 Professional) ..... 101  
     837 Professional Transaction..... 101  
 Section B: Institutional Claims (837 Institutional) ..... 102  
     837 Institutional Transaction..... 102  
 Section C: Dental Claims (837 Dental) ..... 103  
     837 Dental Transaction ..... 103  
 Section D: Pharmacy Claims ..... 104  
     Pharmacy Claims ..... 104  
 Section E: Claim Inquiries/Responses..... 104  
     Claim Inquiry Transaction (Batch) ..... 104  
     Claim Inquiry Response Transaction (Batch)..... 105  
 Section F: Eligibility Inquiries/Responses ..... 105  
     Eligibility Inquiry Transaction (Batch) ..... 105  
     Eligibility Inquiry Transaction..... 106  
 Section G: Remittance Advice (RA)..... 107  
     835 Remittance Advice ..... 107  
 Section H: Electronic Claims/PAs with Paper Attachments ..... 107  
 Section I: Electronic Media Types ..... 109  
     EDI Batched Electronic Transactions..... 109  
 Section J: HIPAA Transaction and Code Set Requirements..... 110  
**Chapter 7: Claims Resolution Process ..... 111**  
 Introduction ..... 111  
 Section A: Claim Creation ..... 111  
     Coding Orientation: R R Y Y J J J I I I I I ..... 111  
 Section B: Data Entry ..... 113  
     MMIS Edits ..... 113  
 Section C: Resolutions..... 114  
     Paid Claims..... 114  
     Denied Claims ..... 115  
     Suspended Claims..... 115  
     Resubmit Status ..... 116  
     Working Denied Claims..... 116  
**Chapter 8: Paid Claim Adjustment Procedures..... 118**  
 Introduction ..... 118

<b>Section A: Adjustment Categories</b> .....	118
Non-Check Related Adjustments.....	118
Check-Related Adjustments.....	119
Negative Adjustment Amounts (Overpayments) .....	119
Positive Adjustments (Underpayments) .....	120
<b>Section B: Adjustment Types and Workflow</b> .....	121
Non-Check Related Adjustments (regions 50 and 56) .....	121
Check-Related Adjustments (regions 51 and 57).....	121
<b>Chapter 9: Third Party Liability</b> .....	<b>123</b>
Introduction .....	123
OHCA Third Party Liability Program.....	124
<b>Section A: Services Exempt from Third Party</b> .....	125
Liability/Cost Avoidance Requirements .....	125
Cost Avoidance .....	126
Liability Insurance .....	126
<b>Section B: TPL Claim Processing Requirements</b> .....	127
Documentation Requirements .....	127
Third Party Liability Identification.....	128
Prior Authorization .....	128
Billing Procedures .....	129
Non-Covered Services or Lifetime Maximum Exceeded.....	129
Subsequent Third-Party Liability Payment .....	129
Remittance Advice Information .....	130
Insurance Carrier Reimburses OHCA Member.....	130
<b>Section C: Coordination with Commercial Plans</b> .....	130
HMO Billing OHCA.....	131
<b>Section D: Medicare-OHCA Related Reimbursement</b> .....	132
Medicare Enrolled Participating Provider Reimbursement Process .....	132
Medicare Enrolled Non-Participating Provider Reimbursement Process..	133
Crossover Claims.....	133
Prior Authorization .....	134
Medicare Non-Covered or Denied Services .....	134
Other TPL Resources.....	135

Section E: Member TPL Update Procedures ..... 135

    Automated Recovery, Resource Data Request Letters and Questionnaires  
    ..... 135

    General Update Procedures..... 136

    Telephone Inquiry Procedures..... 136

    Written Inquiry Procedures..... 137

    Summary ..... 137

**Chapter 10: Prior Authorization ..... 140**

Introduction ..... 140

Section A: Durable Medical Equipment (DME) / Medical / Therapy –  
Occupational/Physical/Speech (OT/PT/ST) ..... 140

    Prior Authorization Requests..... 140

    Prior Authorization Process..... 140

    Retroactive Authorization..... 141

    Reconsideration and Appeals Procedures ..... 141

        • Level 1—Reconsideration ..... 141

        • Level 2—Appeal ..... 142

Section B: Dental ..... 142

    Dental Requests..... 142

Section C: Pharmacy ..... 143

    Pharmacy Requests..... 143

    www.oklahoma.gov/ohca/pa ..... 144

    Reconsideration and Appeals Procedure..... 144

        • Level 1—Reconsideration ..... 144

        • Level 2—Appeal ..... 144

Section D: Behavioral Health ..... 145

    Outpatient Rehabilitative Behavioral Health, Licensed Behavioral Health  
    Professionals and Psychologist Services ..... 145

    Inpatient Behavioral Health, Detoxification, Residential Substance Use  
    Disorder (SUD) Treatment and Therapeutic Foster Care Services..... 145

    Reconsideration and Appeals Procedure..... 146

        • Level 1—Reconsideration ..... 146

        • Level 2—Appeal ..... 146

Section E: Services to Illegal/Ineligible Aliens/Sooner To Be Sooners ..... 147

    Requests for Services to Illegal/Ineligible Aliens/Sooner To Be Sooners..... 147

Out of State Services .....	148
<b>Section G: Prior Authorization Process</b> .....	<b>151</b>
Retroactive Authorization.....	151
<b>Section H: Reconsideration and Appeal Procedures</b> .....	<b>152</b>
Level 1—Reconsideration .....	152
Level 2—Appeal.....	152
<b>Chapter 11: Financial Services .....</b>	<b>155</b>
Introduction .....	155
<b>Section A: Payment Information</b> .....	<b>155</b>
Payments.....	155
<b>Section B: Remittance Advice (RA)</b> .....	<b>156</b>
Remittance Advice Section Descriptions .....	157
Remittance Advice Sorting Sequence .....	159
EOB Codes.....	160
Remittance Advice Examples .....	160
<b>Section C: Electronic Remittance Advice</b> .....	<b>166</b>
<b>Section D: 1099 &amp; W-2s</b> .....	<b>167</b>
<b>Section E: Stop Payments, Voids, Re-issuance</b> .....	<b>167</b>
Stop Payments.....	167
Check Void.....	167
<b>Section F: Electronic Care Coordination Payments</b> .....	<b>168</b>
<b>Chapter 12: SoonerCare Choice .....</b>	<b>174</b>
Introduction .....	174
Quality Assurance .....	174
<b>Covered Members</b> .....	<b>175</b>
American Indian/Alaska Natives.....	175
SoonerCare Choice Exempt .....	175
<b>Access to Care</b> .....	<b>176</b>
SoonerCare Choice PCPs are required to maintain access to primary and preventive care services in accordance to the contract. The following standards apply:.....	176
Emergency Care .....	176
<b>Member Enrollment/Disenrollment</b> .....	<b>177</b>
SoonerCare Choice Enrollment .....	177

Choosing a PCP.....	178
Capacity (Number of Members requested per PCP).....	178
Changing PCPs.....	178
Disenrollment at the Request of the PCP.....	178
<b>Referrals</b> .....	<b>179</b>
Payment for Referred Services.....	181
Documenting the Medical File.....	181
<b>Early and Periodic Screening Diagnosis and Treatment (EPSDT)</b> .....	<b>181</b>
Schedule of EPSDT Services.....	182
Additional Requirements.....	182
<b>Reporting Requirements</b> .....	<b>182</b>
<b>Reimbursement</b> .....	<b>183</b>
Care Coordination.....	183
SoonerExcel Incentive.....	183
Fee-For-Service.....	183
Claims.....	183
<b>Care Management</b> .....	<b>184</b>
<b>Chapter 13: Insure Oklahoma</b> .....	<b>185</b>
Introduction.....	185
<b>Chapter 14: Pharmacy</b> .....	<b>186</b>
Introduction.....	186
Pharmacy Policy (Rules).....	186
Prescription Drug Benefit.....	187
Product Based Prior Authorization (PBPA).....	187
Pharmacy Lock-In Program.....	188
Durable Medical Equipment (DME).....	190
<b>Chapter 15: LTC Nursing Facilities</b> .....	<b>191</b>
Introduction.....	191
Section A: LTC Nursing Facility Provider Eligibility.....	191
Section B: PASRR.....	191
Section C: ICF/IID Process.....	191
Section D: Member Level of Care Appeals Process.....	192
Section E: Billing Considerations.....	192
<b>Chapter 16: Indian Health Services</b> .....	<b>193</b>

Introduction .....	193
Section A: SoonerCare Eligibility.....	193
Section B: Purchased and Referred Care .....	193
<b>Chapter 17: Utilization Review/Post Payment Audits .....</b>	<b>194</b>
Utilization Review Focus.....	194
Federal Regulations .....	194
Utilization Review Monitoring/Post Payment Audits.....	195
Gainwell Program Integrity System.....	195
Section A: Provider Utilization Review/Post Payment Audits .....	195
Fraud Defined .....	195
Abuse Defined.....	196
Record Retention.....	196
Section B: Member Utilization Review .....	196
Identification of Lock-In Members .....	198
Section C: Utilization Review Trends.....	198
Section D: Administration Review and Appeal Process .....	199
Criminal Penalties.....	199
Basis for Sanctions.....	200
Appeals Procedures (excluding nursing homes and hospitals).....	200
Appeals Procedures for Long-Term Care Nursing Facilities.....	200
<b>Chapter 18: Quality Assurance and Improvement.....</b>	<b>201</b>
Introduction .....	201
Section A: Provider Utilization Review.....	201
Section B: Member or Provider Complaints.....	203
Section C: Quality Improvement Studies/Projects.....	204

# 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 Gainwell Technologies (Gainwell), f/k/a DXC Technology (DXC), 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. Providers who choose to participate in Medicaid must accept the Medicaid payment as payment in full for services covered by Medicaid. Providers are restricted from charging the Medicaid member the difference between the usual customary charge and Medicaid's payment. Services not covered under the Medicaid program may 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 program guidelines for providers that participate in the Oklahoma Medicaid program. Every effort has been made to ensure the accuracy of this manual, *however 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 Gainwell 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 OHCA website at <https://oklahoma.gov/ohca/providers.html> click on Billing Manual under Claims Tools.

# Chapter 2: Contacts and Resources

## Provider Policies

A provider is any OHCA-contracted individual or facility that provides health care services for SoonerCare members.

## Payments

Payments to providers under SoonerCare are made for services rendered on behalf of a SoonerCare patient. There are no exceptions to 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 programs. Services cannot be paid under SoonerCare for ineligible individuals, services not covered under the scope of OHCA's programs or services not meeting documentation requirements. These claims may be denied, or recouped upon post-payment review.

For additional information on provider policies, go to <https://oklahoma.gov/ohca/policies-and-rules/xpolicy.html>.

Oklahoma Health Care Authority

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Oklahoma Health Care Authority > Policy and Rules > Policy and Rules

**Policies and Rules**

- Policy and Rules
- Proposed Changes
- Public Notices
- Native American Consultation
- HIPAA
- Search Policy
- Plans and Waivers
- SoonerCare Out-of-State Services Rule Changes
- Additional Important Statutes

**OHCA Policies and Rules**

[Click Here to Search Entire Policy](#)

<a href="#">Chapter 1</a>	ADMINISTRATIVE OPERATIONS
<a href="#">Chapter 2</a>	GRIEVANCE PROCEDURES AND PROCESS
<a href="#">Chapter 10</a>	PURCHASING
<a href="#">Chapter 25</a>	SOONERCARE
<a href="#">Chapter 30</a>	MEDICAL PROVIDERS-FEE FOR SERVICE
<a href="#">Chapter 35</a>	MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY
<a href="#">Chapter 40</a>	DEVELOPMENTAL DISABILITIES SERVICES
<a href="#">Chapter 45</a>	INSURE OKLAHOMA
<a href="#">Chapter 50</a>	HOME AND COMMUNITY BASED SERVICES WAIVERS
<a href="#">Chapter 55</a>	MANAGED CARE

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.

[Additional Important Statutes](#)

Click **Chapter 30**.

