1500 CLAIM SUBMISSION

SUBMITTING 1500 PROFESSIONAL CLAIMS THROUGH THE OHCA SECURE PROVIDER PORTAL.
CLASS DESCRIPTION

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

Recommended Audience:
• Billing staff who submit 1500 professional claims.
DISCLAIMER

• SoonerCare policy is subject to change.

• The information included in this presentation is current as of January 2021.

• Stay informed with current information found on the new OHCA public website: https://oklahoma.gov/ohca.
AGENDA

• Claim Basics
• Claim Submission
  - Medicaid Primary
  - Medicaid Secondary
  - HMO Co-pay
  - Medicare Crossover
• Claim Functions
• Resources
• Questions
CLAIM BASICS
CLAIM ID NUMBERS

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

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

ICN Orientation: **RRYYJJJIIIIII**

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

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

Region codes indicate the claim submission method used.
CLAIM STATUS

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

• **Paid** – claim has paid all or some of the line items.

• **Denied** – claim is denied either at the header or detail levels.

• **Suspended** – claim is still in process and may require manual review by a resolutions department.

• **Resubmit** – claim was received during the system cycle process time and will finish processing once the cycle is complete.
TIMELY FILING

• Claims must be filed within the first six months from the date of service to establish timely filing.

• Proof of timely filing must be attached if a claim is received after six months from the date of service.

• Timely filing proof is considered a claim from the OHCA secure provider portal that reflects the ICN and line item details or a copy of an OHCA remittance advice with the same information.
CLAIM SUBMISSION
MEDICAID PRIMARY

• Medicaid is considered primary if it is the member’s only source of coverage.

• Medicaid is the payer of last resort.
  - Exceptions to this are Indian Health Services and those eligible for the Crime Victims Compensation Act.

• Providers are reimbursed based on fee schedule allowable rates.
Select **Submit Claim Prof** under the **Claims** tab.
Two types of professional claims:

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

Select *Professional* as the *Claim Type*.
Referring and/or Ordering Provider are required if applicable.

- **Referring Provider** is used if the member has a Patient Centered Medical Home (PCMH) and the service requires a referral.

- **Ordering Provider** is the individual provider that ordered the service. Some services require an ordering provider.
MEDICAID PRIMARY

- **Member ID** is always required. The member demographics will auto populate if the member ID is valid.
- Other Insurance needs to be left at *None*.
- Select **Continue** to proceed to step 2.
• **Diagnosis Code** field is required. Enter the diagnosis code without the decimal point and select the **Add** button.

• Click **Continue** to proceed to step 3.
MEDICAID PRIMARY

- **Charge Amount** must be entered, or claim will deny or pay at $0.
- Most claims will require a **Rendering Provider ID**. Certain provider types do not require it.
- If an **Ordering Provider** is entered in Step 1, it will carry over to Step 3 on all line items.
- Select **Add** to enter additional service lines.
• The National Drug Code (NDC) information must be entered for vaccine codes.

• Select the + sign to expand the NDC box. Enter the information and select Add to save to the line item of service.
• Review the claim to verify the information was entered correctly.
• Information can be changed by selecting Back to Step 1, 2 or 3.
• Select Confirm to finalize the claim.
• Upon confirmation, the claim will adjudicate and the claim ID will populate.
• Status is either Paid, Denied, Suspended or Resubmit.
• Claim Options are Print Preview, Edit, New or View.
MEDICAID SECONDARY

• Medicaid is considered secondary when other insurance or coverage is responsible for payment.

• SoonerCare members may have other insurance in addition to SoonerCare:
  – A commercial group plan through a member’s employer.
  – An individually purchased plan.
  – Insurance available as a result of an accident or injury.
MEDICAID SECONDARY

• Providers must verify if a member has other insurance prior to services rendered.

• The primary insurance guidelines must be met for SoonerCare to consider payment.

