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

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

Region codes indicate the claim submission method used.

CLAIM STATUS

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

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

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

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

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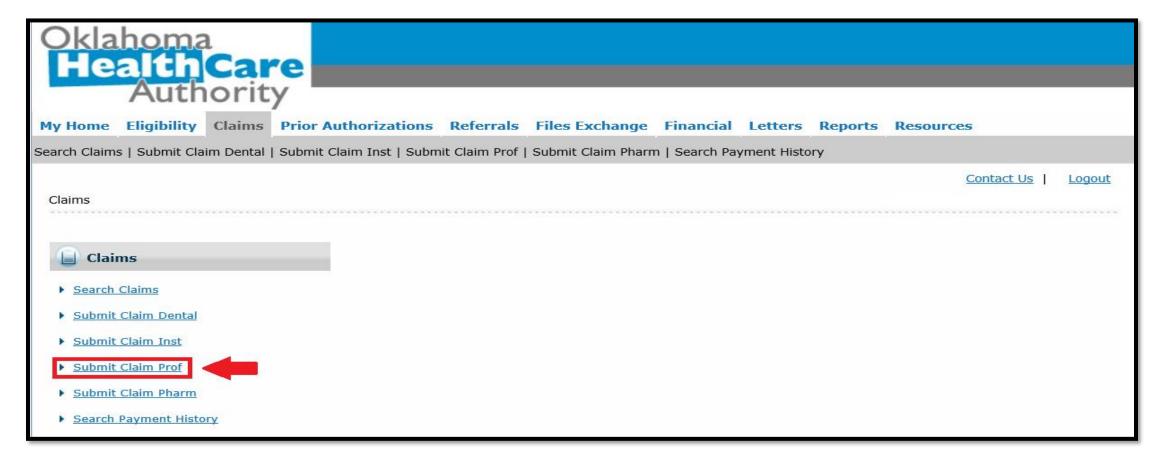
TIMELY FILING

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

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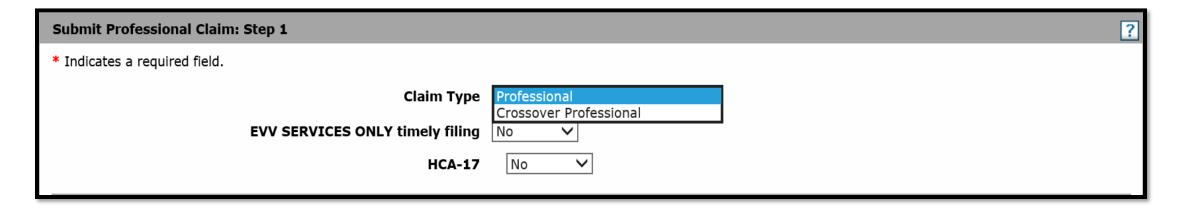
- Timely filing proof is considered a claim from the OHCA secure provider portal that reflects the ICN and line item details or a copy of an OHCA remittance advice with the same information.

CLAIM SUBMISSION

MEDICAID PRIMARY

- Medicaid is considered primary if it is the member's only source of coverage.

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

- Providers are reimbursed based on fee schedule allowable rates.

MEDICAID PRIMARY

Select **Submit Claim Prof** under the **Claims** tab.

MEDICAID PRIMARY

Submit Professional Claim: Step 1

* Indicates a required field.

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

Two types of professional claims:

