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: 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 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 but does not need to be resubmitted.

TIMELY FILING

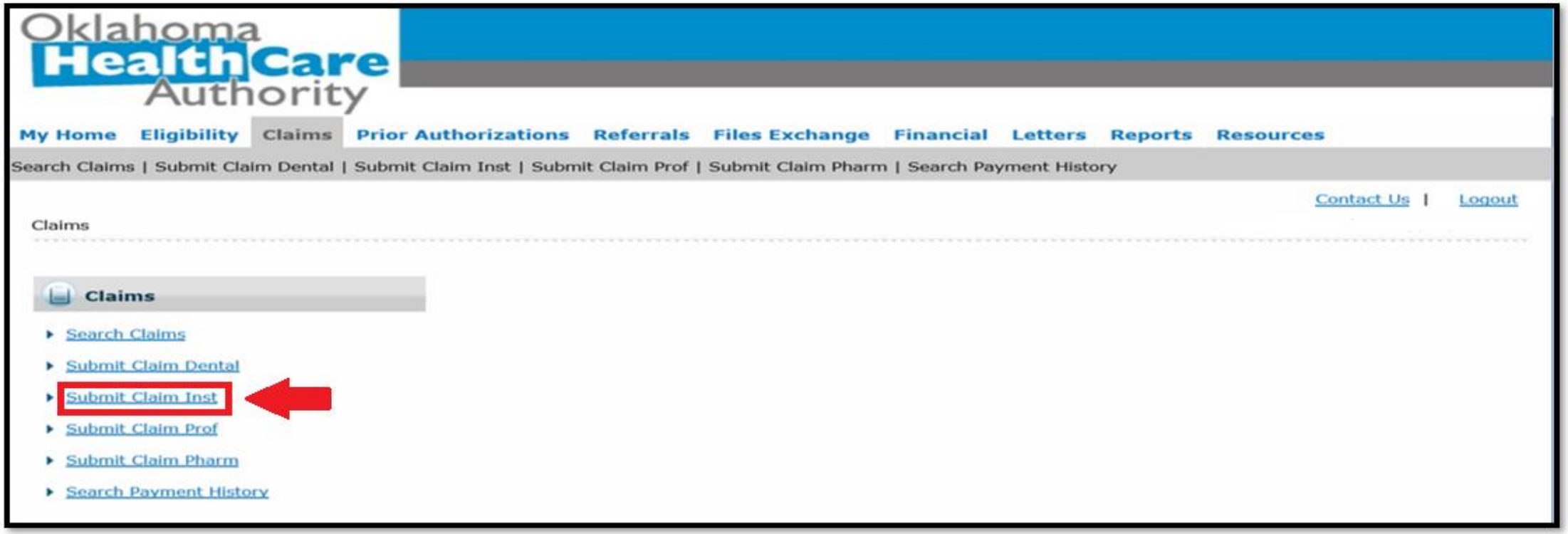
- Claims must be filed within the first six months from the date of service to establish timely filing.
- Proof of timely filing must be attached if a claim is received after six months from the date of service.
- Timely filing proof is considered a claim from the OHCA secure provider portal that reflects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

CLAIM SUBMISSION

MEDICAID PRIMARY

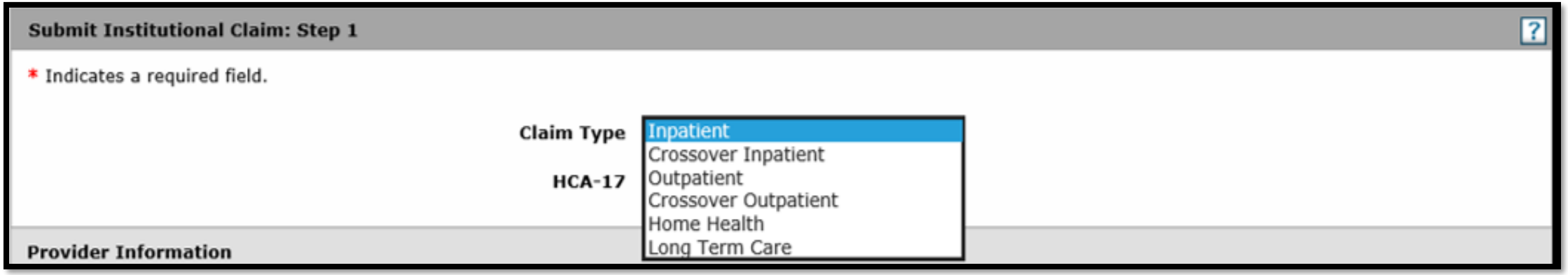
- Medicaid is considered primary if it is the member's only source of coverage.
- Medicaid is the payer of last resort.
  - Exceptions to this are Indian Health Services and those eligible for the Crime Victims Compensation Act.
- Providers are reimbursed based on fee schedule allowable rates.

MEDICAID PRIMARY



Select **Submit Claim Institutional**.

MEDICAID PRIMARY



Types of Institutional Claims:

- Inpatient and Outpatient
- Crossover Inpatient and Outpatient
- Home Health
- Long Term Care

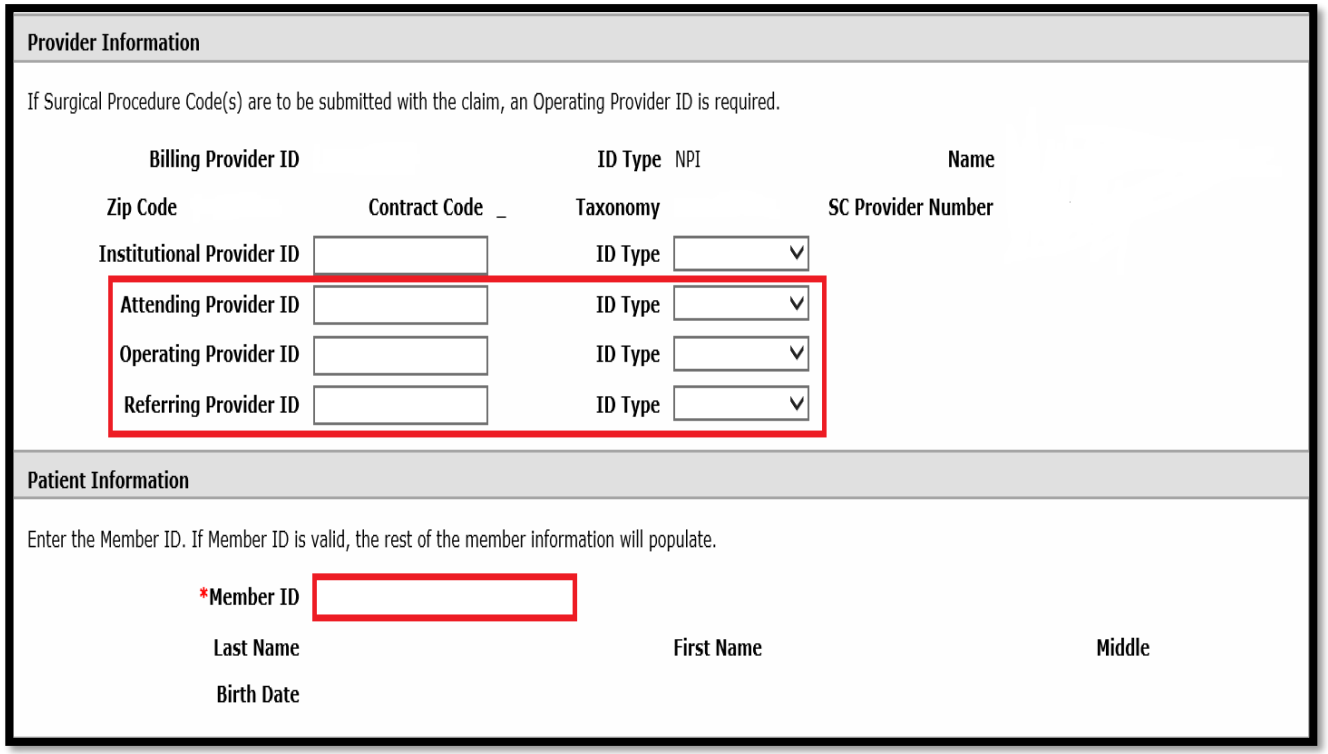
Select the appropriate **Claim Type**.

