UB-04 CLAIM SUBMISSION

SUBMITTING UB-04 INSTITUTIONAL CLAIMS THROUGH THE OHCA SECURE PROVIDER PORTAL
CLASS DESCRIPTION

This class will provide an in-depth look at the UB-04 institutional claims submission 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 UB-04 institutional 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 OHCA public website www.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

When claims are entered into the SoonerCare provider portal, they are issued a tracking number known as the Internal Control Number (ICN) or the Claim ID number.

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

ICN Orientation: RRRYYJJJIIIIII

- **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 assigned when the claim is received.
# CLAIM ID NUMBERS

Region codes indicate the claim submission method used.

<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 – with attachment</td>
</tr>
</tbody>
</table>
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 but does not need to be resubmitted.
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 Institutional.
Types of Institutional Claims:
- Inpatient and Outpatient
- Crossover Inpatient and Outpatient
- Home Health
- Long Term Care

Select the appropriate Claim Type.
**(MEDICAID PRIMARY)**

Attending, Operating and Referring Providers are individual provider identifications and are required, if applicable.

- **Operating Provider** is required when billing a surgical procedure.
- **Referring Provider** is required if the member has a Patient Centered Medical Home (PCMH) and the service requires a referral.

Enter the **Member ID** number. The member demographics will auto populate if the ID is valid.
MEDICAID PRIMARY

Claim Information:
• Inpatient and crossover inpatient claims require that more specific Claim Information be entered.
• Outpatient and crossover outpatient claims require only Covered Dates and Type of Bill be entered.
• Other Insurance needs to be left at None when Medicaid is the primary payer.
• Select Continue after entering required information.
• **Diagnosis Code** field is required. Enter the diagnosis code without the decimal point and select the **Add** button after each diagnosis.

• **Present on Admission** is only entered for inpatient claims.
MEDICAID PRIMARY

Condition Codes, Occurrence Codes and Value Codes are only required if applicable.

• **Condition code** may describe conditions or circumstances surrounding the reason the patient is in a facility.

• **Occurrence code** identifies significant events relating to an institutional claim or encounter record that may affect payer processing. This code is associated with a specific date.

• **Value code** indicates a monetary condition which was used by the intermediary to process an institutional claim. Value Code dollar amount should include cents.
MEDICAID PRIMARY

- Enter the appropriate Revenue Code.
- Enter From and To dates.
- Enter the appropriate Units.
- Charge Amount is the amount billed and must be entered, or claim will deny or pay at $0.
- Add service details.
- Attachments are required, if applicable.
- Select Submit after all service lines are entered.
MEDICAID PRIMARY

- 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

Choose appropriate **Claim Type**.
Attending, Operating and Referring Providers are individual provider identifications, and are required if applicable.

- Operating Provider is required when billing a surgical procedure.

Enter the **Member ID** number. The member demographics will auto populate if the ID is valid.
MEDICAID
SECONDARY

If the primary insurance paid:

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

• After entering the Diagnosis, enter the primary insurance Payer Code and the amount paid in the Prior Amount field.
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 Other Insurance Details are not present.
Condition Codes, Occurrence Codes and Value Codes are only required if applicable.

- **Condition code** may describe conditions or circumstances surrounding the reason the patient is in a facility.

- **Occurrence code** identifies significant events relating to an institutional claim or encounter record that may affect payer processing. This code is associated with a specific date.

- **Value code** indicates a monetary condition which was used by the intermediary to process an institutional claim. Value Code dollar amount should include cents.
**MEDICAID SECONDARY**

- Enter the appropriate Revenue Code.
- Enter From and To dates.
- Enter the appropriate Units.
- **Charge Amount** is the amount billed and must be entered or claim will deny or pay at $0.
- **NDC** field is present for outpatient and home health claim types and is required if billing a vaccine.
- Add service details.

**Service Details**

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

<table>
<thead>
<tr>
<th>Svc #</th>
<th>Revenue Code</th>
<th>HCP/Proc Code</th>
<th>From Date</th>
<th>To Date</th>
<th>Units</th>
<th>Charge Amount</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Add** service details.
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.
MEDICAID SECONDARY

• If primary insurance denied or applied payment to the deductible, the EOB must be attached to the claim. Click the + icon to expand the Attachments section.

• Choose the Attachment Type and Add the attachment.

• Select Submit after all lines of service and attachments have been entered.
- Review the claim to verify the information was entered correctly.
- Information can be changed by selecting **Back to Step 1, 2 or 3**.
- Select **Confirm** to finalize the claim.
MEDICAID SECONDARY

- Upon confirmation, the claim will adjudicate and the claim ID will populate.
- The claim ID will start with 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.
Choose the appropriate Claim Type.
HMO CO-PAY

Attending, Operating and Referring Providers are individual provider identifications and are required if applicable.

• Operating Provider is required when billing a surgical procedure.

Enter the Member ID number. The member demographics will auto populate if the ID is valid.
HMO CO-PAY

• Enter the required Claim Information.
• Leave Other Insurance at None.
• Change HMO Copay to Yes.
• Select Continue to enter diagnosis.
• Diagnosis Code field is required. Enter the diagnosis code without the decimal point and select the Add button after each diagnosis.
Condition Codes, Occurrence Codes and Value Codes are only required if applicable.

- **Condition code** may describe conditions or circumstances surrounding the reason the patient is in a facility.

- **Occurrence code** identifies significant events relating to an institutional claim or encounter record that may affect payer processing. This code is associated with a specific date.