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

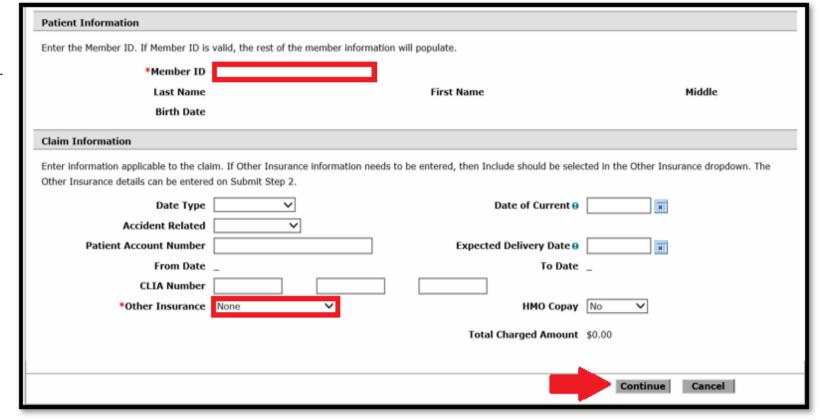- Professional Crossover – Medicare only.
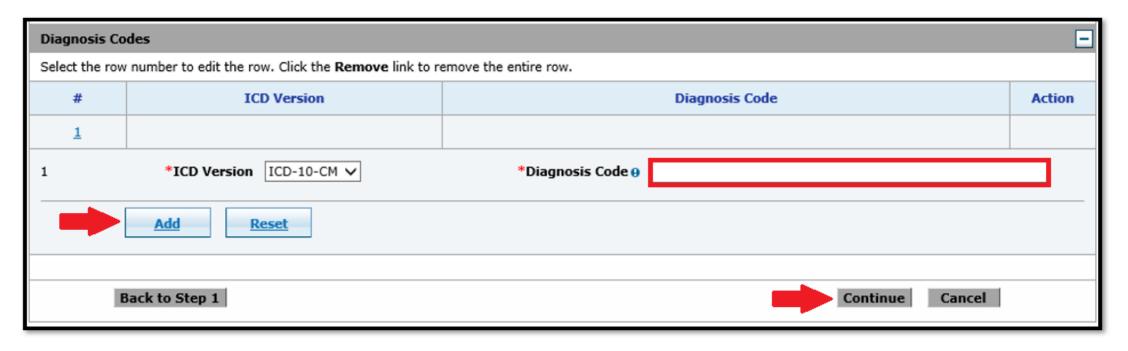
Select *Professional* as the **Claim Type**.

MEDICAID PRIMARY

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.
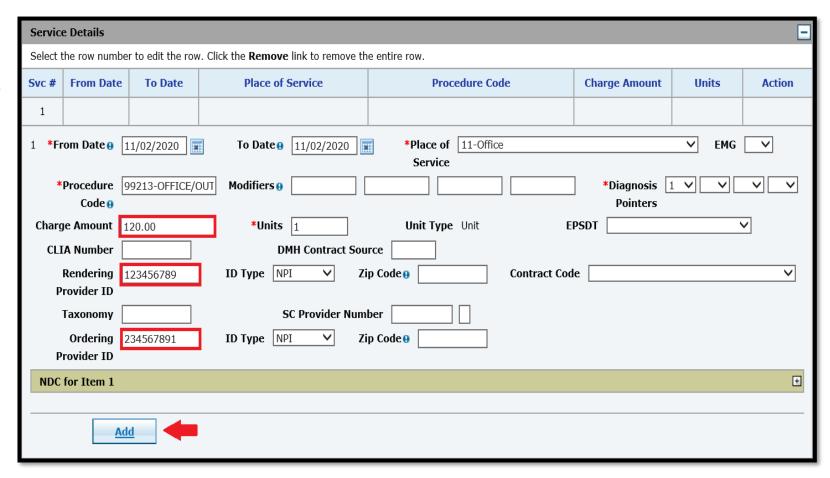
MEDICAID PRIMARY

- **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*.
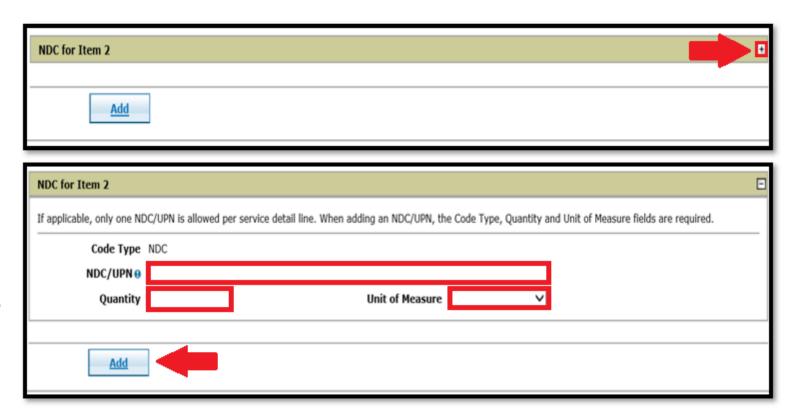
- Select **Continue** to proceed to step 2.