## Provider Contracts

In order to be eligible to participate in SoonerCare, 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 electronically signed by the provider and has been approved by OHCA.

### Provider Contract Maintenance

Provider contracts must be renewed, at maximum, every four years. It is the responsibility of the provider to maintain records and contracts with OHCA. Any provider information changes must be promptly reported by using the SoonerCare provider portal. Failure to maintain current information may result in delays or denials of payments.

For more information on Provider Enrollment, you may email: [ProviderEnrollment@okhca.org](mailto:ProviderEnrollment@okhca.org) or call 1-800-522-0114, option 5. You may also visit [Oklahoma.gov/ohca.html](http://Oklahoma.gov/ohca.html) – Providers; Provider Enrollment.

## Provider Resources

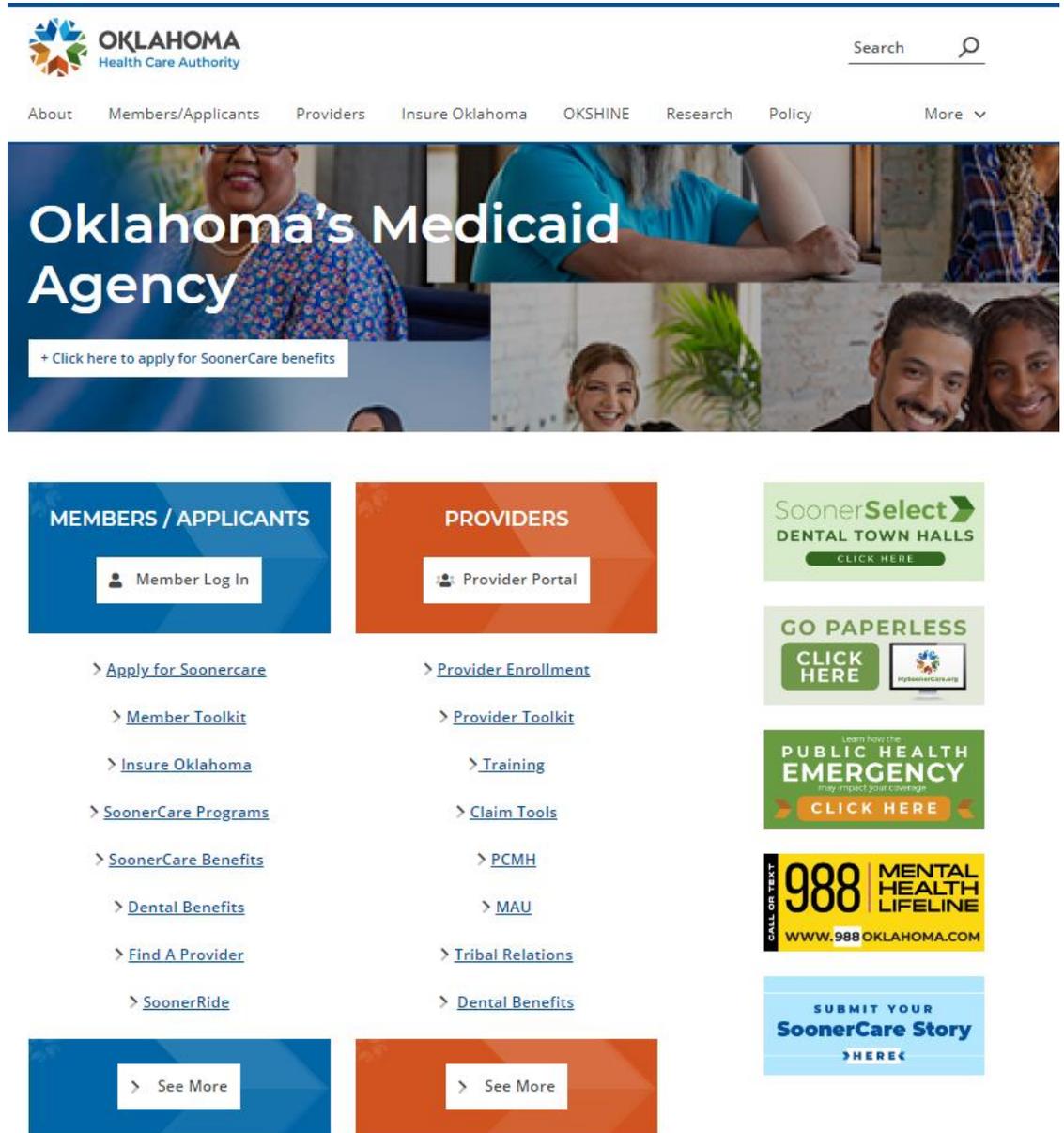
### OHCA Call Tree

1- 800-522-0114

Option	Unit	Call Types	Availability
1	OHCA Call	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
3, 2	Third Party Liability	Health insurance injury/accident questionnaires, third party insurance inquiries, estate recovery or subrogation	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	For Out-Patient Behavioral Health authorizations.	8 a.m. to 5 p.m. M-F
6,2,2	Behavioral Health	For In-Patient Behavioral Health authorizations.	8 a.m. to 5 p.m. M-F
6, 3	Medical Authorizatio	Medical authorization status.	8 a.m. to 5 p.m. M-F
6,4	Prior Authorizatio ns	For prior authorizations for DME, medical services and emergency services for	8 a.m. to 5 p.m. M-F
6, 5	Dental Authorization	Dental authorizations (status only).	8 a.m. to 5 p.m. M-F

## OHCA Public Site

OHCA administers the state of Oklahoma’s Medicaid agency program known as SoonerCare. Primary programs under SoonerCare include: SoonerCare Traditional, SoonerCare Choice and SoonerPlan. OHCA public site, [Oklahoma Health Care Authority](#), (see screen sample below) provides information for Medicaid members and providers, including data on programs, and health and medical policies.



## Provider Inquiries

The SoonerCare Call Center is open from 8:00 a.m. and 5:00 p.m., Monday through Friday. OHCA is committed to providing excellent customer service to providers, members, and other community stakeholders.

The Pharmacy Help Desk is operational seven days a week, and the hours of operation are 8:00 am to 7:00 pm Monday through Friday, 9am-5pm Saturday and 11am-5pm Sunday.

### OHCA 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 Authorizations
- Medical
- Dental
- Behavioral Health

### Before You Call

When calling 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

## Forms

Updated versions of forms are located at:  
<https://oklahoma.gov/ohca/providers/forms.html>.


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Oklahoma Health Care Authority > Providers > Forms

### Providers

- Types 
- Provider Portal
- Forms 
  - OHCA Pharmacy Forms
  - Provider Training
  - Provider Services
  - Provider Enrollment
  - Provider Toolkit
  - Policy and Rules 
  - Publications
  - Electronic Health Record Incentive Program
  - Updates 

## Forms

FORM NUMBER	TITLE
<a href="#">After Hours</a>	<a href="#">After Hours Participation Form</a>
<a href="#">CH-1</a>	<a href="#">Week Old Visit</a>
<a href="#">CH-2</a>	<a href="#">1 Month Visit</a>
<a href="#">CH-3</a>	<a href="#">2 Month Visit</a>
<a href="#">CH-4</a>	<a href="#">4 Month Visit</a>
<a href="#">CH-5</a>	<a href="#">6 Month Visit</a>
<a href="#">CH-6</a>	<a href="#">9 Month Visit</a>
<a href="#">CH-7</a>	<a href="#">12 Month Visit</a>
<a href="#">CH-8</a>	<a href="#">15 Month Visit</a>
<a href="#">CH-9</a>	<a href="#">18 Month Visit</a>
<a href="#">CH-10</a>	<a href="#">24 Month Visit</a>
<a href="#">CH-11</a>	<a href="#">30 Month Visit</a>
<a href="#">CH-12</a>	<a href="#">3 Year Old Visit</a>
<a href="#">CH-13</a>	<a href="#">4 Year Old Visit</a>
<a href="#">CH-14</a>	<a href="#">5 Year Old Visit</a>
<a href="#">CH-15</a>	<a href="#">6 to 10 Year Old Visit</a>
<a href="#">CH-16</a>	<a href="#">11 to 20 Year Old Visit</a>

## Call Centers

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.

## 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>	Gainwell Technologies P.O. Box 18430 Oklahoma City, OK
<b>Dental (ADA)</b>	Gainwell Technologies P.O. Box 18110 Oklahoma City, OK
<b>Form 1500</b>	Gainwell Technologies P.O. Box 54740 Oklahoma City, OK
<b>HMO Copay/Personal Care Services (Individual; not agency)</b>	Gainwell Technologies P.O. Box 18500 Oklahoma City, OK
<b>Long-Term Care Nursing Facilities</b>	Gainwell Technologies P.O. Box 54200 Oklahoma City, OK
<b>Pharmacy</b>	Gainwell Technologies P.O. Box 18650 Oklahoma City, OK
<b>Waiver Provider</b>	Gainwell Technologies P.O. Box 54016 Oklahoma City, OK

## 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).

## 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: 800-987-7767

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

## SoonerCare Provider Portal

The SoonerCare Provider Portal is OHCA's secure website offering providers a centralized location to meet business needs such as: submitting claims and verification of claim status. The SoonerCare Provider Portal is available 24 hours a day, 7 days a week, excluding during scheduled maintenance.

- New providers are assigned a PIN to access the website. To access the SoonerCare Provider Portal, go to <https://oklahoma.gov/ohca.html>, 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 sub-section 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

## **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 the SoonerCare Provider Portal. Provider Education Specialists provide training through on-site, virtual, or telephonic provider visits and 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 webinars
- Conduct policy and portal training through webinars, and on-site, virtual, or telephonic provider visits

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.

## OHCA Contact Information

Providers may contact the SoonerCare Education team to request assistance from a Provider Education Specialist by emailing [SoonerCareEducation@okhca.org](mailto:SoonerCareEducation@okhca.org)

# OHCA Provider Webpage

OHCA Provider webpage may be found at:  
<https://oklahoma.gov/ohca/providers.html>

The screenshot displays the OHCA Provider Webpage interface. At the top, there is a navigation bar with the OHCA logo and a search function. Below the navigation bar, a breadcrumb trail indicates the current location: Oklahoma Health Care Authority > Providers. The main content area is divided into several sections:

- Providers:** A large section with a '+ Provider Portal' button. It features a 'SAVE THE DATE!' announcement for Home & Community Based Services Focus Group Sessions, with a link to download the document and an 'RSVP NOW!' button.
- Types:** A list of provider types including All Types, Behavioral Health, Child Health/EPSTD, Dental, Durable Medical Equipment, Federally Qualified Health Centers, Hospitals, Long-Term Care Services, Medical Authorization Unit (MAU), Other Provider Types, Patient-Centered Medical Home, Perinatal Services, Pharmacy, Physicians, Rural Health Clinics, School-Based, SoonerCare Choice, SoonerPlan Family Planning Waiver, and Tribal Relations.
- Claim Tools:** A list of tools and resources such as NCPDP D.0, ICD-10 FAQs, Adjustments, AVR/EVS (Member Eligibility), Billing Manual, Electronic Data Interchange, Error Codes, National Correct Coding Initiative, Provider Secure Site, Provider Reimbursement Notices, SoonerCare Fee Schedules, Third Party Liability, Prior Authorization, Behavioral Health, Dental, Durable Medical Equipment, Medical, Pharmacy, and Therapy.
- Resources:** A list of resources including Care Coordination Resources, OHCA Call Tree, Provider Toolkit, SoonerQuit for Providers, EHR Incentive, and Soon-to-be-Sooners.
- Training:** A list of training opportunities including SoonerCare Training, Pharmacy Training, and School-Based Training.
- Enrollment:** A list of enrollment-related resources, including 'Become a SoonerCare Provider'.

# 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:

- 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 <https://oklahoma.gov/ohca.html>.
2. Select the Provider Portal link located under the Providers section of the home page.
3. You can do directly to the login page at [ohcaprovider.com](https://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 Gainwell. 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**

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**

Messages will only display on the login splash page; all providers will see these messages.

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.