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.

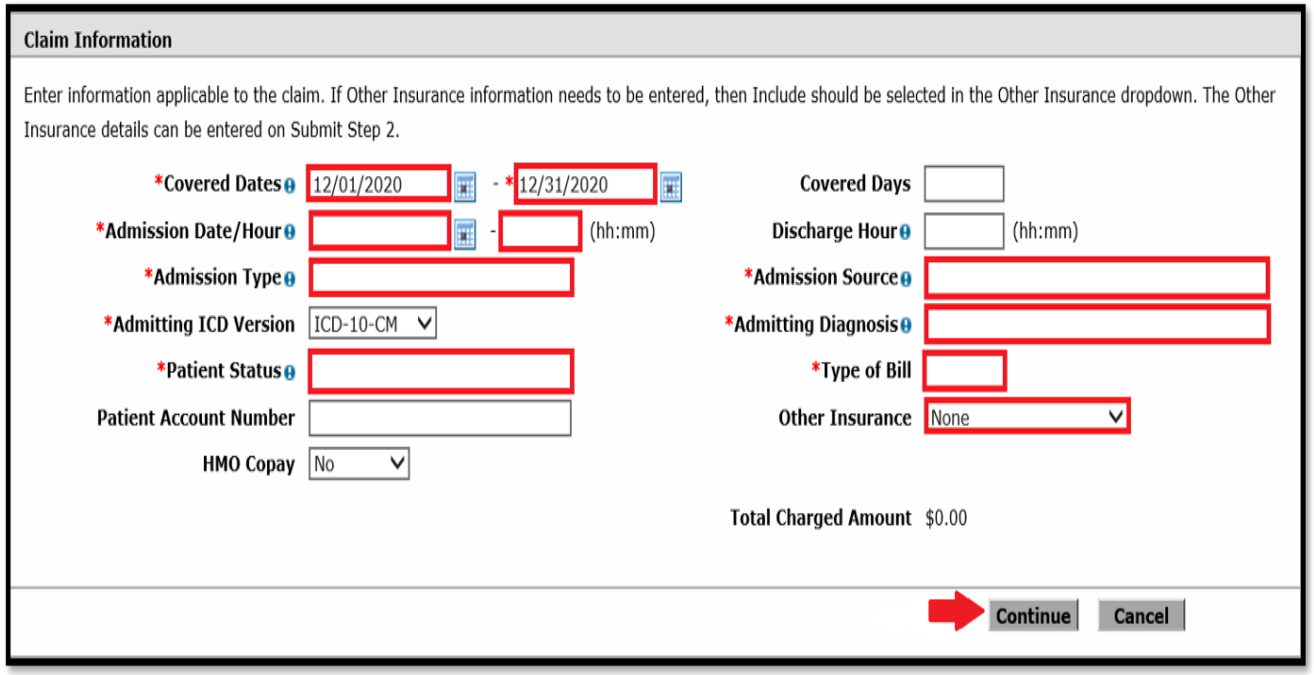
Enter the Member ID number. The member demographics will auto populate if the ID is valid.



MEDICAID PRIMARY

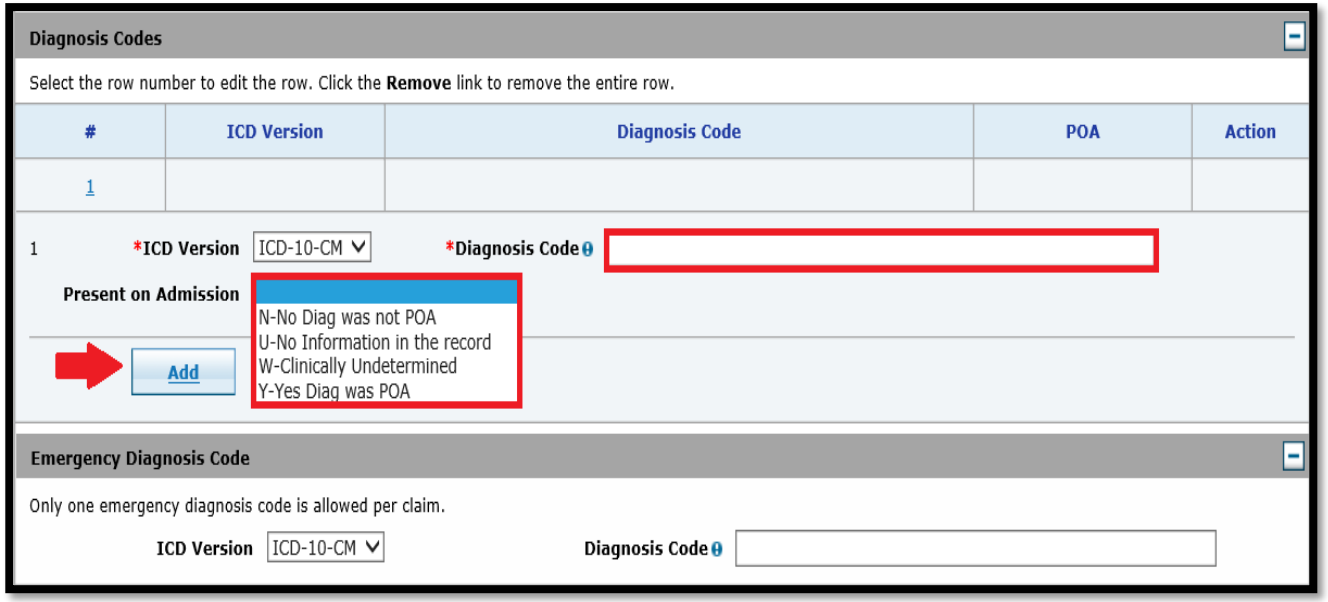
Claim Information:

- 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.