• Providers accept the SoonerCare allowable as payment in full and may not bill the member for any remaining balance.
MEDICAID SECONDARY

Two types of professional claims:

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

Select *Professional* as the **Claim Type**.
## MEDICAID SECONDARY

<table>
<thead>
<tr>
<th>Provider Information</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>This panel contains provider information.</td>
<td></td>
</tr>
<tr>
<td><strong>Billing Provider ID</strong></td>
<td><strong>ID Type</strong></td>
</tr>
<tr>
<td><strong>Name</strong></td>
<td><strong>NPI</strong></td>
</tr>
<tr>
<td><strong>Zip Code</strong></td>
<td><strong>Contract Code</strong></td>
</tr>
<tr>
<td><strong>Referring Provider ID</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Ordering Provider ID</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Other Facility ID</strong></td>
<td></td>
</tr>
</tbody>
</table>

Referring and/or Ordering Provider are required if applicable.

- **Referring Provider** is used if the member has a Patient Centered Medical Home (PCMH) and the service requires a referral.

- **Ordering Provider** is the provider that ordered the service. Some services require an ordering provider.
If the primary insurance paid:

- Select **Include** under the **Other Insurance** section and **Continue** to step 2.

- After entering the **Diagnosis**, enter the amount the primary insurance paid in the **TPL Amount** field.

- No Explanation of Benefits (EOB) required if primary made a full or partial payment.
If the primary insurance denied or applied to deductible:

- Select Denied under the Other Insurance section and Continue to step 2.

- Enter the diagnosis. Because primary insurance denied, the TPL Amount field is not present.

- Explanation of Benefits (EOB) must be attached after entering the service details.
- Add the service details.
- The primary EOB is not required if the primary insurance made a payment.
- The primary EOB must be attached to the claim if the primary insurance denied or the payment applied to deductible.
- Select Submit.
If the primary insurance denied or the payment applied to the deductible, the EOB must be attached.

- Click the + icon to expand the attachments section.
- Choose the attachment type and Add the attachment.
- Select Submit.
• Review the claim to verify the information was entered correctly.

• Any necessary changes may be entered by selecting Back to Step 1, 2 or 3.

• Select Confirm to finalize the claim.
Upon confirmation, the claim will adjudicate and the claim ID will populate.

The claim ID will start with a 23, which means the claim is a web claim with attachments.

The status of the claim is **Suspended** because the primary EOB documents need to be reviewed.
HMO CO-PAY

• Medicaid is considered secondary when the patient has a private Health Maintenance Organization (HMO) plan.

• OHCA reimburses providers for co-payments and services not covered by commercial plans under a cap arrangement.
  - 1500 Professional - $200
  - UB-04 - $1,000
HMO CO-PAY

• HMO co-pay claims submitted through the OHCA secure provider portal will begin with a region code of 94.

• All HMO co-pay claims must have the primary EOB attached.

• The co-pay amount should only be billed as one line item of service.
HMO CO-PAY CHANGES (MEDICARE)

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

• These claims will need to be filed as a crossover.

• With this change, HMO claims will pay the same percentage of coinsurance and deductible Part C PPO claims currently pay.
Two types of professional claims:

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

Select *Professional* as the *Claim Type*. 
## HMO CO-PAY

Referring and/or Ordering Provider are required if applicable.

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

- Enter the **Member ID** number.
- Leave **Other Insurance** at **None**.
- Change **HMO Copay** to **Yes**.
• **Diagnosis Code** field is required. Enter the diagnosis code without the decimal point and select the **Add** button.
• Select the **Add** button after entering each diagnosis.
Only one Service Detail line item should be submitted with the co-pay amount.
**HMO CO-PAY**

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

• Review the claim to verify the information was entered correctly.

• Any necessary changes may be entered by selecting Back to Step 1, 2 or 3.

• Select Confirm to finalize the claim.
HMO CO-PAY

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

• Members who have Medicare as primary and Medicaid as secondary are considered dual eligible.

• Providers must be in network with Medicare and Medicaid for OHCA to pay as secondary.

• A claim must be submitted to Medicare prior to submitting a claim to OHCA for reimbursement.
**MEDICARE CROSSOVER**

- OHCA reimburses the coinsurance and deductible of Medicare up to a certain percentage.