The screenshot displays the Oklahoma Health Care Authority Provider Portal. At the top, the logo and name 'OKLAHOMA Health Care Authority' are visible, along with the title 'Provider Portal'. A navigation bar contains links for 'My Home', 'Eligibility', 'Claims', 'Prior Authorizations', 'Referrals', 'Files Exchange', 'Financial', 'Letters', 'Reports', and 'Resources'. Below this, there are links for 'Contact Us' and 'Logout', and the current date and time: 'Tuesday 08/09/2022 08:46 AM CST'.

The main content area is divided into several sections:

- Broadcast Messages:** A message about a SoonerQuit webinar on August 23, 2022, at 2 p.m. The message details the webinar's focus on the Tobacco Free Environment Initiative, including topics like tobacco-free workplace policy development, SA's, nicotine replacement therapies, and referral setup.
- User Details:** A sidebar menu with a 'Welcome' message and links for 'My Profile' and 'Manage Accounts'. A red arrow points to the 'Manage Accounts' link.
- Provider:** A section with fields for 'Name', 'Provider ID', 'Taxonomy', and 'SC Provider Number'.
- Provider Services:** A section with a link for 'Search Payment History'.
- Welcome Health Care Professional!:** A central message with a photo of a healthcare professional and text stating the organization's commitment to making it easier for providers to perform their business.
- Helpful Links:** A section with links for 'Contact Us', 'SoonerCare Education', 'Referrals' (with a 'New' badge), 'PA Notice', 'Update Provider Files', 'Upload Service Quality Review Records', and 'Insurance Oklahoma Emolover/Agent Portal'.

At the bottom of the page, there is a footer with the version number 'R4.2' and the copyright notice '© 2022 Gainwell Technologies. All rights reserved. | Privacy Notice'.

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. Selecting Lifetime Date of Service will return services that are only compensable once in a member's lifetime.
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
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**Service Information**

\*Service From Date   To Date    Lifetime

\*Procedure Code Type  Procedure Code

Search Reset

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 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/GAINWELL without the constraint of having to submit the data in HIPAA-compliant format. DDE claim pages are available on 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 OHCA/Gainwell 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

The next section is used to add attachments. The user uploads the file, enters a description of the attachment, and selects Add. Accepted file types are TIF, JPEG, PDF, and XPS. There is a 10MB limit.

Next you will select the appropriate assignment code.

The diagnosis summary box will allow the user to add a primary diagnosis if applicable.

Remarks are optional and can be entered by clicking the Add button.

The Service Detail section is used to enter service type codes and related details. A maximum of 12 lines may be requested per prior authorization.

When complete, 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 OHCA.

### File Upload

The File Upload page allows users to select a file from a local hard drive and upload it to 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 Gainwell 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..

The screenshot shows the Oklahoma Health Care Authority Provider Portal. The header includes the logo and name of the Health Care Authority, and the title "Provider Portal". A navigation menu contains links for My Home, Eligibility, Claims, Prior Authorizations, Referrals, Files Exchange (highlighted), Financial, Letters, Reports, and Resources. Below the menu, there are links for Download Files and Upload Files. The main content area is titled "File Upload" and contains instructions for uploading files. It includes a "Transaction Type" dropdown menu, a "Select File to Upload" button, and a "Save as Filename" text box. A "Reset" button is located at the bottom of the form. The footer contains the version number "R4.2" and copyright information for Gainwell Technologies.

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.

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.

# 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 <https://oklahoma.gov/ohca/individuals/mysoonerCare.html>.

## Member ID Card

SoonerCare members can print their identification card at <https://oklahoma.gov/ohca/individuals/mysoonerCare.html>. 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.



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 three 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 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.

# Chapter 5: Claim Completion

## Introduction

The following information is intended to provide procedures for submitting claims to OHCA. For information on what services are covered by the Oklahoma SoonerCare program, please access the agency rules. Rules can be found at <https://oklahoma.gov/ohca/policies-and-rules>. The main methods for submitting claims to OHCA are paper 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	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	Pharmacy	NCPDP, version 5.1

## Ordering Paper Claim Forms

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

## Section A: Paper Claims

Paper Claims that require special processing must be submitted through the provider portal.

Paper 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.

## 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



## HEALTH INSURANCE CLAIM FORM

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

CARRIER  
 PATIENT AND INSURED INFORMATION  
 PHYSICIAN OR SUPPLIER INFORMATION

<input type="checkbox"/> PICA		PICA <input type="checkbox"/>	
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 SEX (LING ID#) <input type="checkbox"/> OTHER <input type="checkbox"/> (ID#)	
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"/>	
5. PATIENT'S ADDRESS (No., Street)  CITY STATE ZIP CODE TELEPHONE (Include Area Code) ( )		4. INSURED'S NAME (Last Name, First Name, Middle Initial)  7. INSURED'S ADDRESS (No., Street)  CITY STATE ZIP CODE TELEPHONE (Include Area Code) ( )	
9. 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? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State)	
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 _____		11. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>	
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.		12. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input type="checkbox"/> # yes, complete items 9, 9a, and 9d.	
15. OTHER DATE MM DD YY QUAL.		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize payment of medical benefits to the undersigned physician or supplier for services described below.	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		SIGNED _____	
17a. NPI		18. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		18. 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) ICD Ind.		20. OUTSIDE LAB? YES <input type="checkbox"/> NO <input type="checkbox"/> # CHARGES	
A. _____ B. _____ C. _____ D. _____		22. RESUBMISSION CODE ORIGINAL REF. NO.	
E. _____ F. _____ G. _____ H. _____		23. PRIOR AUTHORIZATION NUMBER	
I. _____ J. _____ K. _____ L. _____		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) E. DIAGNOSIS POINTER F. # CHARGES G. DAYS OR UNITS H. FROST/FURY Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #	
25. FEDERAL TAX I.D. NUMBER SBN EIN		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. Revised 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.)		32. SERVICE FACILITY LOCATION INFORMATION	
SIGNED _____ DATE _____		33. BILLING PROVIDER INFO & PH # ( )	
a. NPI b.		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.
18	Situational	Hospitalization Dates Related to Current Service: Enter the requested FROM and TO dates.
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., N499999999999); NDC should go directly over dates, do not enter any spaces or dashes.

24B	<b>Required</b>	<p><b>Place of Service:</b>  <i>Unshaded (bottom):</i> Enter the place of service code for the place services were rendered.</p> <p>Place of Service Codes: <u>CODE DESCRIPTION</u></p> <ul style="list-style-type: none"> <li>11 Office</li> <li>12 Home</li> <li>20 Urgent care facility</li> <li>21 Inpatient hospital</li> <li>22 Outpatient hospital</li> <li>23 Emergency room</li> <li>24 Ambulatory surgical center (ASC)</li> <li>25 Birthing center</li> <li>26 Military treatment facility</li> <li>31 Skilled nursing facility (SNF)</li> <li>32 Nursing facility (NF)</li> <li>33 Custodial care facility</li> <li>34 Hospice</li> <li>41 Ambulance – land</li> <li>42 Ambulance – air or water</li> <li>51 Inpatient psychiatric facility</li> <li>52 Psychiatric facility – partial hospitalization</li> <li>53 Community mental health center</li> <li>54 Intermediate care facility/developmentally disabled (ICF/MR)</li> <li>55 Residential substance abuse treatment facility</li> <li>56 Psychiatric residential treatment center</li> <li>61 Comprehensive inpatient rehabilitation facility</li> <li>62 Comprehensive outpatient rehabilitation facility</li> <li>65 End-stage renal disease treatment facility</li> <li>71 State or local public health clinic</li> <li>72 Rural health clinic (RHC)</li> <li>81 Independent laboratory</li> <li>99 Other unlisted facility</li> </ul>
		<i>Shaded (top):</i> Do not enter anything in this field.
24C	<b>Not Required</b>	<p><b>Emergency Indicator (EMG):</b>  <i>Unshaded (bottom):</i> If services are related to an emergency, enter Y; if not, enter N.</p>
		<i>Shaded (top):</i> Do not enter anything in this field.

24D	Situational	<p><b>Procedures, Services or Supplies (Explain unusual circumstances):</b> CPT/HCPCS; Modifier  <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>  <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</p> <p><i>Shaded</i> (top): Do not enter anything in this field.</p>
24F	Required	<p><b>\$ Charges:</b>  <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>  <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>  <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.  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.  When entering the provider’s NPI number, use the unshaded area of 24J.</p>

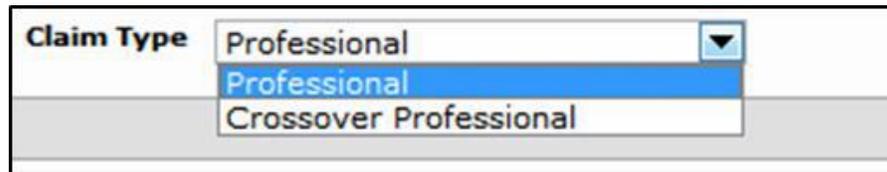
24I	Not Required	<b>ID Qualifier:</b> <i>Unshaded</i> (bottom): This field is already populated with NPI, indicating that the provider number listed for the rendering provider is the NPI.
		<i>Shaded</i> (top): Enter the 2-character qualifier indicating the type of provider number being used for the 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.

2B	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.



**OKLAHOMA Health Care Authority** **Provider Portal**

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

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

Claims > Submit Claim Prof Contact Us | Logout  
Friday 02/04/2022 09:43 AM CST

**Submit Professional Claim: Step 1**

\* Indicates a required field.

Claim Type: Professional  
 EVV SERVICES ONLY timely filing: No  
 HCA-17: No

**Provider Information**  
 This panel contains provider information.

Billing Provider ID: Name, ID Type: NPI  
 Zip Code: 73020-8428, Contract Code: G, Taxonomy: , SC Provider Number:   
 Referring Provider ID: , ID Type:   
 Ordering Provider ID: , ID Type: , Ordering Zip Code:   
 Other Facility 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.

Date Type: , Date of Current:   
 Accident Related: , Expected Delivery Date:   
 Patient Account Number: , From Date: , To Date:   
 CLIA Number: , \*Other Insurance: None, HMO Copy: No  
 Total Charged Amount: \$0.00

[Continue](#) [Cancel](#)

[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: ICD-9-CM \*Diagnosis Code:   
[Add](#) [Reset](#)

**Other Insurance Details**

TPL Amount:   
[Back to Step 1](#) [Continue](#) [Cancel](#)

**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**

[Add](#)

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).

**OKLAHOMA**  
Health Care Authority

## Provider Portal

[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 Prof](#) Tuesday 08/09/2022 12:58 PM CST

### Submit Professional Claim: Step 1

\* Indicates a required field.

Claim Type: **Crossover Professional**

HCA-17: **No**

#### 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>Contract Code</b> _
<b>Referring Provider ID</b>	<b>Taxonomy</b>
<b>Ordering Provider ID</b>	<b>ID Type</b>
<b>Other Facility ID</b>	<b>ID Type</b>
	<b>SC Provider Number</b>
	<b>Ordering Zip Code</b>

#### Patient Information

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

\*Member ID: b30599827

Last Name: BECERRA      First Name: MARK      Middle:

Birth Date: 07/01/1994

#### 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.

<b>Date Type</b>	<b>Date of Current</b>
<b>Accident Related</b>	
<b>Patient Account Number</b>	<b>Expected Delivery Date</b>
* <b>From Date</b>	* <b>To Date</b>
<b>CLIA Number</b>	
* <b>Other Insurance</b>	

Total Charged Amount: \$0.00

[Continue](#) [Cancel](#)

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

**Submit Professional Claim: Step 2** ?

\* Indicates a required field.

**Claim Type** Crossover Professional  
HCA-17 No

**Provider Information**

<b>Billing Provider ID</b>	<b>ID Type</b> NPI	<b>Name</b>	
Zip Code 73140	Contract Code _	Taxonomy 261QF0400X	SC Provider Number

**Patient and Claim Information**

<b>Member ID</b>	<b>Gender</b> Male
<b>Member</b>	<b>Total Charged Amount</b> \$0.00
<b>Birth Date</b>	<b>To Date</b>
<b>From Date</b>	
<b>CLIA Number</b>	

[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
<a href="#">1</a>	ICD-10-CM	A0102-TYPHOID FEVER WITH HEART INVOLVEMENT	<a href="#">Remove</a>
<a href="#">2</a>			

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

[Go to Top](#)

34.2
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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.