MEDICAID PRIMARY

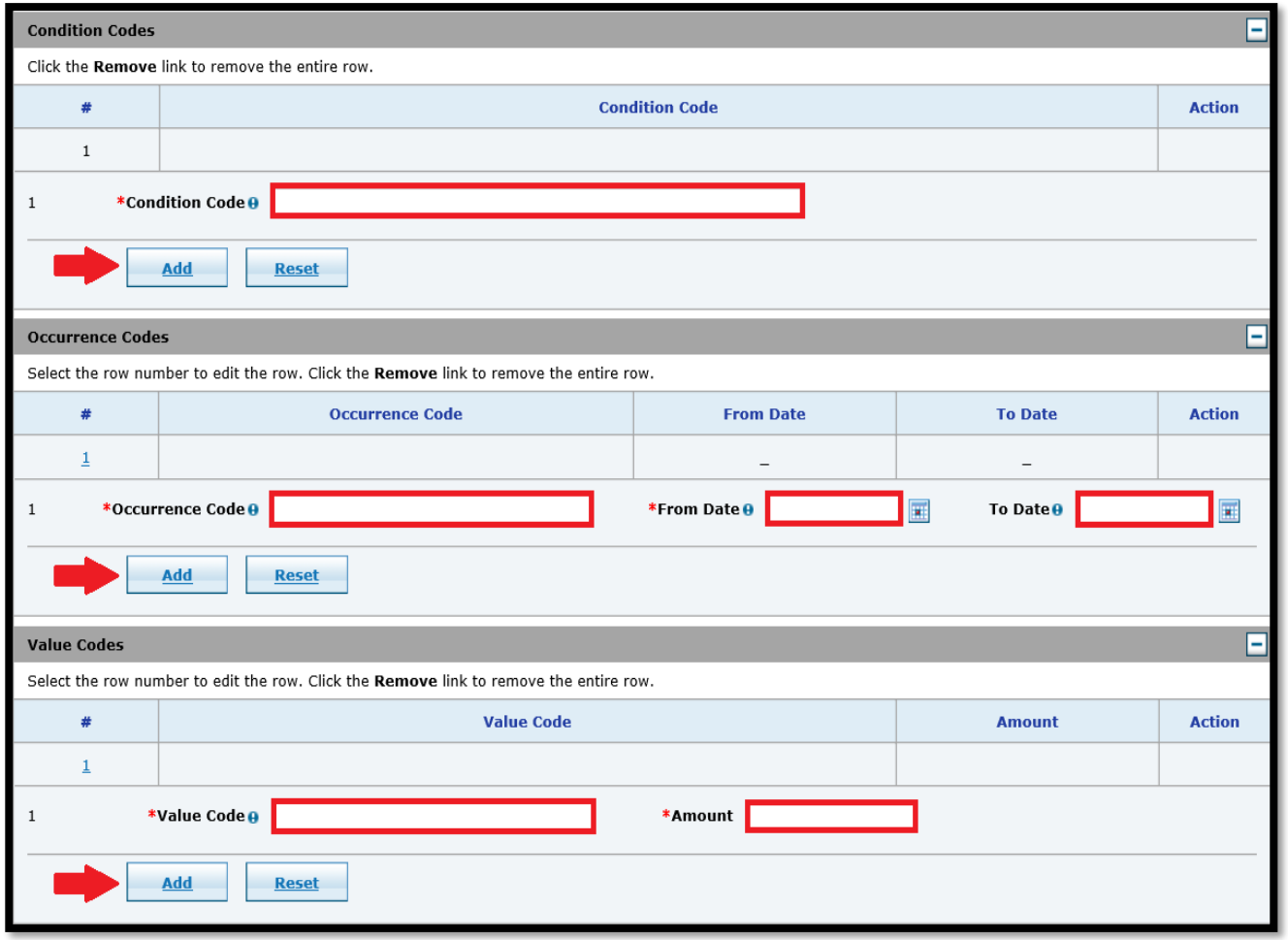
- Diagnosis Code field is required. Enter the diagnosis code without the decimal point and select the Add button after each diagnosis.
- Present on Admission is only entered for inpatient claims.



MEDICAID PRIMARY

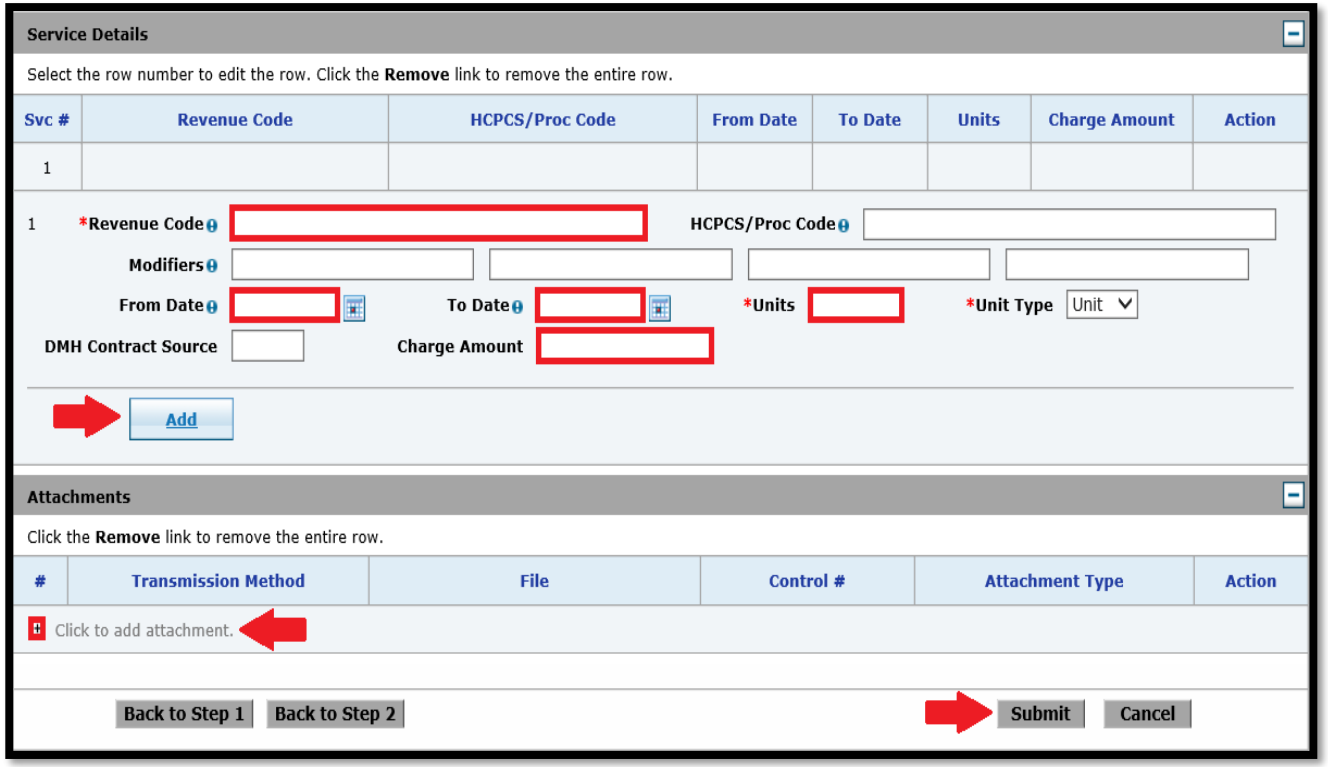
Condition Codes, Occurrence Codes and Value Codes are only required if applicable.

- 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.