- The claim must be submitted as a professional crossover.

- Medicare coinsurance, deductible and paid date must be reported under the crossover details section of the claim.
  - The Explanation of Medicare Benefits (EOMB) is not required when the Medicare payment is reported.
  - The HCA-28B form is not required.
MEDICARE CROSSOVER

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

• These claims will need to be filed as a crossover.

• With this change, HMO claims will pay the same percentage of coinsurance and deductible Part C PPO claims currently pay.
Two types of professional claims:

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

Select *Professional Crossover* as the *Claim Type*. 
MEDICARE CROSSOVER

- Enter the Member ID number.
- Enter the From and To Date of service.
- Leave Other Insurance dropdown as None.
- Select Continue to proceed to step 2.
Diagnosis Code field is required. Enter the diagnosis code without the decimal point and select the **Add** button.

Select the **Add** button after entering each diagnosis.
MEDICARE CROSSOVER

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

• Review the claim to verify the information was entered correctly.

• Any necessary changes may be entered by selecting Back to Step 1, 2 or 3.

• Select Confirm to finalize the claim.
MEDICARE CROSSOVER

- Upon confirmation, the claim will adjudicate, and the claim ID will populate.
- Claim status: Paid, Denied, Suspended or Resubmit.
CLAIM FUNCTIONS
Claims may be searched by:

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

Search Results

To see additional claim information, or view a remittance advice, click on the ' +' next to the Claim ID. To view the entire claim, click on the Claim ID.

<table>
<thead>
<tr>
<th>Claim ID</th>
<th>Claim Type</th>
<th>Claim Status</th>
<th>Service Date</th>
<th>Member ID</th>
<th>Patient Acct Number</th>
<th>Billed Amount</th>
<th>Medicaid Paid Amount</th>
<th>Paid Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>2220xxxxxxx</td>
<td>Professional</td>
<td>Paid</td>
<td>11/06/2020</td>
<td></td>
<td></td>
<td>$120.00</td>
<td>$66.86</td>
<td></td>
</tr>
<tr>
<td>2320xxxxxxx</td>
<td>Professional</td>
<td>Denied</td>
<td>11/02/2020</td>
<td></td>
<td></td>
<td>$170.00</td>
<td>$0.00</td>
<td></td>
</tr>
<tr>
<td>2320xxxxxxx</td>
<td>Professional</td>
<td>Denied</td>
<td>11/02/2020</td>
<td></td>
<td></td>
<td>$120.00</td>
<td>$0.00</td>
<td></td>
</tr>
<tr>
<td>9420xxxxxxx</td>
<td>Professional</td>
<td>Denied</td>
<td>11/02/2020</td>
<td></td>
<td></td>
<td>$60.00</td>
<td>$0.00</td>
<td></td>
</tr>
<tr>
<td>2220xxxxxxx</td>
<td>Crossover</td>
<td>Denied</td>
<td>11/02/2020</td>
<td></td>
<td></td>
<td>$120.00</td>
<td>$0.00</td>
<td></td>
</tr>
<tr>
<td>2320xxxxxxx</td>
<td>Professional</td>
<td>Denied</td>
<td>11/02/2020</td>
<td></td>
<td></td>
<td>$120.00</td>
<td>$0.00</td>
<td></td>
</tr>
</tbody>
</table>

Click on the blue Claim ID hyperlink to view the claim.
Claims in a paid status allows the user to copy or void.
PAID CLAIM FUNCTIONS

• Copy options for paid claims:
  – Member Information,
  – Service Information,
  – Member Information and Service Information
  – Entire Claim

• Claims voided after six months from the date of service are subject to timely filing limitations.

• Claims nearing the timely filing limitation should not be voided without instruction from OHCA.
Copy claim:
• Select the information to copy.
PAID CLAIM FUNCTIONS

Void claim:
• Select OK to Confirm.
DENIED CLAIM FUNCTIONS

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

- **Header**: contains information about the member and provider but not about the services performed.
  - The system will verify member’s eligibility and provider’s contract information, causing the entire claim to deny.