**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

Rendering Provider ID  ID Type  Zip Code  Contract Code

Taxonomy

Ordering Provider ID  ID Type  Zip Code

**NDC for Item 1**

**Medicare Crossover Details for Item 1**

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

<b>Allowed Medicare Amount</b> <input style="border: 2px solid red;" type="text" value="\$0.00"/>	<b>Co-insurance Amount</b> <input type="text" value="\$0.00"/>
<b>Deductible Amount</b> <input type="text" value="\$0.00"/>	<b>Psychiatric Services Amount</b> <input type="text" value="\$0.00"/>
<b>Medicare Payment Amount</b> <input type="text" value="\$0.00"/>	<b>Medicare Payment Date</b> <input type="text"/>

**Attachments**

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

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

[Go to Top](#)

14.2
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## DDE Professional Claim Submission Instructions

<b>Provider Information</b>		
<b>Form Locator</b>	<b>DDE Professional Claim Submission</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	
Ordering ZIP Code	Enter the ZIP Code.	
<b>Patient Information</b>		
<b>Form Locator</b>	<b>DDE Professional Claim Submission</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</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	
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	This field will auto-populate.	
<b>Medicare Crossover Details (when Crossover Professional is selected)</b>		
<b>Form Locator</b>	<b>DDE Professional Claim Submission</b>	<b>Requirement</b>
Allowed Medicare	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	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</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</b>	<b>Requirement</b>
TPL Amount	Enter the TPL amount.	
<b>Service Information</b>		
<b>Form Locator</b>	<b>DDE Professional Claim Submission</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. See 1500 form locator 24D for additional information.	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	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	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	Required, if applicabl
ID Type	Select from the drop-down list to determine ID	
ZIP Code	Enter rendering provider's ZIP code +4, if	
Contract Code	Select from drop-down list, if applicable.	
Taxonomy	Enter rendering provider's taxonomy, if	
SC Provider Number	Enter the Oklahoma SoonerCare provider	
<b>NDC for Item #</b>		
<b>Form Locator</b>	<b>DDE Professional Claim Submission</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</b>	<b>Requirement</b>
Transmission Method	Select from the drop-down list how the attachment(s) will be sent.	Required, if
Upload File	Click Browse to locate file to be uploaded; <i>available when FT-File Transfer is selected.</i>	Required, if
Attachment Type	Select file type of the attachment from the drop-down list.	Required, if
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	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 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 Universal Billing Claim Form

1		2		3a PAE CNTL # b MED REC #		4 TYPE OF BILL	
5 PATIENT NAME				6 STATEMENT COVERS PERIOD FROM THROUGH			
8 PATIENT NAME				9 PATIENT ADDRESS			
10 BIRTHDATE		11 SEX		12 DATE		13 ADMISSION HRS	
14 TYPE		15 SPEC		16 DHR		17 STAT	
18		19		20		21	
22		23		24		25	
26		27		28		29 ACCT STATE	
30		31 OCCURRENCE DATE		32 OCCURRENCE DATE		33 OCCURRENCE DATE	
34		35		36		37	
38		39 VALUE CODES AMOUNT		40 VALUE CODES AMOUNT		41 VALUE CODES AMOUNT	
42 REV. CD.		43 DESCRIPTION		44 HCPCS / RATE / ICD-9 CODE		45 SERV. DATE	
46 SERV. UNITS		47 TOTAL CHARGES		48 NON-COVERED CHARGES		49	
PAGE		OF		CREATION DATE		TOTALS	
50 PAYER NAME		51 HEALTH PLAN ID		52 PBL RFD		53 ASG BEN	
54 PRIOR PAYMENTS		55 EST. AMOUNT DUE		56 NPI		57 OTHER PPRV ID	
58 INSURED'S NAME		59 PPEL		60 INSURED'S UNIQUE ID		61 GROUP NAME	
62 INSURANCE GROUP NO.		63 TREATMENT AUTHORIZATION CODES		64 DOCUMENT CONTROL NUMBER		65 EMPLOYER NAME	
66		67		68		69	
70		71		72		73	
74 PRINCIPAL PROCEDURE CODE		75 OTHER PROCEDURE CODE		76 ATTENDING		77 OPERATING	
78 OTHER PROCEDURE CODE		79 OTHER PROCEDURE CODE		80 OTHER PROCEDURE CODE		81 OTHER PROCEDURE CODE	
80 REMARKS		81a		81b		81c	
81d		81e		81f		81g	

**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 MMDDYY 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: N499999999999UN999.99. Corresponding HCPCS code(s) should be placed on the same line as NDC.
43, line 23	<i>Not Used</i>	<i>Page ___ of ___; 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)</i>
53A-C	<i>Not Captured</i>	<i>ASG BEN (Assignment of Benefits Certification)</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.
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 Health Care Authority** Provider Portal

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  
Tuesday 08/09/2022 01:17 PM CST

**Submit Institutional Claim: Step 1**

\* Indicates a required field.

Claim Type:    
 HCA-17:

**Provider Information**

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

Billing Provider ID	ID Type	NPI	Name
Zip Code: 73140	Contract Code: _	Taxonomy: 261QF0400X	SC Provider Number
Institutional Provider ID: <input type="text"/>	ID Type: <input type="text"/>		
Attending Provider ID: <input type="text"/>	ID Type: <input type="text"/>		
Operating Provider ID: <input type="text"/>	ID Type: <input type="text"/>		
Referring Provider ID: <input type="text"/>	ID Type: <input type="text"/>		

**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:  -  Covered Days:

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

\*Admission Type:  \*Admission Source:

\*Admitting ICD Version:  \*Admitting Diagnosis:

\*Patient Status:  \*Type of Bill:

Patient Account Number:  Other Insurance:

HMO Copy:  Total Charged Amount: \$0.00

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### DDE Institutional Claim Submission Instructions

Provider Information		
Form Locator	DDE Institutional Claim Submission	Requirement
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.	
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. See <i>UB-04 form locator 7 for additional information.</i>	Required, if applicable

Patient Information		
Form Locator	DDE Institutional Claim Submission	Requirement

**Service Details** -

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**

**DMH Contract Source**  **Charge Amount**

**Attachments** -

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

#	Transmission Method	File	Control #	Attachment Type	Action
<input style="font-size: small;" type="button" value="+"/> Click to add attachment.					

[Go to Top](#)

4.2
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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</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	Patient account number will be captured if entered in this field.	Not Required
Other Insurance	Select the applicable option for other insurance.	
Total Charged	This field will automatically populate.	<i>Auto</i>
<b><u>Medicare Crossover Details (when applicable) This is done at this level on Inpatient Step 3 on Outpatient</u></b>		
<b>Form Locator</b>	<b>DDE Institutional Claim Submission</b>	<b>Requirement</b>
Deductible Amount	Enter the deductible amount.	
Coinsurance Amount	Enter the coinsurance amount.	
Blood Deductible	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</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</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</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</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</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</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</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</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</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; <i>see 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; <i>see 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</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</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 (see section F in this chapter for instructions on sending an HCA-13 form by fax or mail).</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 Health Care Authority** Provider Portal

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 Thursday 08/11/2022 10:57 AM CST

**Submit Institutional Claim: Step 1**

\* Indicates a required field.

Claim Type **Crossover Inpatient**

HCA-17 **No**

**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 73703		Taxonomy	333600000X	SC Provider Number
<b>Institutional Provider ID</b>		<b>ID Type</b>	<b>NPI</b>	
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 - Covered Days

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

\*Admission Type - Admission Source

\*Admitting ICD Version ICD-10-CM - Admitting Diagnosis

Patient Status - Type of Bill

Patient Account Number - Other Insurance

Total Charged Amount \$0.00

**Medicare Crossover Details**

Institutional Medicare Crossover Instructions

Deductible Amount \$0.00 Co-insurance Amount \$0.00

Blood Deductible Amount \$0.00 \*Medicare Payment Date

Continue Cancel

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



### OKLAHOMA Health Care Authority

## Provider Portal

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[Search Claims](#) | 
 [Submit Claim Dental](#) | 
 [Submit Claim Inst](#) | 
 [Submit Claim Prof](#) | 
 [Submit Claim Pharm](#) | 
 [Search Payment History](#)
Thursday 08/11/2022 08:42 AM CST

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**Submit Institutional Claim: Step 1** ?

\* Indicates a required field.

**Claim Type** Crossover Outpatient

**HCA-17** No

---

**Provider Information**

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

<b>Billing Provider ID</b> 1265415806	<b>ID Type</b> NPI	<b>Name</b> MARY MAHONEY MEMORIAL HEALTH CENTER
<b>Zip Code</b> 73140	<b>Contract Code</b> _	<b>Taxonomy</b> 261QF0400X
<b>Institutional Provider ID</b> 1265415806	<b>ID Type</b> NPI	<b>SC Provider Number</b> 100709120 B
<b>Attending Provider ID</b> <input type="text"/>	<b>ID Type</b> <span style="border: 1px solid #ccc; padding: 2px;">▼</span>	
<b>Operating Provider ID</b> <input type="text"/>	<b>ID Type</b> <span style="border: 1px solid #ccc; padding: 2px;">▼</span>	
<b>Referring Provider ID</b> <input type="text"/>	<b>ID Type</b> <span style="border: 1px solid #ccc; padding: 2px;">▼</span>	

---

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

Continue
Cancel

**Service Details** -

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"/>
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.					

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

**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

**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)

**PATIENT INFORMATION**

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

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. Cpt	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

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

34a. Diagnosis Code(s) A: \_\_\_\_\_ C: \_\_\_\_\_  
 B: \_\_\_\_\_ D: \_\_\_\_\_ (Primary diagnosis in 'A')

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 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=OP Hospital) (Use "Place of Service Codes for Professional Claims")

39. Enclosures (Y or N)

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

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

42. Months of Treatment \_\_\_\_\_

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 \_\_\_\_\_

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

54. NPI \_\_\_\_\_    55. License Number \_\_\_\_\_

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

57. Phone Number \_\_\_\_\_    58. Additional Provider ID \_\_\_\_\_

©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

**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
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	<i>Not Captured</i>	<i>Reserved for Future Use</i>
20	Required	Name (Last, First, Middle Initial, Suffix), Address, City, State, ZIP Code: Enter the member's name and full
21	Not Required	Date of Birth (MM/DD/CCYY): Enter member's date of birth.
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: <i>UL—Upper Left, UR—Upper Right, LL—Lower Left, LR—Lower Right, Maxillary Arch 01, Mandibular Arch 02, L &amp; R</i>
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: <i>M—Mesial, D—Distal, O—Occlusal, L—Lingual, F—Facial, B—Buccal, I—Incisal</i>
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
31	Required	Fee: Enter your customary fee for the procedure.
31A	<i>Not Used</i>	<i>Other Fee(s): Payment amounts made by other insurance plans. This field is not used for Oklahoma SoonerCare billing.</i>
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: <i>B=ICD-9, AB=ICD-10</i>
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	<i>Not Used</i>	<i>Patient/Guardian Signature, Date: Signature and date are entered here. This field is not used for Oklahoma SoonerCare billing.</i>
37	<i>Not Used</i>	<i>Subscriber Signature, Date: Signature and date are entered here. This field is not used for Oklahoma SoonerCare billing.</i>
38	Required, if applicable	Place of Treatment: Enter the 2-digit Place of Service Code for Professional Claims. Frequently used codes are: <i>11—Office, 12—Home, 21—Inpatient Hospital, 22—Outpatient Hospital, 31—Skilled Nursing Facility, 32—Nursing Facility</i>
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.
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. (100000000A)

### 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).



# Provider Portal

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[Prior Authorizations](#)
[Referrals](#)
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[Search Claims](#)
[Submit Claim Dental](#)
[Submit Claim Inst](#)
[Submit Claim Prof](#)
[Submit Claim Pharm](#)
[Search Payment History](#)

[Contact Us](#) | [Logout](#)  
Thursday 08/11/2022 07:43 AM CST

**Claims > Submit Claim Dental**

---

**Submit Dental Claim: Step 1** ?

\* Indicates a required field.