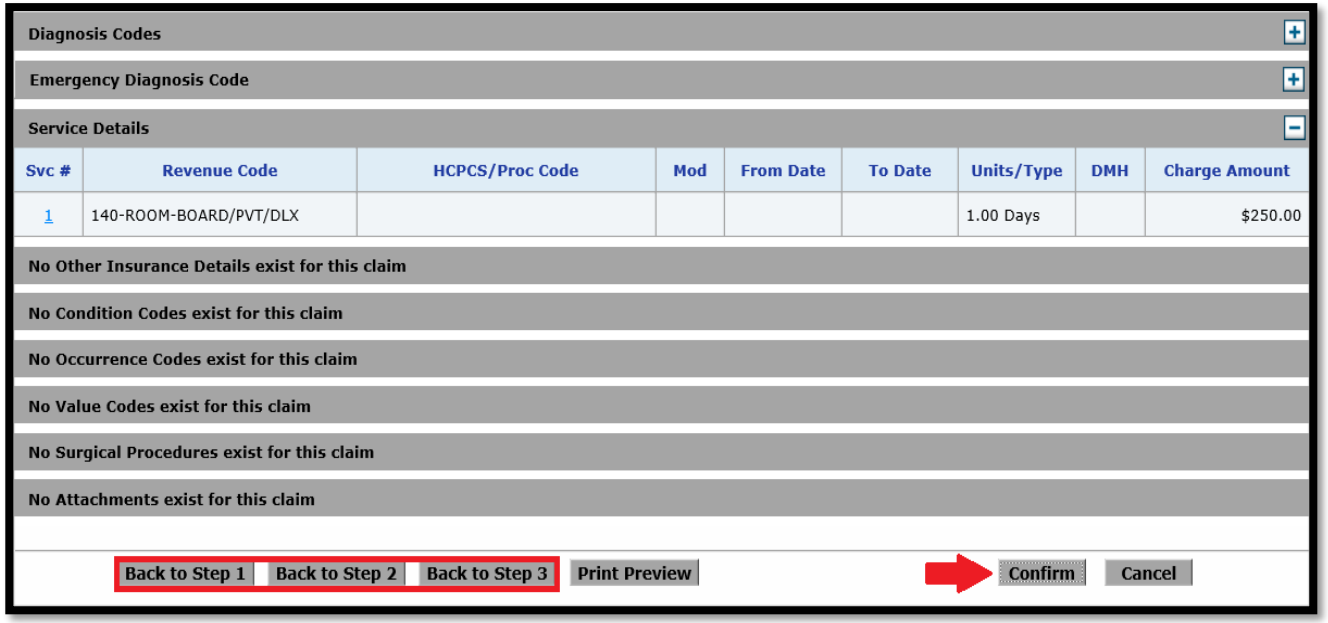
MEDICAID PRIMARY

- 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.



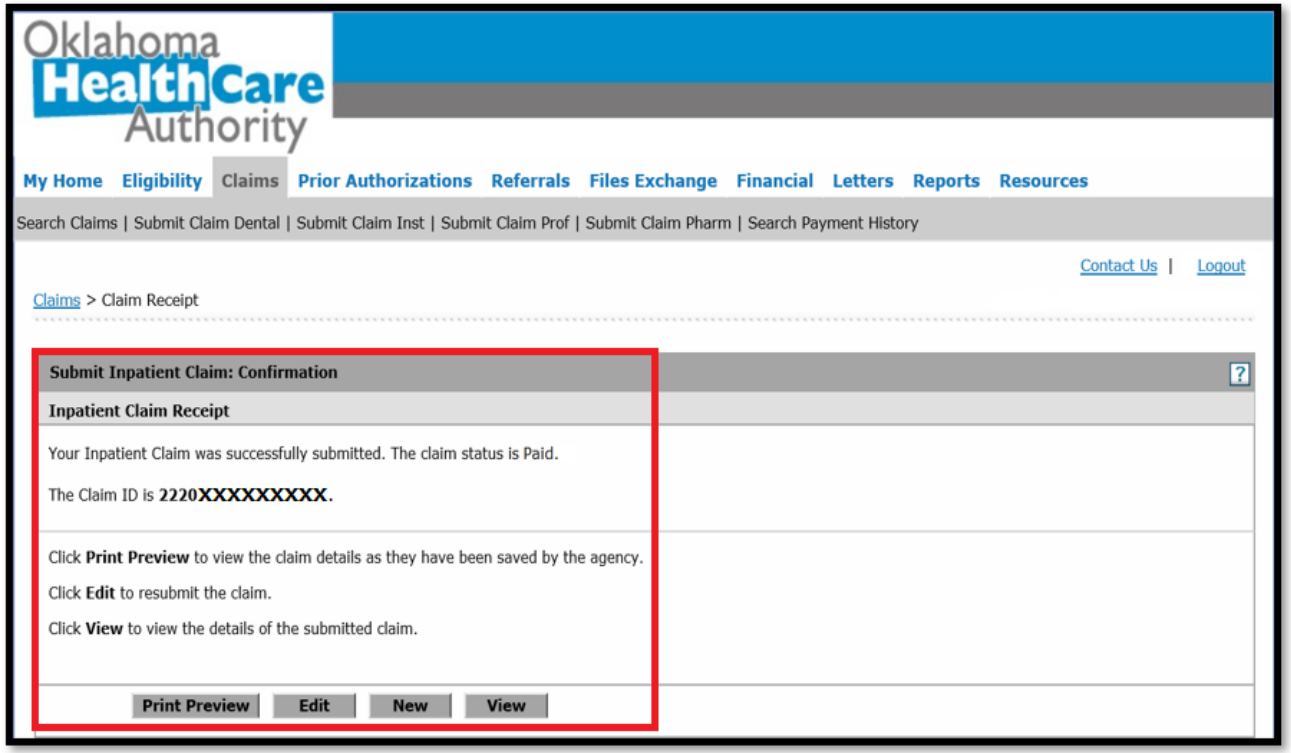
MEDICAID PRIMARY

- 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.



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

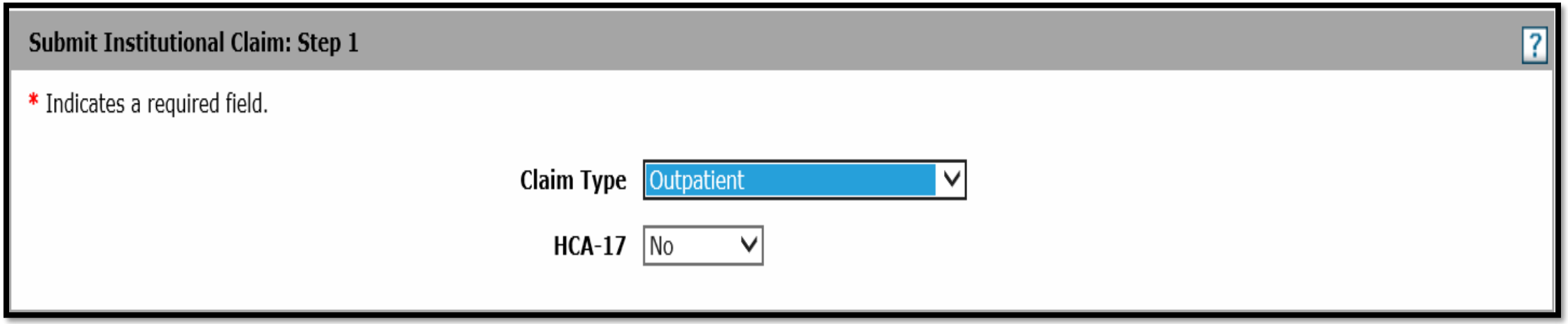
- Medicaid is considered secondary when other insurance or coverage is responsible for payment.