MEDICAID PRIMARY

- **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.

MEDICAID PRIMARY

- The National Drug Code (NDC) information must be entered for vaccine codes.

- Select the **+** sign to expand the **NDC** box. Enter the information and select **Add** to save to the line item of service.

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.

MEDICAID PRIMARY

- Upon confirmation, the claim will adjudicate and the claim ID will populate.

- Status is either Paid, Denied, Suspended or Resubmit.

- Claim Options are Print Preview, Edit, New or View.

MEDICAID SECONDARY

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

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

MEDICAID SECONDARY

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

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

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

MEDICAID SECONDARY

Submit Professional Claim: Step 1

* Indicates a required field.

Claim Type
Professional
Crossover Professional

EVV SERVICES ONLY timely filing No

HCA-17 No

Two types of professional claims:

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

- Professional Crossover – Medicare only.

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

MEDICAID SECONDARY

Referring and/or Ordering Provider are required if applicable.

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

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

MEDICAID SECONDARY

If the primary insurance **paid**:

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

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

- No Explanation of Benefits (EOB) required if primary made a full or partial payment.

MEDICAID SECONDARY

If the primary insurance **denied** or **applied to deductible**:

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

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

- Explanation of Benefits (EOB) **must** be attached after entering the service details.

MEDICAID SECONDARY

- Add the service details.

- The primary EOB is not required if the primary insurance made a payment.

- The primary EOB must be attached to the claim if the primary insurance denied or the payment applied to deductible.

- Select Submit.

MEDICAID SECONDARY

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

- Click the **+** icon to expand the attachments section.

- Choose the attachment type and **Add** the attachment.

- Select **Submit**.

MEDICAID SECONDARY

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

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

- Select Confirm to finalize the claim.

MEDICAID SECONDARY

- Upon confirmation, the claim will adjudicate and the claim ID will populate.

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

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

HMO CO-PAY

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

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

HMO CO-PAY

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

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

- The co-pay amount should only be billed as one line item of service.

HMO CO-PAY CHANGES (MEDICARE)

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

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

- With this change, HMO claims will pay the same percentage of coinsurance and deductible Part C PPO claims currently pay.

HMO CO-PAY

Two types of professional claims:

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

- Professional Crossover – Medicare only.

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

HMO CO-PAY

Provider Information

This panel contains provider information.

Billing Provider ID		**ID Type** NPI
Name		

Zip Code	Contract Code	Taxonomy	SC Provider Number
Referring Provider ID		**ID Type**	
Ordering Provider ID		**ID Type**	**Ordering Zip Code** ⓘ
Other Facility ID		**ID 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 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*.

HMO CO-PAY

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

- Select the **Add** button after entering each diagnosis.

HMO CO-PAY

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.

MEDICARE CROSSOVER

Two types of professional claims:

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

- Professional Crossover – Medicare only.