HCA-17

**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>
<b>Referring Provider ID</b> <input type="text"/>	<b>ID Type</b> <input type="text"/>	

**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> <input type="text" value="11-Office"/>	<b>Patient Account Number</b> <input type="text"/>	
<b>Other Insurance</b> <input type="text" value="None"/>		

**Total Charged Amount** \$0.00

**Diagnosis Codes**

Diagnosis Code is Optional. If a diagnosis is included, both the ICD Version and the Diagnosis Code need to be entered. 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 ICD-10-CM    \*Diagnosis Code

---

**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							

1    \*Svc Date      Oral Cavity Area      Tooth Number  

Tooth Surface                          Prosthesis  

Cavity Code                 

\*Procedure Code      Modifiers            

Diagnosis Pointers                 

\*Units 1    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.					

### 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	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	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 <https://oklahoma.gov/ohca/providers/forms/rxforms.html>.

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**  
Gainwell Technologies  
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</b>	Enter the member's 9-character Oklahoma SoonerCare identification	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.,	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</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</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><u>not</u></b> acceptable.	Required
27	<b>Date Billed</b>	Enter the date the bill is submitted. ( <i>MMDDYY</i> )	Required

## Compound Prescription Drug Claim Form





Compound Prescription Drug Claim Form

PLEASE PRINT CLEARLY

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

Provider's Name and Address ?  
18

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  
19

Date Billed  
20

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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
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 0—No product selection indicated 1—Substitution not allowed by prescriber, dispense as written
10	Required	Refill: Refill Indicator; enter two (2) digits to indicate the number of times the prescription has been dispensed. Example: 00— original dispensing, 01-99—refill number
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	Not Used	Local Use Only
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 (MM/DD/YY)
<b>Service Lines</b>		
<b>Field</b>	<b>Requirement</b>	<b>Compound Drug (PHARM-2) Field</b>
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).



# Provider Portal

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](#)  
Thursday 08/18/2022 09:35 AM CST

[Claims](#) > Submit Claim Pharm

---

**Submit Pharmacy Claim: Step 1** ?

\* Indicates a required field.

**Provider Information**

This panel contains provider information.

<b>Service Provider ID</b>	<b>ID Type NPI</b>	<b>Name</b>
<b>Rendering Provider NPI</b>	<b>SC Provider Number</b>	
	<b>Rendering Provider Number</b>	

**Patient and Claim Information**

Enter information applicable to the claim. Select 'Pharmacy' or 'Compound' from the Claim Type dropdown to indicate what type of claim is being submitted. If a TPL Amount needs to be entered, then 'Other coverage exists' should be selected in the Other Coverage Code dropdown. A TPL Amount can be entered on the third step of Submit Pharmacy Claim.

*Member ID <input type="text"/>		
Last Name <input type="text"/>	First Name <input type="text"/>	Middle <input type="text"/>
*Birth Date <input type="text"/>		
Transaction Code <input type="text" value="B1-Billing"/>		
*Claim Type <input type="text" value="1-Pharmacy"/>		
*Other Coverage Code <input type="text" value="1-No other coverage identified"/>		
Pregnancy <input type="text" value="No"/>	Emergency <input type="text" value="No"/>	Nursing Facility <input type="text" value="No"/>

**Claim Information**

General Claim Information Instructions

*Prescriber ID <input type="text"/>	ID Type NPI <input type="text"/>	*Last Name <input type="text"/>	
*Prescription # <input type="text"/>	*Fill # <input type="text" value="0"/>	*Date Written <input type="text"/>	*Date of Service <input type="text" value="12/13/2013"/>
*Days Supply <input type="text"/>	Dispense/Written <input type="text"/>		

**Compound Information**

General Compound Information Instructions

Ingredient Component Count

**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	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	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, 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. The form is partially expanded, showing fields for:
 

- \*Transmission Method**: A dropdown menu is open, showing options: AA-Available on Request at Provider Site, BM-By Mail, EM-E-Mail, FT-File Transfer, and FX-By Fax.
- \*Attachment Type**: A dropdown menu.
- Description**: A text input field.

 At the bottom of the form are "Add" and "Cancel" buttons.

### Claim Attachments Mailing Address

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

**Gainwell Technologies**  
 P.O. Box 18500  
 Oklahoma City, OK 73154

This screenshot shows the same "Attachments" form as above, but with a different dropdown menu open. The dropdown is for the "Attachment Type" field and shows options: BM - By Mail, FT - File Transfer, and FX - By Fax. The "Transmission Method" field is now empty. The "Description" field remains empty. The "Add" and "Cancel" buttons are still at the bottom.

### **Helpful Tips**

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

## Attachment Form Cover Sheet (HCA-13)

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

*Four fields below are required and must match claim.*

1. **Provider Number** 100000000D  
 2. **Client ID Number** 001122334  
 3. **Attachment Control Number** 2001070899555  
 4. **Claim Number** 23220811111111  
 5. **Date/Time** 03/22/2022 9:41 AM

**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 that will be used for filing the electronic claim.
2. In box 2, fill in the nine-digit client identification number that was submitted on the electronic claim.
3. In box 3, fill in the fill in the Attachment Control Number (ACN) that was used for filing the electronic claim. The ACN on this form must be the same number as the assigned control number field of the SoonerCare Portal 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. Alphabetic and numeric are the only characters that should be used in the ACN selection. Do not use dashes and spaces in the ACNs.
4. In box 4, fill in the identification number that was assigned to the electronically submitted claim.
5. Place the completed form on top of the attachment(s) for each electronic claim.
6. Mail to EDS, P.O. Box 18500 OKC, OK 73154, fax 405-947-3394

**Note: Do not place another Fax Cover Sheet on top.  
\*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 transmission 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.

OKLA HCA  
Revised 06/24/09

HCA-13

Print

Close

## Section G: Electronic Special Process Claims (HCA-17A)

### Special Process Claims (1500, Institutional, Dental)

#### 1500

The screenshot shows the Oklahoma Health Care Authority Provider Portal. The header includes the logo and the text 'OKLAHOMA Health Care Authority' and 'Provider Portal'. A navigation menu contains 'My Home', 'Eligibility', 'Claims', 'Prior Authorizations', 'Referrals', 'Files Exchange', 'Financial', 'Letters', 'Reports', and 'Resources'. Below the menu is a search bar with options: 'Search Claims | Submit Claim Dental | Submit Claim Inst | Submit Claim Prof | Submit Claim Pharm | Search Payment History'. On the right, there are links for 'Contact Us' and 'Logout', and the date 'Wednesday 07/06/2022 12:50 PM CST'. The main content area is titled 'Submit Professional Claim: Step 1' and includes a help icon. A note states '\* Indicates a required field.' The form contains three dropdown menus: 'Claim Type' set to 'Professional', 'EVV SERVICES ONLY timely filing' set to 'No', and 'HCA-17' set to 'Yes'.

#### Institutional

The screenshot shows the Oklahoma Health Care Authority Provider Portal. The header includes the logo and the text 'OKLAHOMA Health Care Authority' and 'Provider Portal'. A navigation menu contains 'My Home', 'Eligibility', 'Claims', 'Prior Authorizations', 'Referrals', 'Files Exchange', 'Financial', 'Letters', 'Reports', and 'Resources'. Below the menu is a search bar with options: 'Search Claims | Submit Claim Dental | Submit Claim Inst | Submit Claim Prof | Submit Claim Pharm | Search Payment History'. On the right, there are links for 'Contact Us' and 'Logout', and the date 'Wednesday 07/06/2022 12:52 PM CST'. The main content area is titled 'Submit Institutional Claim: Step 1' and includes a help icon. A note states '\* Indicates a required field.' The form contains two dropdown menus: 'Claim Type' set to 'Inpatient' and 'HCA-17' set to 'Yes'.

## Dental

**OKLAHOMA**  
Health Care Authority

### Provider Portal

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 Wednesday 07/06/2022 12:51 PM CST

**Submit Dental Claim: Step 1** ?

\* Indicates a required field.

HCA-17

1. The HCA-17 box defaults to No.
2. Once the Yes box is chosen: These claims will require a Completed HCA-17A form and applicable attachments to be uploaded upon submission.
3. Fill out the claim form as usual.

## Attachments

**Attachments** -

Click the **Remove** link to remove the entire row.  
**Instructions for submission of HCA-17 claims MUST be followed. Please read carefully.**

**Required Attachments to be uploaded MUST include:**

- Completed [HCA-17A Form](#) ←
- All Supporting documentation for review

**Attachment Indicators(below) MUST include:**

- Transmission Method: File Transfer
- Attachment Type: 77-Support Documentation for Verification
- Description: e.g. Duplicate services on same day or Medicare non - covered services

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

STATE OF OKLAHOMA  
OKLAHOMA HEALTH CARE AUTHORITY

**PROVIDER PORTAL CLAIM APPEAL AND REVIEW COVER SHEET**

**THIS COVER SHEET MUST BE UPLOADED AS AN ATTACHMENT**

This cover sheet is **ONLY** for claim appeals sent via the Provider Portal. Please include original information and **ANY** additional documentation to support your request along with this cover sheet. A completed cover sheet and supporting documentation is required for each appeal.

**PROVIDER INFORMATION**

Provider Name and Address:	Provider Number:
	Group Number: (if applicable)
	Telephone:

**CLAIM INFORMATION**

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

Contact Name (printed):	Date:
Phone Number:	
Email Address:	

For Internal Use Only	<b>THIS COVER SHEET MUST BE UPLOADED AS AN ATTACHMENT</b>
-----------------------	---

OKLA HCA Revised: 8/20/20 HCA-17A

1. Select the **[+]** to expand and add an attachment.
2. Select the method of sending attachments from the Transmission Method drop-down list.
3. Click **Browse** to locate and upload to the Upload File field.  
  
The Upload File option is only enabled when the transmission method is set to File Transfer.
4. Select the type of attachment being sent from the Attachment Type drop-down list.
5. Enter a description of the attachment in the Description field.

6. If additional attachments are to be sent on this submission, click **Add** and repeat the process.
7. Click **Remove** to remove an existing attachment.
8. When finished, click **Submit**.
9. Verify the claim information, and then click **Confirm**.

Information is now ready to be uploaded with the claim. Click submit then after reviewing the information, click confirm. Claim will suspend for review, and you will get a claim ID number starting with 93 indicating this was a Special Batch Claim submitted via the Provider Portal.

Depending on the status and attachments selected, there are different options to choose from:

- **Attachment Coversheet(s)**—Coversheets are generated automatically and pre-populated when Transmission Method-Fax and Transmission Method-Mail are selected. Each attachment has its own completed coversheet. Selecting Transmission Method-File Transfer does not generate a coversheet, because those attachments are uploaded directly. See section 5.11, **Error! Reference source not found.**, for more information on attachment coversheets.
- **Print Preview**—Displays and prints the claim.
- **Copy**—Copies specific details from one claim to another; the options are preset.
- **New**—Begins a new claim.
- **Edit**—Enables the current claim submitted to be edited.
- **View**—Displays the details of the claim.