- 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



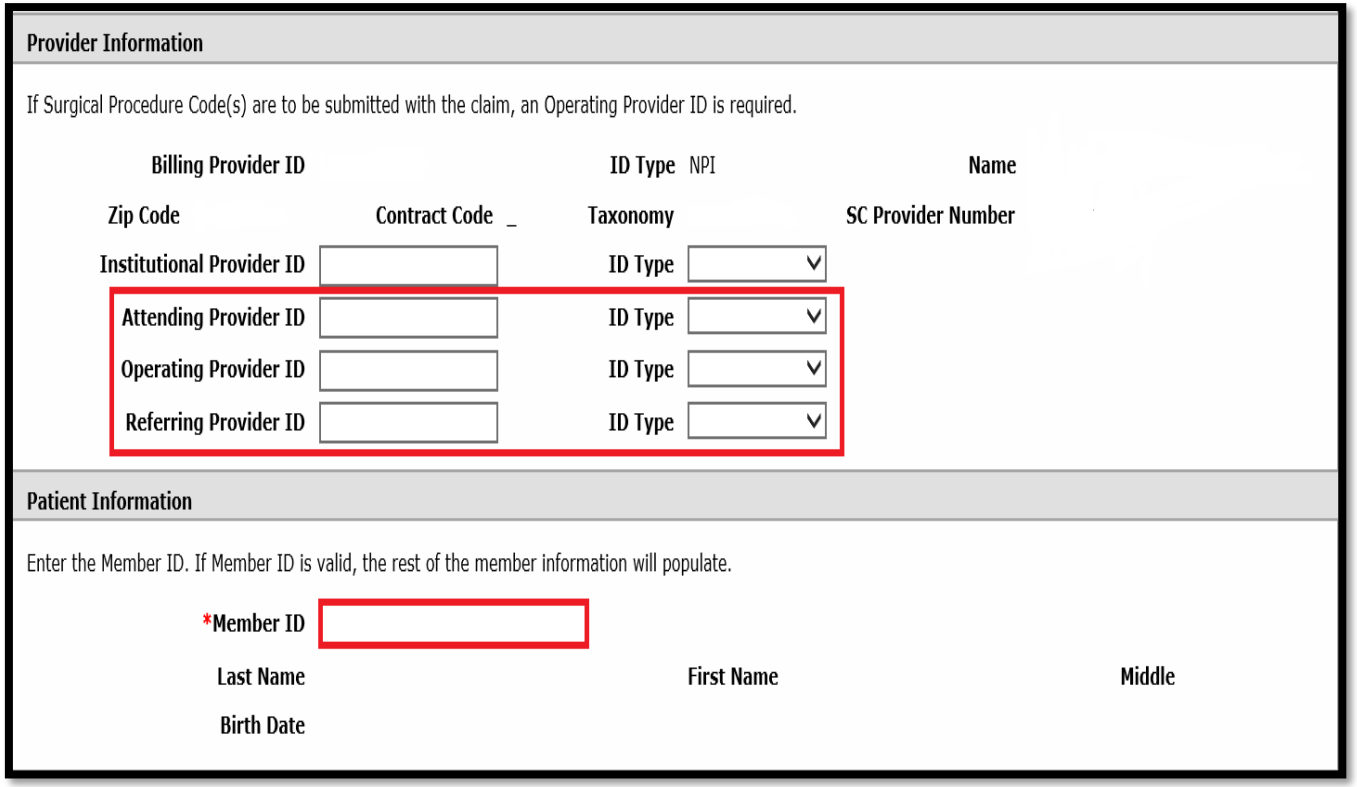
Choose appropriate **Claim Type**.

MEDICAID SECONDARY

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

- Operating Provider is required when billing a surgical procedure.

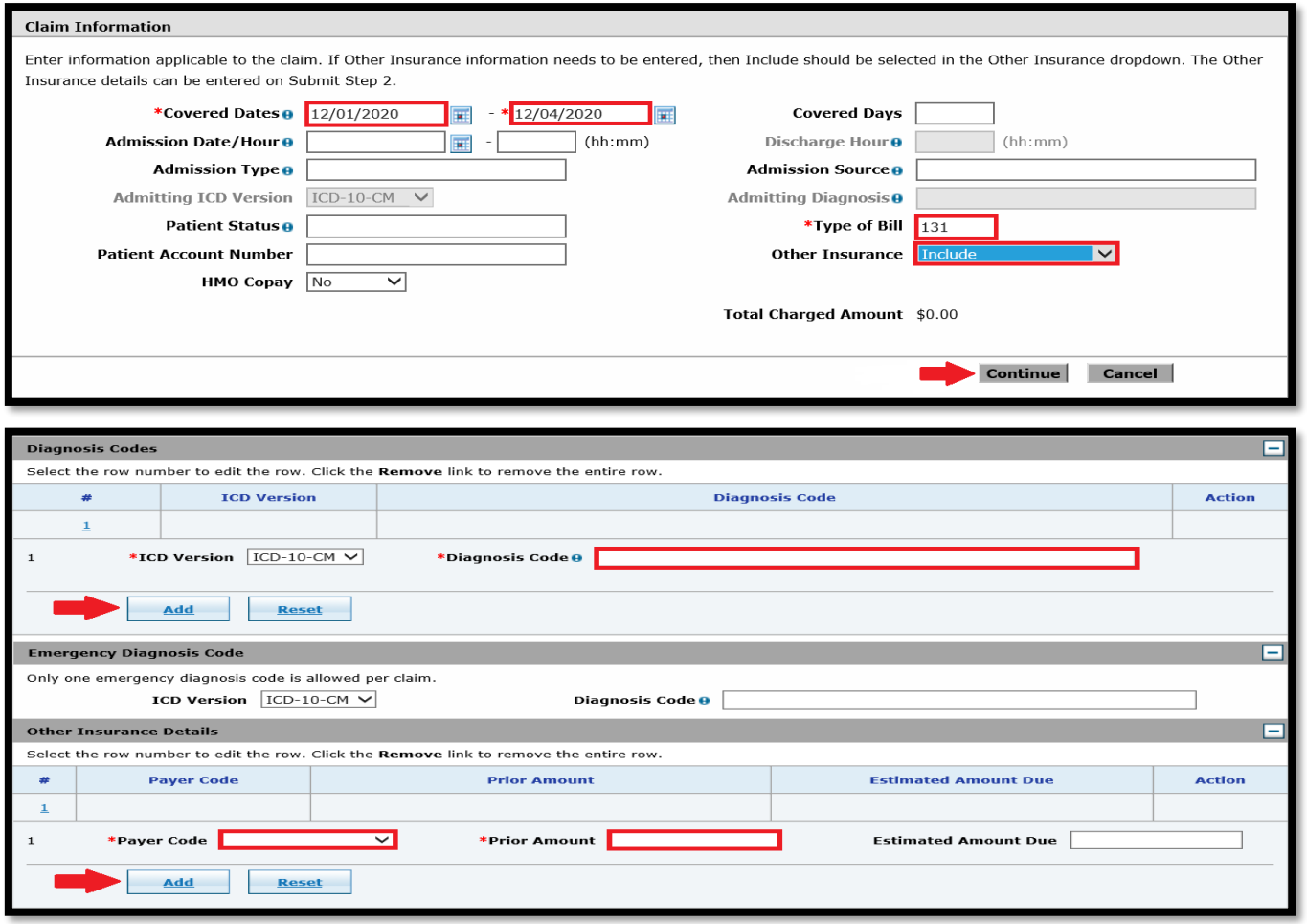
Enter the Member ID number. The member demographics will auto populate if the ID is valid.