- **Detail**: contains information specific to the services performed.
  - The system verifies coverage of services, policy limitations or program restrictions which will cause specific service lines to deny and not the entire claim.
DENIED CLAIM FUNCTIONS

• The OHCA secure provider portal provides HIPAA and EOB remark codes for the denial reason.

• Denied claims can be edited for changes and resubmitted through the provider portal.

• Claims in a denied status cannot be voided.
DENIED CLAIM FUNCTIONS

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

Click the + sign icon on the **Adjudication Errors** bar to view the denial reasons.
### Denied Claim Functions

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

<table>
<thead>
<tr>
<th>Claim / Service #</th>
<th>HIPAA Adj</th>
<th>Description</th>
<th>HIPAA Adj Remark</th>
<th>Description</th>
<th>EOB</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service # 1</td>
<td>A1</td>
<td>Claim denied charges.</td>
<td>N115</td>
<td>This decision was based on a Local Coverage Determination (LCD). An LCD provides a guide to assist in determining whether a particular item or service is covered. A copy of this policy is available at <a href="http://www.cms.gov/mcd">www.cms.gov/mcd</a>, or if you do not have web access, you may contact the contractor to request a copy</td>
<td>9098</td>
<td>CLAIM WAS PRICED IN ACCORDANCE WITH CURRENT OKLAHOMA HEALTH COVERAGE PROGRAM 10</td>
</tr>
<tr>
<td>Service # 1</td>
<td>18</td>
<td>Duplicate claim/service.</td>
<td>N109</td>
<td>This claim was chosen for complex review and was denied after reviewing the medical records.</td>
<td>4318</td>
<td>PROCEDURE DENIED DUE TO NEW VISIT FREQUENCY</td>
</tr>
</tbody>
</table>
### Denied Claim Functions

Select **Edit** to modify the claim.

![Denied Claim Functions](image-url)

<table>
<thead>
<tr>
<th>Svc #</th>
<th>From Date</th>
<th>To Date</th>
<th>Place of Service</th>
<th>EMG</th>
<th>Procedure Code</th>
<th>Mod</th>
<th>Diag Code Ptrs</th>
<th>Units</th>
<th>EPSDT</th>
<th>Charge Amount</th>
<th>Allowed Amount</th>
<th>Co-pay Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>09/24/2020</td>
<td>09/24/2020</td>
<td>11</td>
<td>Unknown</td>
<td>99383</td>
<td>1</td>
<td>1.00 Unit</td>
<td>$115.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**No Other Insurance Details exist for this claim**

**No Attachments exist for this claim**
DENIED CLAIM FUNCTIONS

Click **Resubmit** once all edits are saved.
RESOURCES
BMI SCREENING INFORMATION

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

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

• OHCA call center
  800-522-0114 or 405-522-6205; option 1.

• Internet help desk.
  800-522-0114 or 405-522-6205; option 2, 1.

• EDI help desk.
  800-522-0114 or 405-522-6205; option 2, 2.
HELPFUL LINKS

• NEW Agency Website
  https://oklahoma.gov/ohca

• Coronavirus Information
  https://oklahoma.gov/ohca/about/covid19/coronavirus.html

• Managed Care
  https://oklahoma.gov/ohca/about/medicaid-expansion/soonerselect.html

• Telehealth Services
  https://oklahoma.gov/ohca/providers/telehealth.html

• OHCA Provider Portal.
  www.ohcaprovider.com
HELPFUL LINKS

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

Visit [https://oklahoma.gov/ohca/providers/provider-training](https://oklahoma.gov/ohca/providers/provider-training).
A telephonic or virtual visit with a provider education specialist may be requested for specific training on a topic.

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

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

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


- Provider policies and rules and Oklahoma Health Care Authority Medicaid rules.
  - Chapter 25 – SoonerCare Choice.
  - Chapter 30 – Fee for Service.
QUESTIONS?