# Chapter 6: Electronic Data Interchange

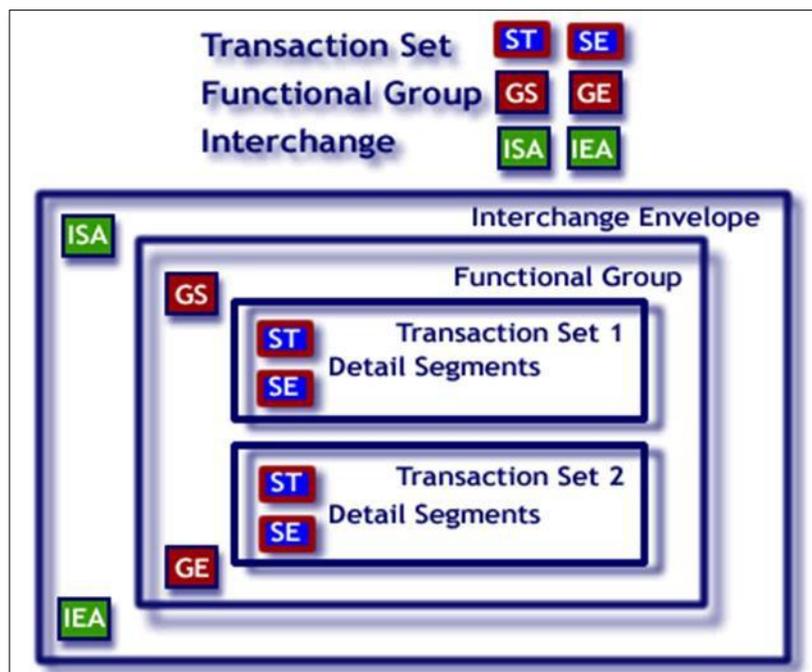
## Introduction

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 OHCA website at <https://oklahoma.gov/ohca/providers/claim-tools/electronic-data-interchange.html> 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.

Gainwell 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 OHCA public website at: <https://oklahoma.gov/ohca/providers/claim-tools/ncpdp.html>.

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@gainwelltechnologies.com](mailto:okxixedi@gainwelltechnologies.com).

## **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 <https://oklahoma.gov/ohca/providers/claim-tools/ncpdp.html> 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 Gainwell 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.



**OKLAHOMA**  
Health Care Authority

**Electronic Claim Paper Attachment  
Form Cover Sheet**

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

**1. Provider Number**

**2. Client ID Number**

**3. Attachment Control Number**

**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: Gainwell Technologies  
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.

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REVISED 2/11/21 HCA-13

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 OHCA website at [www.oklahoma.gov/ohca](http://www.oklahoma.gov/ohca)
  - By calling the Gainwell Call Center at 1-800-522-0114
  - Insert copy of HCA13 here

## Section I: Electronic Media Types

EDI transactions can be submitted to Gainwell via:

- OHCA SoonerCare Provider Portal.
- Batch upload process.

### EDI Batched Electronic Transactions

Batch transactions/files sent to Gainwell via 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/admnsimp/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.

# 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
<b>RR</b>	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.
<b>YY</b>	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.
<b>JJJ</b>	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,
<b>IIIIII</b>	The final six digits of the ICN refer to the claim number, which is assigned when the claim comes into the

Based on this information, an ICN number of 2022099123456 indicates that the claim was received via EDI (region code 20), in the year 2022 (22), on April 9th (099). 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 GAINWELL 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 Gainwell systems engineers
90	Special projects
91	Batches requiring manual review
92	HMO Copays – paper

93	Electronic Special processing
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. 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 general and should not be considered a full and comprehensive list of all the edits used by the OKMMIS system.

### MMIS Edits

OKMMIS edits includes a wide-ranging of 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.

## ClaimsXten Edits

**ClaimsXten** edits evaluate claims for coding accuracy. **ClaimsXten** 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 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 OHCA call center for assistance or log onto the SoonerCare

Provider Portal at <https://oklahoma.gov/ohca.html> 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 denied due to policy limitations or program restrictions.

# 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 (MMIS). 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.

### 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 OHCA has recognized that a full overpayment for a claim occurred, and the provider or 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 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 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 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 73105

If the payment is not received, recoupment procedures will be initiated by 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, 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 with a 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 to assist 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 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 MMIS.

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

Check-related adjustment requests are cash receipts

received and dispositioned as claim-specific refunds to OHCA. The refunded dollar amount is posted to the specific claim as the adjustment is processed in the MMIS. 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 MMIS.

# 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 because 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 OHCA does not pay expenses covered by other sources, federal regulation (*42 CFR 433.139*) established 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 OHCA. Other resources include, but are not limited to:

- Commercial health insurance policies, both group and individual
- Medicare
- TRICARE
- 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 OHCA.

## **OHCA Third Party Liability Program**

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 OHCA.

OHCA has full authority to fulfill these responsibilities. OHCA member must sign an assignment of rights form, which allows the third-party payment to be made directly to OHCA. This is one of the eligibility conditions to OHCA membership. Each member must further agree to cooperate with 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 MMIS with that information.

### **Providers**

During 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 OHCA by written notice, phone call or inclusion on a claim form.

Providers should request that 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**

OHCA uses private vendors, Health Management Systems (HMS) and Gainwell Technologies (Gainwell) 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 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 Gainwell 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 OHCA website. It is in the Forms section under TPL forms. Regardless of the source, all TPL coverage information is stored in the Gainwell 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 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 OHCA. If the EVS indicates TPL resource information and the provider submits a claim to 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 OHCA would have paid, the provider can rebill 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, 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 OHCA or pursue payment from the liable party. If 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 OHCA after the one-year timely filing limit are denied.

When 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, 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 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 OHCA, except for programs that are secondary to OHCA. The TPL Unit is available to assist with determining other insurance resources and maintaining the most current member TPL files.

### Documentation Requirements

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

OHCA cannot be used to supplement OHCA allowable charges. If OHCA paid the provider for services rendered and the provider subsequently receives payment from any other source for the same services, OHCA payment must be refunded within 30 days. The refund should not exceed OHCA payment to the provider.

Checks must be made payable to 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 OHCA member, the provider should request that 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 OHCA when submitting claims for a member enrolled in private preferred provider organization (PPO) or private health maintenance organization (HMO) plans.

### **HMO Billing OHCA**

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

#### **Copayment Billing**

In 2001, OHCA implemented a procedure for providers to bill 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:

#### **Gainwell Technologies**

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 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 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. 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, 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 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 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 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 OHCA member.

In either scenario, 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. 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. 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.

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 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 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 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 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 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, 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 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 OHCA. The information is transmitted electronically via real-time transaction to OHCA. The county office and 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 OHCA website. When a questionnaire is completed, the provider can fax or mail it to the Gainwell 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 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 OHCA member insurance information, coordinates with the carrier, if required, and makes necessary changes to the TPL file in 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 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 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 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 OHCA website.
- Do not send TPL-related claims to the TPL unit for processing.
- TPL can be added and end dated on the portal.

#### Adding or removing TPL From a Members File

- If the member does not show having other insurance when checking eligibility, click on the + sign to open the window, and add all of the information you have on their insurance. Once this information is confirmed, it will be added to the members eligibility file.
- If the member shows another insurance, but it has ended, put the end date in the same window, and once the information has been confirmed, it will be removed from their eligibility file.

[Print Preview](#)  
[Display Member ID Card](#)

**Coverage Details for Member ID** [Back to Eligibility Verification Request](#) ?

**NOTICE: There is no copay due for this member.**  
 Effective/End dates are shown only for the period of time requested.  
**Verification Number** 2222257L35 - 8/10/2022 - Status: A [Expand All](#) | [Collapse All](#)

Eligibility		
Coverage	Effective Date	End Date
Non Emergency Transportation	08/10/2022	08/10/2022
Mental Health and Substance Abuse	08/10/2022	08/10/2022
Expansion Healthy Adult Program	08/10/2022	08/10/2022

[Medicare](#) +  
[CCBHC](#) +  
[Visits](#) +  
[TPL](#) -

Click '+' to add a row.

Carrier Name (Carrier ID)	Policy Number	Group ID (Employer ID)	Policy Holder (Relationship)	Policy Type	Coverage Type	Rx-BIN	Rx-PCN	Effective	End
<div style="border: 1px solid #ccc; padding: 5px;"> <p><input type="checkbox"/> Click to collapse</p> <p>* Indicates a required field.</p> <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>*Carrier Name <input type="text"/></p> <p>*Policy Number <input type="text"/></p> <p>*Policy Holder is <input checked="" type="radio"/> Person <input type="radio"/> Organization</p> <p>*Policy Holder Last Name <input type="text"/></p> <p>Policy Type <input type="text"/></p> <p>*Coverage Type <input type="text"/></p> <p>*Relationship <input type="text"/></p> <p>Effective <input type="text"/> <input type="text"/></p> <p>Rx-BIN <input type="text"/></p> </div> <div style="width: 45%;"> <p>Carrier ID <input type="text"/></p> <p>Group ID <input type="text"/></p> <p>*First Name <input type="text"/> MI <input type="checkbox"/></p> <p>Employer ID <input type="text"/></p> <p>End <input type="text"/> <input type="text"/></p> <p>Rx-PCN <input type="text"/></p> </div> </div> <p style="text-align: center;"> <input type="button" value="Add"/> <input type="button" value="Reset"/> </p> </div>									

# 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 OHCA website at <https://oklahoma.gov/ohca.html>

All services requiring PA will be authorized based on the service procedure code. 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: Durable Medical Equipment (DME) / Medical / Therapy – Occupational/Physical/Speech (OT/PT/ST)

### Prior Authorization Requests

The Medical Authorization Unit (MAU) processes the requests for DME, high tech imaging, medical procedures and supplies and therapy (OT/PT/ST). Requests must be submitted electronically thru the SoonerCare Provider Portal. All appropriate forms, if applicable, and supporting medical documentation must be uploaded at the time of the initial Prior Authorization submission.

### Prior Authorization Process

The MAU staff will issue a determination for each requested service requiring a PA. A computer-generated PA request decision form showing OHCA determination of the service is mailed to the member. Providers will receive notice of PA request decision thru the Provider Portal. 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 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**

Requests for services 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 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

### **Reconsideration and Appeals Procedures**

- **Level 1—Reconsideration**

All denial reconsiderations for DME, Medical, Therapy -OT/PT/ST 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.

- **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 <https://oklahoma.gov/ohca.html> , 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 B: Dental

### Dental Requests

Dental prior authorization requests (PAR) must be submitted electronically through the SoonerCare Provider Portal.

#### Provider Portal PA Submission:

How to submit

<https://oklahoma.gov/content/dam/ok/en/okhca/docs/providers/training/2022/Dental%20Prior%20Authorization%20and%20Amendments%202022.pdf> .

All prior authorization requests must demonstrate medical necessity.

#### Dental PAR Requirements:

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

- Comprehensive treatment plan.
- Right and left bitewing X-rays or panoramic X-ray.
- Request for endodontic therapy and crowns should also include periapical film(s) of tooth/teeth involved. A minimum of 3 mm surrounding apical bone should be

visible.

- Tooth number identified and dated; all images must be of diagnostic quality.
- Requests for **scaling and root planning** should also include periodontal charting.
- For additional code requirement information please view dental policy, PA guidelines, and quick reference resources at <https://oklahoma.gov/ohca/providers/types/dental/dental.html>.

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

- Caries Risk Assessment.
- Completed DEN-6 HLLD form.
- DEN-2 Referral form 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—We are unable to accept faxed PAR submissions. All request must be submitted through provider portal.**

## Section C: Pharmacy

### 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.oklahoma.gov/ohca/rxforms](http://www.oklahoma.gov/ohca/rxforms). 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:**

[www.oklahoma.gov/ohca/rxforms](http://www.oklahoma.gov/ohca/rxforms)

**Pharmacy PA Criteria:**

[www.oklahoma.gov/ohca/pa](http://www.oklahoma.gov/ohca/pa)

**Reconsideration and Appeals Procedure**

- **Level 1—Reconsideration**

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

**University of Oklahoma College of Pharmacy**

Pharmacy Management Consultants

Medication Coverage Authorization Unit

P.O. Box 26901 ORI W-

4403

Oklahoma City, OK 73126-0901

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-1 Form to the OHCA Legal Division within 30 days of Notice of Prior Authorization receipt. Individuals may represent themselves, have another party represent them or have an attorney represent them. An LD-1 form may be obtained from the OHCA website at [www.oklahoma.gov/ohca](http://www.oklahoma.gov/ohca) by contacting the Legal Division of the OHCA at 405-522-7217 or by sending a request to:

Oklahoma Health Care Authority  
Grievance 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: Behavioral Health

### **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, Residential Substance Use Disorder (SUD) Treatment and Therapeutic Foster Care Services**

Psychiatric services for SoonerCare members must be prior authorized before the service is provided. 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 Substance Use Disorder \(SUD\) Services](#)

Please complete the appropriate prior authorization form located on the OHCA Behavioral Health webpage:

<https://oklahoma.gov/ohca/providers/types/behavioral-health-and-substance-abuse-services/behavioral-health-and-substance-abuse-services.html>

For Residential Substance Use Disorder (SUD) Treatment services, complete the Customer Data Core (CDC) Form and ASAM tool via the PI Client Information System (PICIS) found at <https://ww4.odmhsas.org/cdc/>.