MEDICAID SECONDARY

If the primary insurance **paid**:

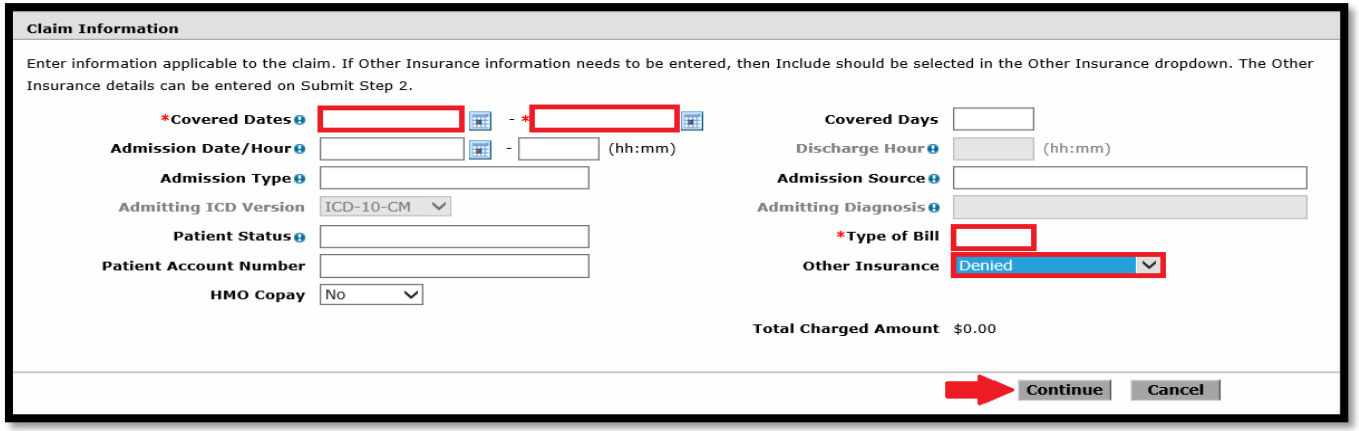
- Select *Include* under the **Other Insurance** section and **Continue** to step 2.
- After entering the **Diagnosis**, enter the primary insurance **Payer Code** and the amount paid in the **Prior Amount** field.

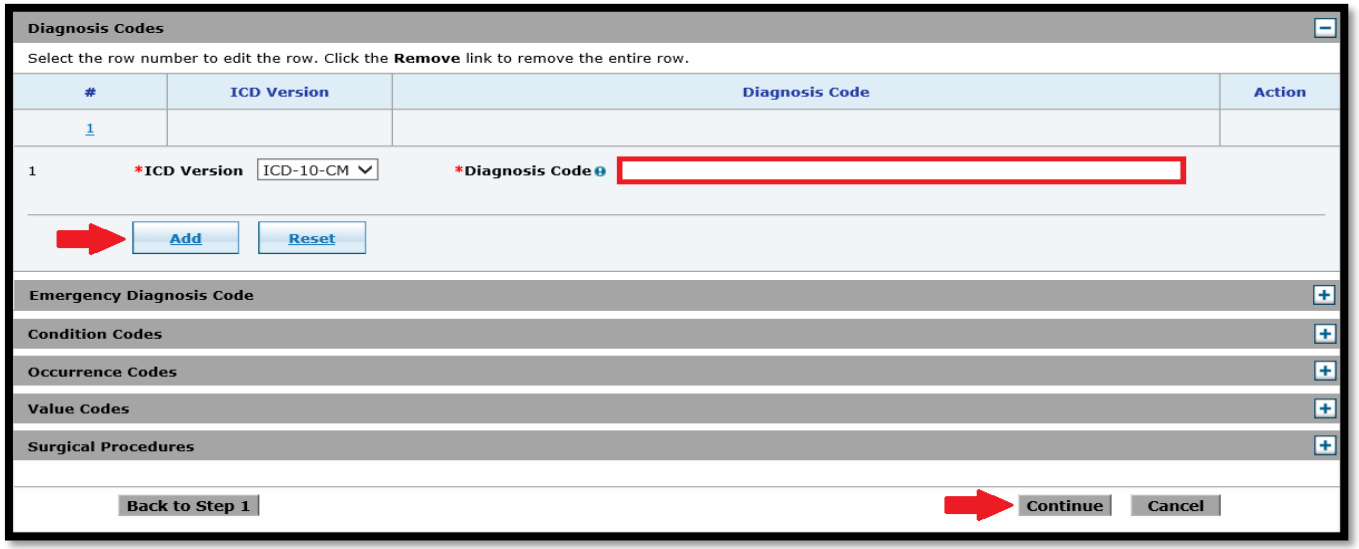


MEDICAID SECONDARY

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 **Other Insurance** Details are not present.