- **Value code** indicates a monetary condition which was used by the intermediary to process an institutional claim. Value Code dollar amount should include cents.
HMO CO-PAY

• Enter the appropriate Revenue Code.
• Enter From and To dates.
• Enter the appropriate Units.
• The Charge Amount should be the copay amount only, and must be entered, or claim will deny or pay at $0.
• There should only be one line item with a payable code.
• Add service details.
The EOB must be attached after entering the service detail lines.

- Click the + icon to expand the Attachments section.
- Choose the Attachment Type and Add the attachment.
- Select Submit after all lines of service and attachments have been entered.
**HMO CO-PAY**

- 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.
HMO CO-PAY

- Upon confirmation, the claim will adjudicate and claim ID will populate.
- HMO web claim IDs begin with 94.
- This claim is Suspended because the documents uploaded 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 crossover inpatient or crossover outpatient.

• 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 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 Medicare Crossover Claims:
• Crossover Inpatient
• Crossover Outpatient

Choose the appropriate Claim Type.
MEDICARE CROSSOVER

Attending, Operating and Referring Providers are individual provider identifications and are required if applicable.

- Operating Provider is required when billing a surgical procedure.

Enter the Member ID number. The member demographics will auto populate if the ID is valid.
MEDICARE CROSSOVER

- Enter the required Claim Information.
- Leave Other Insurance at None.
- Diagnosis Code field is required. Enter the diagnosis code without the decimal point and select the Add button after each diagnosis.
Condition Codes, Occurrence Codes and Value Codes are only required if applicable.

- **Condition code** may describe conditions or circumstances surrounding the reason the patient is in a facility.

- **Occurrence code** identifies significant events relating to an institutional claim or encounter record that may affect payer processing. This code is associated with a specific date.

- **Value code** indicates a monetary condition which was used by the intermediary to process an institutional claim. Value Code dollar amount should include cents.
MEDICARE CROSSOVER

- Reference the Medicare EOB for the Crossover Details.
- This is broken down per line item.
- Add service details.
- It is not necessary to attach the EOB from Medicare.
- Select Submit after all lines of service have been entered.
• 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 claim ID will populate.

Claim ID beginning with 22 region code indicates an internet claim with no attachments.
Claims may be searched by:

- Claim ID
- Member ID
- Service From and To dates (auto-populates with last 90-day range).
Click on the blue **Claim ID** hyperlink to view the claim.
PAID CLAIM FUNCTIONS

Claims in a paid status allows the user to **Copy** or **Void**.

### Claim Information

<table>
<thead>
<tr>
<th>Claim Status</th>
<th>Date Type</th>
<th>Accident Related</th>
<th>Patient Account Number</th>
<th>From Date</th>
<th>CLIA Number</th>
<th>Related Claim ICN</th>
<th>Paid Date</th>
<th>Date of Current</th>
<th>Expected Delivery Date</th>
<th>To Date</th>
<th>HMO Copay</th>
<th>Total Charged Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paid</td>
<td></td>
<td></td>
<td></td>
<td>11/06/2020</td>
<td></td>
<td></td>
<td>12/08/2020</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$120.00</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Total Co-pay Amount</th>
<th>Total Allowed Amount</th>
<th>Total Paid Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>$0.00</td>
<td>$66.86</td>
<td>$66.86</td>
</tr>
</tbody>
</table>

### Adjudication Errors

No Other Insurance Details exist for this claim

### Diagnosis Codes

No Attachments exist for this claim

### Service Details

<table>
<thead>
<tr>
<th>Serv #</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>Dial Code Pts</th>
<th>Units</th>
<th>EPIDT</th>
<th>Charge Amount</th>
<th>Allowed Amount</th>
<th>Co-pay Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paid</td>
<td>11/06/2020</td>
<td>11/06/2020</td>
<td>11</td>
<td>N</td>
<td>99213</td>
<td>1</td>
<td>1.50 Unit</td>
<td>$120.00</td>
<td>$66.86</td>
<td>$0.00</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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 allows the user to view Adjudication Errors or Edit the claim.
## Denied Claim Functions

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

<table>
<thead>
<tr>
<th>Svc #</th>
<th>Revenue Code</th>
<th>HCPCS/Proc Code</th>
<th>Mod</th>
<th>From Date</th>
<th>To Date</th>
<th>Units/Type</th>
<th>Charge Amount</th>
<th>Allowed Amount</th>
<th>Co-pay Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Denied</td>
<td>490</td>
<td></td>
<td>12/17/2020</td>
<td>12/18/2020</td>
<td>2.00 Unit</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
</tbody>
</table>
## 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 of this policy.</td>
<td>9998</td>
<td>CLAIM WAS PRICED IN ACCORDANCE WITH CURRENT OKLAHOMA HEALTH COVERAGE PROGRAM PO</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

**Adjudication Errors**

**Diagnosis Codes**

**Other Insurance was denied for this claim.**

**Service Details**

<table>
<thead>
<tr>
<th>Svc #</th>
<th>Revenue Code</th>
<th>HCPCS/Proc Code</th>
<th>Mod</th>
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<td>12/16/2020</td>
<td>2.00 Unit</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
</tbody>
</table>

**No Emergency Diagnosis Code exist for this claim**

**No Condition Codes exist for this claim**

**No Occurrence Codes exist for this claim**

**No Value Codes exist for this claim**

**No Surgical Procedures exist for this claim**

**No Attachments exist for this claim**

Select [Edit](#) to modify the claim.
DENIED CLAIM FUNCTIONS

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Click **Resubmit** once all edits are saved.
RESOURCES
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 at
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 emailing SoonerCareEducation@okhca.org.
PROVIDER VISITS

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

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

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?