## **Reconsideration and Appeals Procedure**

- **Level 1—Reconsideration**

All denial reconsiderations for behavioral health must be submitted as a new authorization request (see Section A). The provider is allowed until 5pm the following business day to submit additional information for reconsideration.

If the denial is upheld after the additional information is reviewed, the provider has another 24 business hours to schedule a physician-to-physician review.

- **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 E: Services to Illegal/Ineligible Aliens/Sooner To Be Sooners

### 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 GAINWELL 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 F: 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

**Out of State Services**

- All out of state (OOS) care requires a prior authorization for the out of state service location if the rendering provider and servicing location is greater than 50 miles from the border of Oklahoma unless it is an emergency (100 miles for dental services.)
- OOS prior authorization requests must come from a contracted OHCA provider. OHCA does not allow requests from non-contracted providers or self-referrals from members.
- A complete OOS request, along with all required documentation, must be submitted in writing to OHCA Population Care Management at least 10 calendar days prior to the appointment. An OOS request form (HCA-65) is available on the public website at the following location and is recommended for use.

<https://oklahoma.gov/content/dam/ok/en/okhca/documents/a0304/23782.pdf>

**Required documentation is:**

- Documentation to establish the medical necessity of services requested, such as medical records.
- Letter of medical necessity or another thorough summary document that includes:

- Summary of member's condition and history of treatment related to the request.
- History of other providers who have evaluated, treated, or consulted member related to the request.
- Recommended treatment or further diagnostic needed.
- Reasons medical care cannot be completed in Oklahoma or the next closest location.
- Telephone requests for OOS services will only be approved in true urgent situations and must be followed promptly with the submission of all required documentation. For an urgent request, please call OHCA Population Care Management department 877-252-6002.
- Providers can submit the OOS request by fax 405-530-3217.
- OHCA has the authority to deny out of state prior authorizations if:
  - Care can be provided in the state of Oklahoma
  - Care is not medically necessary
  - A complete request is not received at least 10 calendar days prior to the date of service
- IMPORTANT: If a service is to be conducted greater than 50 miles from the Oklahoma border, and the CPT/HCPCS code(s) also require a traditional prior authorization (such as an MRI), the service will require both an OOS service approval via our Population Care Management department as well as a standard prior authorization via our Medical Authorization Unit. The latter authorization request is submitted via the provider portal.
- If the member has primary insurance and OHCA will be the second payer, an OOS prior authorization approval is still needed by OHCA for the claim to be paid.
- Pre-payment claim reviews will be completed on all OOS claims billed to OHCA. If a claim is billed with no prior authorization, the claim can be denied.
- Additional information regarding our OOS process may be located at:
  - [317:30-3-90. Out-of-state services \(oklahoma.gov\)](https://www.oklahoma.gov/317:30-3-90)
  - [Out-of-State Services Changes \(oklahoma.gov\)](https://www.oklahoma.gov/out-of-state-services-changes)

### **Lodging and/or Meal Services**

If a member must travel a long distance to access OHCA approved medical services with a specialty provider (50 miles or greater), then Population Care Management can be contacted at 877-252-6002 to request help with lodging and/or meals by the member or provider.

A hospital social worker or doctor's office can submit a Lodging and/or Meals Request form (referral form) to Population Care

Management by fax 405-530-3217. A Lodging/Meals provider may not submit their own request for services.

The referral form can be found at the following link:

<https://oklahoma.gov/content/dam/ok/en/okhca/documents/a0302/23620.pdf>

The full policy regarding the lodging and meals program can be found at:

[317:30-3-92. Payment for lodging and meals \(oklahoma.gov\)](#)

### **Private Duty Nursing Services**

Private duty nursing (PDN) is a benefit available to children aged 0-20 who require a substantial amount of medically necessary skilled nursing care in the home. All private duty nursing must be prior authorized by OHCA.

A medical provider initiates the process by requesting that an OHCA contracted PDN agency conduct an intake assessment. The PDN agency then conducts an assessment and submits an authorization request to OHCA. The PDN authorization request should include the following attachments:

- Letter of medical necessity
- Plan of care

Upon receipt of the authorization request, a nurse from OHCA's Population Care Management Department will conduct a PDN assessment which is reviewed by an OHCA physician for a determination.

Please note the following:

- If PDN is approved, approvals are generally for 3-6months.
- An updated plan of care is required by CMS every 60 days.
- Any request for an increase in already approved PDN hours must be accompanied by:
  - Cover sheet requesting increase in hours
  - Updated letter of medical necessity
  - Updated plan of care
- Any request for transfer of approved PDN services to another PDN agency must be accompanied by:
  - Completed and signed SC-16 form
  - Letter of medical necessity
  - Plan of care

The full PDN policy is located at: <https://oklahoma.gov/ohca/policies-and-rules/xpolicy/medical-providers-fee-for-service/individual-providers->

[and-specialties/private-duty-nursing.html](#)

## Section G: Prior Authorization Process

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:

3. The services rendered must be covered under the SoonerCare program.
4. 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 <https://oklahoma.gov/ohca/providers/medical-authorization-unit.html> for information

## Section H: 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 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 OHCA website at <https://oklahoma.gov/ohca.html> by contacting the Legal Division of 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 I: 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**

P.O. Box 25352  
Oklahoma City, OK 73125-9975  
918-933-4900  
800-435-4711

[Application for In-Home Assistance \(mediware.com\)](#)

[ADvantage Waiver \(oklahoma.gov\)](#) or

<https://oklahoma.gov/ohca/individuals/advantage-waiver-program.html>

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

#### **DHS/Developmental Disabilities Services (DDS)**

405-521-6267

<https://oklahoma.gov/okdhs/services/dd/areacontactinfo.html>

[Online Application for DDS Services](#)

#### **Medically Fragile Waiver:**

Oklahoma Health Care Authority

888-287-2443

<https://oklahoma.gov/ohca/individuals/programs/medically-fragile.html>

or

<https://oklahoma.gov/ohca/individuals/programs/long-term-care-services/intakeform/long-term-care-waiver-operations-division-living-choice-common-intake-form.html>

# 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 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 OHCA SoonerCare Provider Portal available at <https://oklahoma.gov/ohca.html>. 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: <https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/HIPAA-ACA/PrivacyandSecurityInformation>

For a detailed listing of these new HIPAA codes, visit:

<https://x12.org/codes>

## Remittance Advice Examples

The following pages display examples of 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

Field	Description	Field Type	
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
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

Field	Description	Field Type	
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
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	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

Field	Description	Field Type	
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
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) transaction is established	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

Field	Description	Field Type	
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 number of detail lines billed.	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
Rendering Provider	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

Field	Description	Field Type	
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	Number	6
Units (LTC)	This is the number of units of service.	Number	8
Units (Compound	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 pending 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 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 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 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 Gainwell 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-000-W          STATE OF OKLAHOMA          DATE: MMDDYY
PROCESS: FNIO3011         MEDICAID MANAGEMENT INFORMATION SYSTEM    PAGE: 9,999
LOCATION: FINJW201         PROVIDER REMITTANCE ADVICE
                          PROVIDER BANNER MESSAGES

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXX 99999-9999

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

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXX 99999-9999

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: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX CLIENT NO.: XXXXXXXXXXXXXXXX
RRYJJBBSSS   MMDDYY MMDDYY  9,999,999.99  9,999,999.99  999,999.99  9,999,999.99
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
                                9,999,999.99  999,999.99  9,999,999.99

HEADER EOB: 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 EOB
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
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
    