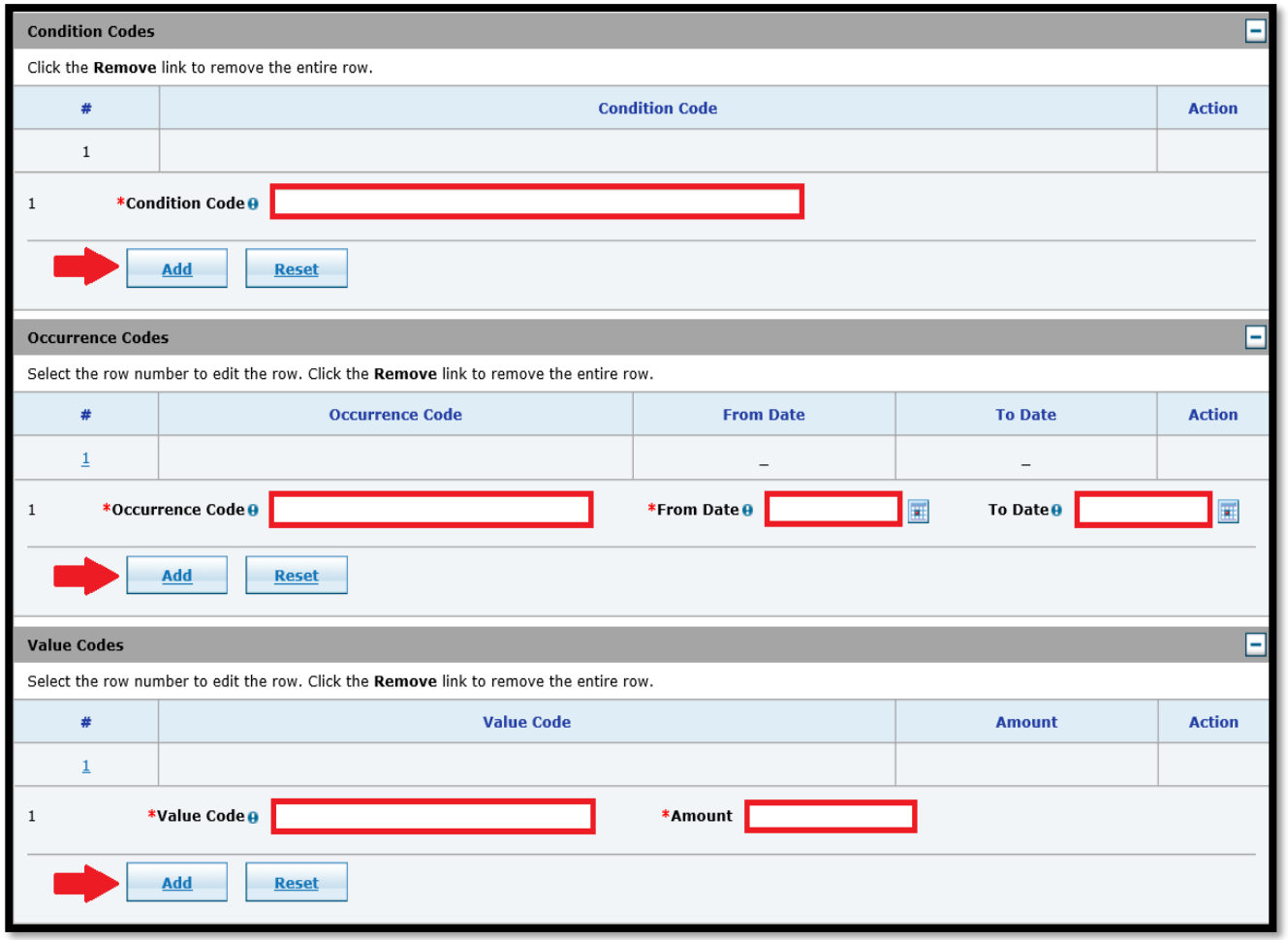




MEDICAID SECONDARY

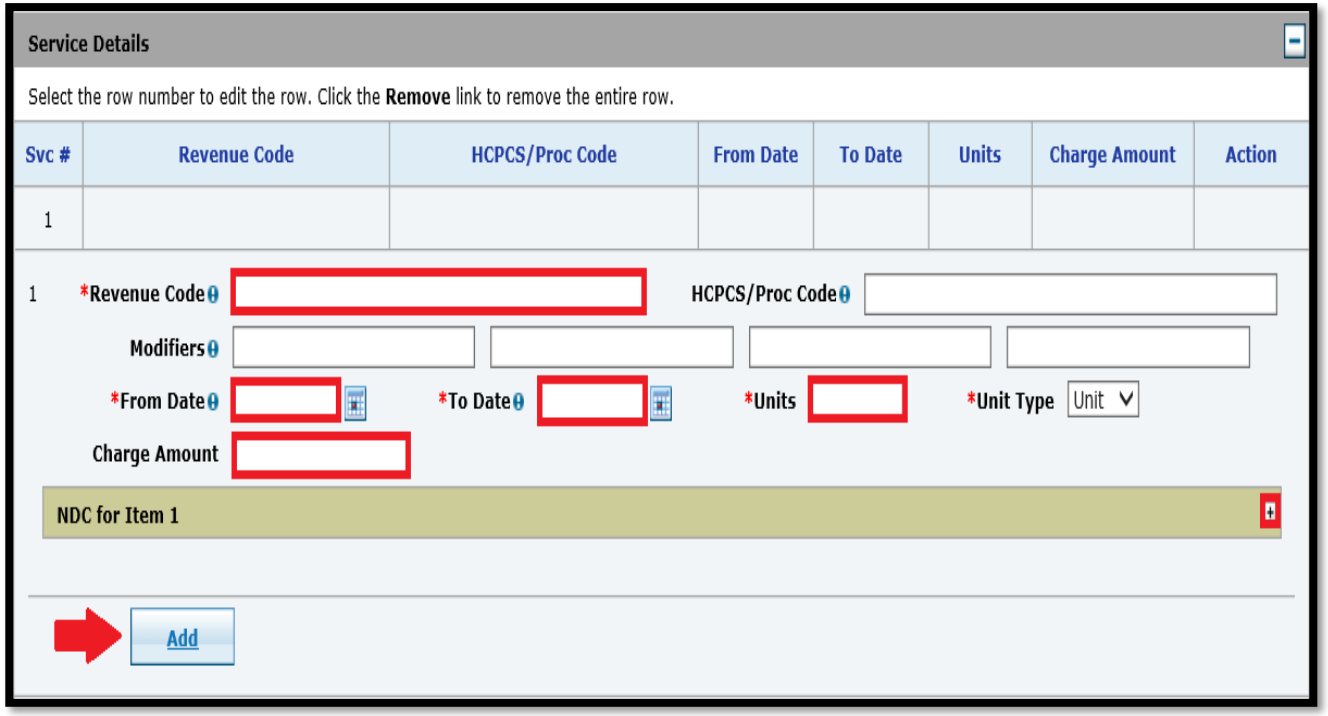
Condition Codes, Occurrence Codes and Value Codes are only required if applicable.

- 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.



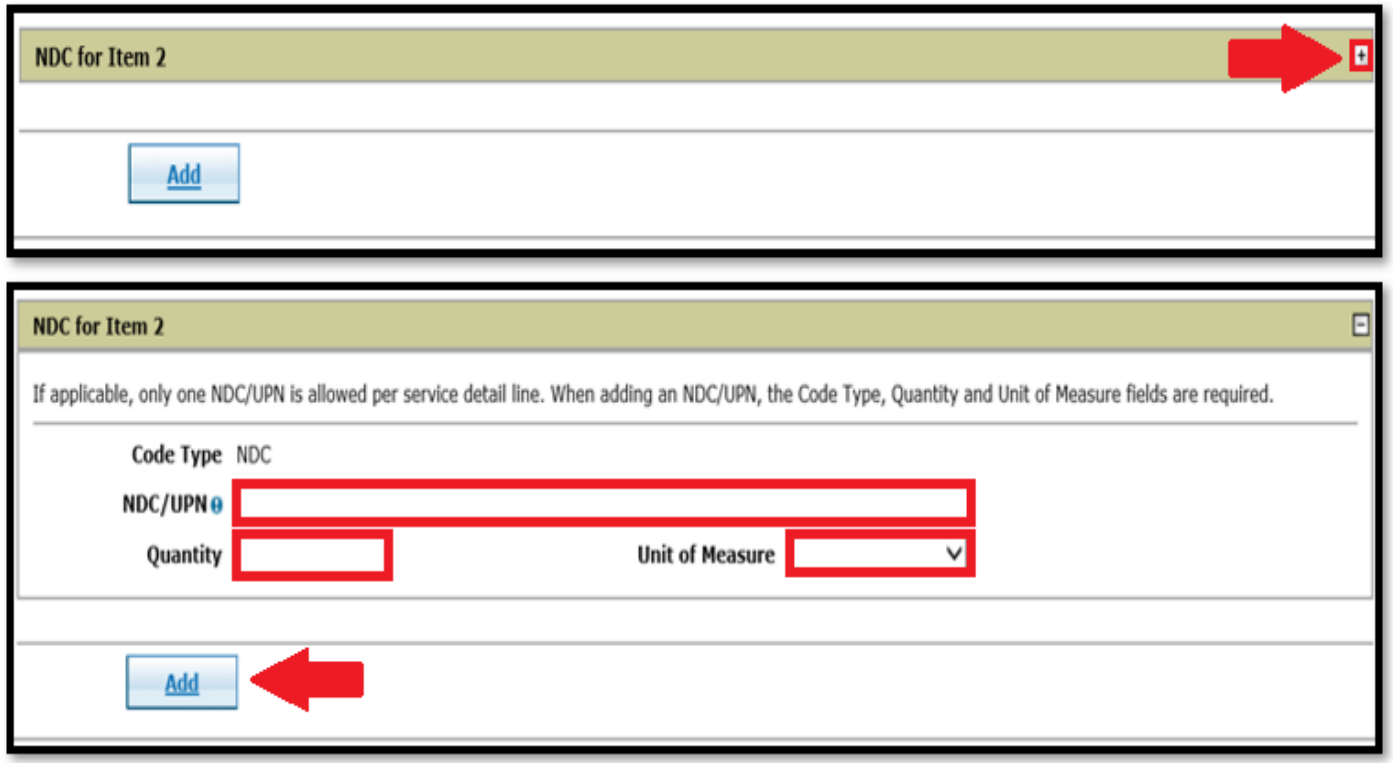
MEDICAID SECONDARY

- 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.