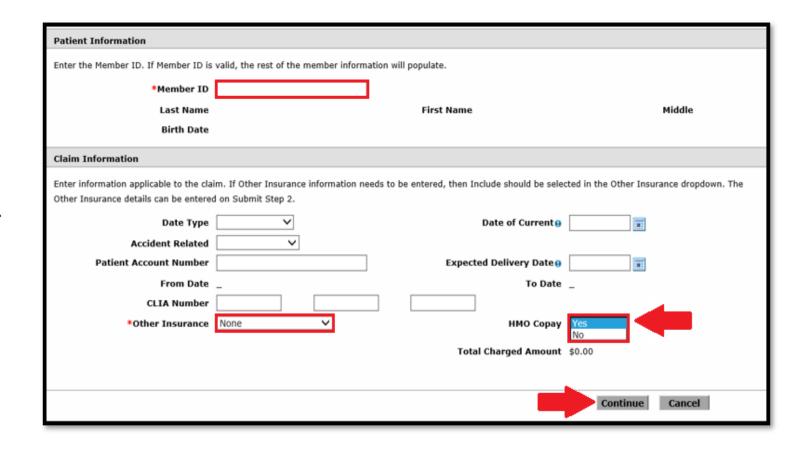Select *Professional Crossover* as the **Claim Type**.

MEDICARE CROSSOVER

- Enter the **Member ID** number.

- Enter the **From** and **To Date** of service.

- Leave **Other Insurance** dropdown as *None*.

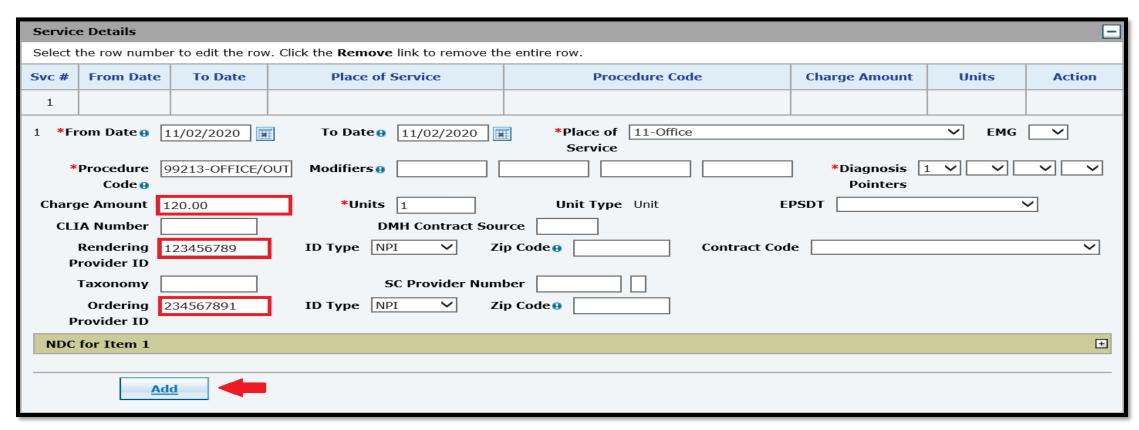- Select **Continue** to proceed to step 2.

MEDICARE CROSSOVER

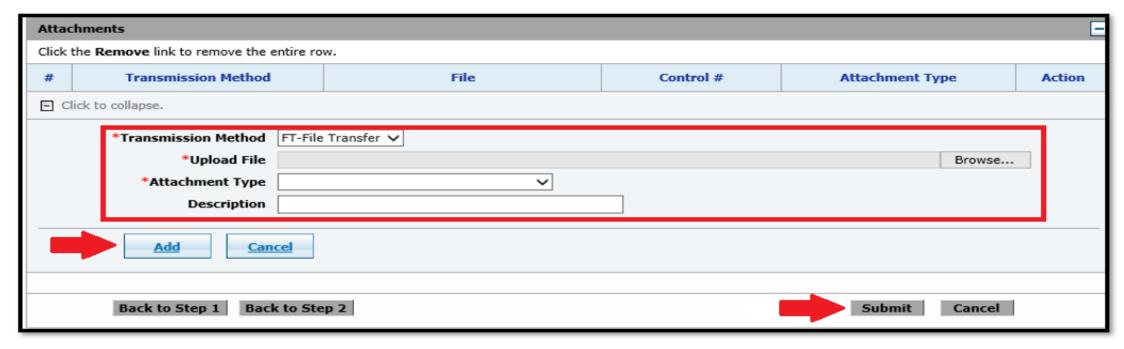- **Diagnosis Code** field is required. Enter the diagnosis code without the decimal point and select the **Add** button.