```







# Chapter 12: SoonerCare Choice

## Introduction

SoonerCare Choice is a managed care model in which each member is linked to a Primary Care Provider (PCP) who serves as the “medical home”. PCPs 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 OHCA current FFS payment methodology. PCPs may also qualify for SoonerExcel incentive payments based on individual performance. Physicians nurse practitioners and physician assistants in primary care specialties can contract as PCPs.

### Quality Assurance

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.

### After-Hours Surveys

Telephone surveys are conducted by OHCA or one of its agents to ensure that PCPs 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 OHCA for research and/or resolution.

### On-site Audits

On-site audits are conducted by OHCA Quality Improvement Department 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.

## Covered Members

OHCA determines eligibility for SoonerCare members using [MySoonerCare.org](https://mysooner.org). This system is a secure web-based application process that provides real-time eligibility. The Oklahoma Department of Human Services (OHS) 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, expansion adults, 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).

## American Indian/Alaska Natives

In order for American Indian/Alaska Natives who are eligible for **SoonerCare Choice**, they must enroll with a PCP. 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 American Indian/Alaska Native 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 are eligible to be enrolled in the **SoonerCare Choice** program. Individuals exempt from this are:

- Individuals eligible for Medicare and SoonerCare Traditional
- Individuals enrolled in a waiver program (Advantage waiver, Home/Community waiver, etc.)

- Individuals residing in a long-term care center or institution
- Individuals with other forms of credible health insurance coverage
- Children in subsidized adoption
- Children in state or tribal custody
- Individuals in the former foster care children's group [see Oklahoma Administrative Code (OAC) 317:35-5-2]
- Individuals in benefit programs with limited scope, such as Tuberculosis, Family Planning, or pregnancy only
- Non-qualified or ineligible aliens

## Access to Care

**SoonerCare Choice** PCPs are required to maintain access to primary and preventive care services in accordance to the contract. The following standards apply:

1. PCPs 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. PCPs must offer hours of operation that are no fewer than the hours of operation offered to commercial patients or SoonerCare Traditional members.
3. PCPs 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. PCPs can charge the appropriate copayment to SoonerCare Choice members ages 21 and over. PCPs may not deny services based on the member's inability to pay the appropriate copayment.

### Emergency Care

PCPs are not required to provide emergency care either in office or in an emergency room. PCPs that do provide emergency care

in the emergency room will be reimbursed based on current OHCA policy.

PCPs 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. PCPs should manage follow-up care from the emergency room, as needed.

## Member Enrollment/Disenrollment

### SoonerCare Choice Enrollment

SoonerCare member benefits start when SoonerCare eligibility 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 prior to expiration of benefits.

Breaks in eligibility may result in a disruption in the continuity of care. If the PCPs capacity is limited in comparison to demand, the member may not be able to regain his or her place on that PCPs panel.

Members may re-enroll with a PCP 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, if the PCP has available capacity and if the member's age is within the PCPs scope of practice.

## Choosing a PCP

OHCA offers all members the opportunity to choose a PCP from the provider directory. If a member does not choose a PCP, OHCA will send the member a letter assisting them in choosing a medical home.

Families with more than one eligible member can choose a different PCP for each eligible member.

Enrollment with a PCP takes effect on the day the selection is made. Prior to the first day of each month, OHCA provides the PCP with a SoonerCare Choice eligibility listing of new enrollees and continuing members.

## Capacity (Number of Members requested per PCP)

The PCP shall specify a capacity of SoonerCare Choice members he/she/they is willing to accept. Providers shall specify a capacity of at least 50 members.

A Provider may request to change his/her/their capacity through the Electronic Provider Enrollment (EPE) system. This request is subject to review and approval according to program standards. In the event the provider requests a lower capacity, OHCA may lower the capacity by disenrolling members to achieve that number or allowing the capacity to adjust as members change their PCP or lost eligibility.

## Changing PCPs

OHCA or the SoonerCare Helpline may change a member from one PCP to another PCP for the following reasons:

- Member can request change without cause.
- When a PCP terminates his or her participation in the **SoonerCare Choice** program.

## Disenrollment at the Request of the PCP

OHCA may also change a member from the assigned PCP to another PCP for good cause and upon electronic request of the assigned PCP. If the request is a good cause change, OHCA will act upon the request within 30 days of receipt from OHCA.

Per 317:25-7-28, good cause is defined as:

- Non-compliance with PCPs direction.
- Abuse of PCP and/or staff (includes disruptive behavior).

- Deterioration of PCP member relationship.
- Excessive no-show appointments above the PCP 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 until approval for disenrollment is granted by 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.
- Must have the correct individual referring provider's NPI number to ensure payment to the referred to provider (provider/referral numbers are site specific).

Referrals must be created by the PCP or a designee within the PCP's office who is authorized to create referrals for the provider.

Some services may require Prior Authorization (PA). It is to the responsibility of the referred to provider, or provider ordering services, to obtain prior authorization as needed. Prior authorization for services is obtained through OHCA Medical Authorization Unit (MAU) or one of its agents. A PA is not a guarantee of payment.

**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.

**SoonerCare Choice** referrals may be made to another PCP 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 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.

Per OAC 317:25-7-10, **SoonerCare Choice** referrals are not required for:

- Child physical/sexual abuse exams
- Services provided by a PCP for members enrolled or assigned to the PCP
- Emergency room care
- Obstetrical care
- Vision screenings for members younger than 21 years
- Basic dental
- Behavioral/mental health
- Family planning
- Inpatient hospital services
- Routine laboratory and X-ray
- Services provided to American Indian/Alaska Natives in a tribal, IHS or Urban Indian Clinic facility

Referrals can be submitted using the SC-10 form. This form can be found at <https://oklahoma.gov/ohca/providers/forms.html>

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 are excluded from this limitation. To ensure payment, PCPs must refer only to SoonerCare providers who have an active SoonerCare Traditional contract.

SoonerCare Choice expansion adults may request more than 4 specialty visits, if medically necessary.

### **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 shall report their findings to the referring PCP. In the event a medical report is not received within a reasonable time, the PCP 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 to members 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

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.

## Reporting Requirements

Data, information, and reports collected or prepared by PCPs in the course of performing duties and obligations as a PCP are owned by the state of Oklahoma. 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 is required to report to 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 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 PCPs are paid a monthly Care Coordination fee for panel members who have established a visit care within the last 15 months. Established care is defined as the member having a claim on file with their assigned PCP.

Care Coordination payments fees vary according to the type of members the PCP services serves (children only, children and adults, adults only) and their approved level of medical home (Entry, Advanced and/or Optimal).

Care Coordination payments are made as a single monthly payment by the 10th working day of each month for all eligible members enrolled with the PCP/CM on the first day of each month. PCPs receive a monthly roster report that includes a listing of the members assigned to their panel for the month. A single monthly payment is generated and accompanies the Care Coordination Listing or is deposited directly.

### SoonerExcel Incentive

SoonerCare Choice PCPs are paid a quarterly performance-based bonus component that recognizes achievement of quality and efficiency goals. SoonerExcel payments are not patient specific and are found on the financial transaction page under non-claim specific payouts. The SoonerExcel Performance Measures and Payment Criteria manual offers guidance to providers on the specifications of the SoonerExcel clinical measures.

### Fee-For-Service

SoonerCare Choice PCPs are paid a visit-based fee-for-service component that recognizes visit based services that are currently paid under the present fee-for-service payment system.

### Claims

PCPs are required to file a claim with OHCA each time a service is rendered to a member. Claims filed will be paid subject to the

current SoonerCare Traditional fee schedule and reimbursement policies.

Claims shall be submitted on the appropriate claim form within 180 days of the date of service.

## Care Management

SoonerCare offers a variety of care coordination services for members and providers.

Population Care Management (PCM) Our PCM department is staffed with nurse care managers and social service workers who work with members who need episodic care coordination or those who request or receive certain benefits such as private duty nursing or out-of-state services.

Health Care Systems Innovation (HCSI) Our HCSI department offers care coordination services via a variety of programs for members with or at risk for chronic health conditions.

More information on our current care coordination services can be found at:

<https://oklahoma.gov/ohca/providers/sooneercare-care-coordination-resources.html>

# 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 OHCA. This program consists of two benefits branches.

Insure Oklahoma consists of one (1) benefit branch:

- 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.

Member eligibility for this program 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 above 138 percent of the federal poverty level (FPL) and work for an Insure Oklahoma employer.

# 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-day supply if on the maintenance drug list.
- Covered Drugs: Must be FDA-approved and 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), Specialty Pharmaceutical Allowable Cost (SPAC) ,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
  - medication assisted treatment (MAT), naloxone, and smoking cessation medications
- 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 OHCA website at

<https://oklahoma.gov/ohca/providers/types/pharmacy/pharmacy.html>.

### **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 (MAT), 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 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 OHCA website at.

<https://oklahoma.gov/ohca/providers/medical-authorization-unit.html>

### **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 for two years. 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 <https://oklahoma.gov/ohca/providers/claim-tools/prior-authorization/durable-medical-equipment.html>. 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 <https://www.oklahoma.gov/ohca/providers/claim-tools/prior-authorization/durable-medical-equipment.html>.

## **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, ReliOn, and True Metrix 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 OHCA website at [www.oklahoma.gov/ohca/rxforms](http://www.oklahoma.gov/ohca/rxforms). For a list of covered products, please visit the main pharmacy page at: [www.oklahoma.gov/ohca/rx](http://www.oklahoma.gov/ohca/rx). Diabetic supplies are zero copay and do not count against the monthly prescription limit.

# 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 OHCA.

To obtain additional information, visit:

<https://oklahoma.gov/ohca/policies-and-rules/xpolicy.html> - 317:30-5-120.

## Section B: PASRR

Preadmission Screening and Resident Review (PASRR) is a federal requirement to help ensure individuals are not inappropriately placed in a 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 must submit the LTC-300R electronically using OHCA SoonerCare Provider Portal.

For additional information, visit:

<https://oklahoma.gov/ohca/policies-and-rules/xpolicy.html> - 317:35-19-8 and 317:35-19-9.

## 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, visit:

<https://oklahoma.gov/ohca/policies-and-rules/xpolicy.html> - [317:35-9-45](#) and [317:35-9-48](#).

## 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 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 OHCA form LD-2 by contacting OHCA Grievance Docket Clerk Legal Division at 405-522-7217.

For additional information on documentation standards, visit:

<https://oklahoma.gov/ohca/policies-and-rules/xpolicy.html> - [317:35-19-16](#).

## 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 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.

# 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: Purchased and Referred Care

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. Purchased and referred care 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 purchased and referred care 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.

# Chapter 17: Utilization Review/Post Payment Audits

Utilization review activities required by 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
- Inaccurate coding
- Non-qualified/non-contracted providers rendering services

## Utilization Review Focus

Utilization review activities ensure the efficient and cost-effective administration of 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 455 and 456 mandate that utilization review of OHCA services provide methods and procedures to safeguard against unnecessary use of care and services.

These federal regulations also require that 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 OHCA.

## Utilization Review Monitoring/Post Payment Audits

### Gainwell Program Integrity System

The Program Integrity Subsystem of the Oklahoma interChange (iCE) MMIS provides 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 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/Post Payment Audits

### 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 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 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 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, <https://oklahoma.gov/ohca.html> select the Policy link from the Providers section (see screen sample below), and then select 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.

## **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 <https://oklahoma.gov/ohca.html>, 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.

Oklahoma Health Care Authority > Policy and Rules > Policy and Rules

## Policies and Rules

Policy and Rules

Proposed Changes

Public Notices

Native American Consultation

HIPAA

Search Policy

Plans and Waivers

SoonerCare Out-of-State Services Rule Changes

Additional Important Statutes

## OHCA Policies and Rules

[Click Here to Search Entire Policy](#)

<a href="#">Chapter 1</a>	ADMINISTRATIVE OPERATIONS
<a href="#">Chapter 2</a>	GRIEVANCE PROCEDURES AND PROCESS
<a href="#">Chapter 10</a>	PURCHASING
<a href="#">Chapter 25</a>	SOONERCARE
<a href="#">Chapter 30</a>	MEDICAL PROVIDERS-FEE FOR SERVICE
<a href="#">Chapter 35</a>	MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY
<a href="#">Chapter 40</a>	DEVELOPMENTAL DISABILITIES SERVICES
<a href="#">Chapter 45</a>	INSURE OKLAHOMA
<a href="#">Chapter 50</a>	HOME AND COMMUNITY BASED SERVICES WAIVERS
<a href="#">Chapter 55</a>	MANAGED CARE

**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.

[Additional Important Statutes](#)

Oklahoma Health Care Authority  
4345 N Lincoln Blvd  
Oklahoma City, OK 73105

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The Oklahoma Health Care Authority collects the personally identifiable data submitted and received in regard to applications for services, renewals, appeals, provision of health care and processing of claims. This data is treated as confidential and is stored securely in accordance with applicable law and regulations. OHCA may share this personally identifiable data with its authorized business associates, government agencies with jurisdiction over the OHCA, or as otherwise required or permitted by applicable law.

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## 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

<https://oklahoma.gov/content/dam/ok/en/okhca/documents/a0304/16524.pdf>

## 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

Oklahoma Health Care Authority  
Member Audits  
4345 N. Lincoln Blvd.  
Oklahoma City, OK 73105  
(855) 817-3728  
(405) 522-5508  
[Member.investigation@okhca.org](mailto:Member.investigation@okhca.org)

### **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**

OHCA may sanction a medical provider who has an agreement with OHCA. To obtain more information on sanctions, go to <https://oklahoma.gov/ohca>, select the Policy link under the Providers section, and then scroll down and select 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.

### **Appeals Procedures (excluding nursing homes and hospitals)**

To obtain more information on appeals, go to <https://oklahoma.gov/ohca>, select the Policy link in the Providers section, and then scroll down and select OHCA Rules link under Policies & Rules at left. Select the Chapter 2 and 30 links and scroll to O.A.C. 317:2-3-4 (Member grievances) and O.A.C. 317:2-3-5 (Member appeals), or O.A.C. 317:2-1-7 (Program Integrity Audit Appeals).

### **Appeals Procedures for Long-Term Care Nursing Facilities**

To obtain more information on long term care facility appeals, go to <https://oklahoma.gov/ohca>, select the Policy link in the Providers section, and then scroll down and 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.

# Chapter 18: Quality Assurance and Improvement

## Introduction

The Quality Improvement Unit 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 activities include:

- monitoring of utilization for the various SoonerCare programs;
- on-site review for Patient Center Medical Home (PCMH) tier contract compliance;
- Program Integrity conducts clinical provider onsite audits for post payment audits
- 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, OHCA contracts with a Quality Improvement Organization (QIO) to conduct medical and utilization reviews. The Kansas Foundation for Medical Care (KFMC) serves as the contracted QIO for 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 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, in the event the medical record does not substantiate the services rendered, 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.

OHCA Quality Improvement Unit 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. 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 B: Member or Provider Complaints**

Quality Improvement staff members conduct reviews and follow-ups for potential quality of care issues. These cases are identified by OHCA staff, members, or care givers, 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. When there appears to be a pattern of quality-of-care concerns, providers may be referred to

the QIO for the Medical Education and Intervention Team (MEIT) process. This may involve a formal peer review of records, a meeting with the provider to explain concerns with the documented care, a corrective action plan. This is designed to be an educational experience to improve the quality of care that SoonerCare members receive. However, in the event that improvement is not demonstrated, contract action may be considered.

## Section C: Quality Improvement Studies/Projects

OHCA conducts ongoing Quality Improvement projects. Some of these projects are ad hoc in nature and developed in response to an identified area of focus for improvement.

The completion of some QI 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 Improvement Unit participates as support staff in various initiatives, such as prescription drug related deaths of SoonerCare members Smoking Cessation initiatives, Teenage pregnancy prevention, Obesity research, provider satisfaction surveys, and CAHPS for 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.