- 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

SEARCH CLAIMS

Claims may be searched by:

- Claim ID

- Member ID

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

SEARCH CLAIMS

Search Results

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

Total Records: 6

	Claim ID	Claim Type	Claim Status	Service Date ▼	Member ID	Patient Acct Number	Billed Amount	Medicaid Paid Amount	Paid Date
➕	2220xxxxxxxx	Professional	Paid	11/06/2020			$120.00	$66.86	_
➕	2320xxxxxxxx	Professional	Denied	11/02/2020			$170.00	$0.00	_
➕	2320xxxxxxxx	Professional	Denied	11/02/2020			$120.00	$0.00	_
➕	9420xxxxxxxx	Professional	Denied	11/02/2020			$60.00	$0.00	_
➕	2220xxxxxxxx	Crossover Professional	Denied	11/02/2020			$120.00	$0.00	_
➕	2320xxxxxxxx	Professional	Denied	11/02/2020			$120.00	$0.00	_

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

PAID CLAIM FUNCTIONS

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

Claim Information

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

Expand All | Collapse All

Adjudication Errors ➕

Diagnosis Codes ➕

Service Details ➖

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

No Other Insurance Details exist for this claim

No Attachments exist for this claim

Copy   Void   Print Preview   RA Copy

PAID CLAIM FUNCTIONS

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

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

- Claims nearing the timely filing limitation should not be voided without instruction from OHCA.

PAID CLAIM FUNCTIONS

Copy claim:

- Select the information to copy.

Copy Professional Claim

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

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

Copy   **Cancel**

PAID CLAIM FUNCTIONS

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.

Adjudication Errors											+
Diagnosis Codes											+
Service Details											−

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

DENIED CLAIM FUNCTIONS

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

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

DENIED CLAIM FUNCTIONS

Adjudication Errors												➕
Diagnosis Codes												➕
Service Details												➖

Svc #	From Date	To Date	Place of Service	EMG	Procedure Code	Mod	Diag Code Ptrs	Units	EPSDT	Charge Amount	Allowed Amount	Co-pay Amount
1 Denied	09/24/2020	09/24/2020	11	Unknown	99383		1	1.00 Unit		$115.00	$0.00	$0.00

No Other Insurance Details exist for this claim

No Attachments exist for this claim

➡️ **Edit** | **Print Preview**

Select **Edit** to modify the claim.

DENIED CLAIM FUNCTIONS

Adjudication Errors					⊞
Diagnosis Codes					⊞
Service Details					⊞
Attachments					⊟

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

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

Back to Step 1   Back to Step 2   Resubmit   Cancel

Click **Resubmit** once all edits are saved.

RESOURCES

BMI SCREENING INFORMATION

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

- The diagnosis code on the claim is used to capture the screening information.

- An appropriate BMI screening diagnosis code must be used

- The BMI screen diagnosis code cannot be used as the primary diagnosis – it must be secondary or further within the diagnosis hierarchy.

- There is no CPT code associated with this service.

HELPFUL TELEPHONE NUMBERS

- OHCA call center

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

- Internet help desk.

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

- EDI help desk.

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

HELPFUL LINKS

- NEW Agency Website

   https://oklahoma.gov/ohca

- Coronavirus Information

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

- Managed Care

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

- Telehealth Services

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

- OHCA Provider Portal.

   www.ohcaprovider.com

HELPFUL LINKS

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

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

PROVIDER VISITS

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

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

PROVIDER VISITS

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

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

POLICY & RULES

OHCA Policy and Rules:

- https://oklahoma.gov/ohca/policies-and-rules/xpolicy.html.

- Provider policies and rules and Oklahoma Health Care Authority Medicaid rules.

    - Chapter 25 – SoonerCare Choice.

    - Chapter 30 – Fee for Service.

QUESTIONS?

OKLAHOMA
Health Care Authority

GET IN TOUCH

4345 N. Lincoln Blvd.
Oklahoma City, OK 73105

oklahoma.gov/ohca
mysoonercare.org

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