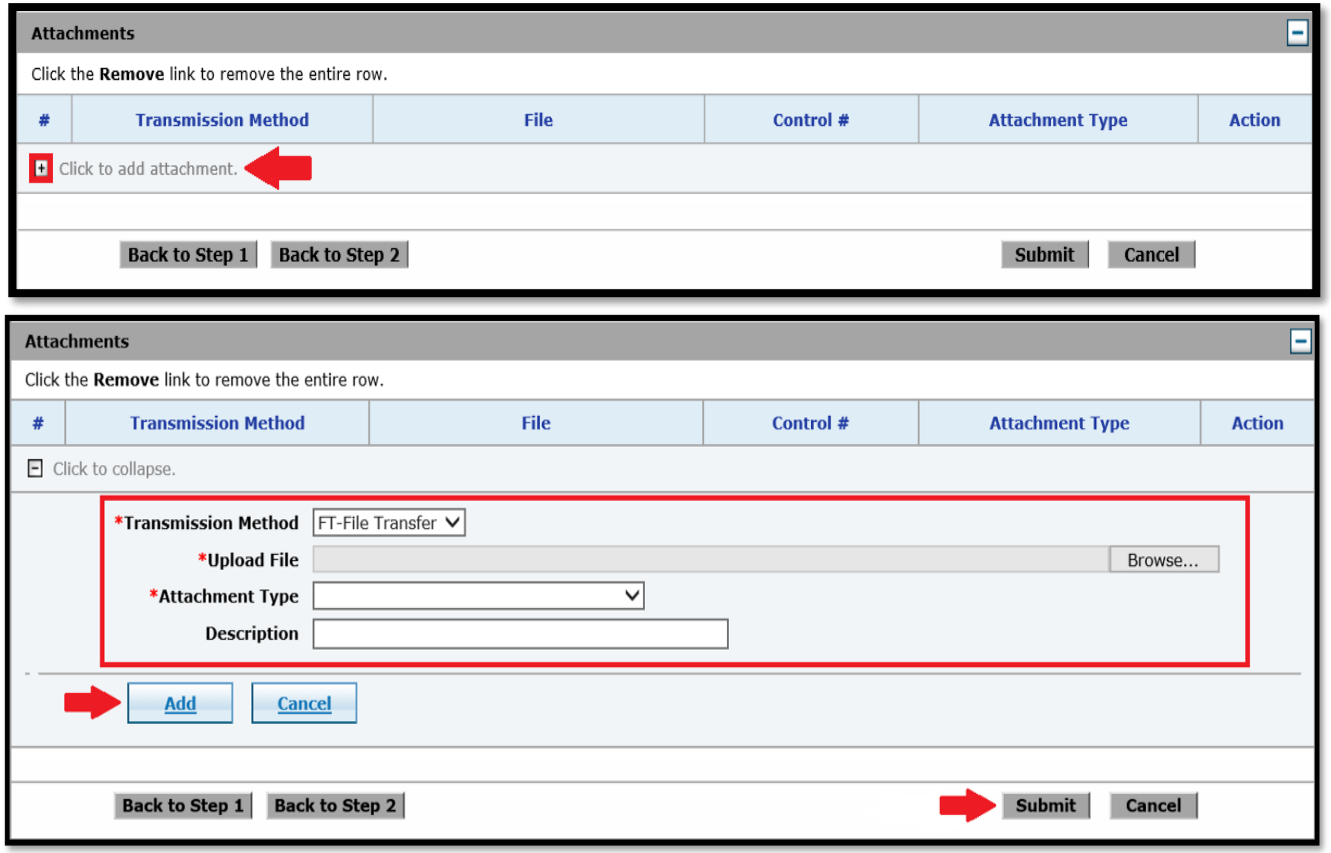
MEDICAID SECONDARY

- 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.



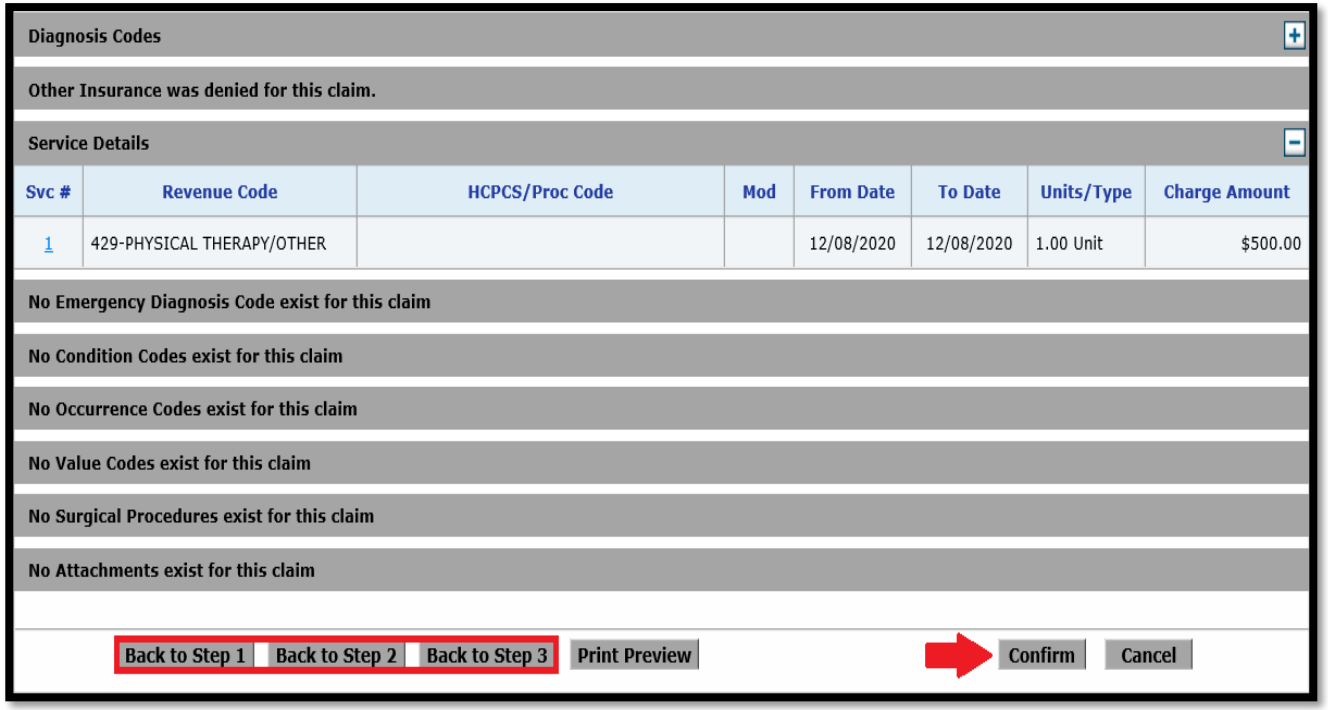
MEDICAID SECONDARY

- 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.



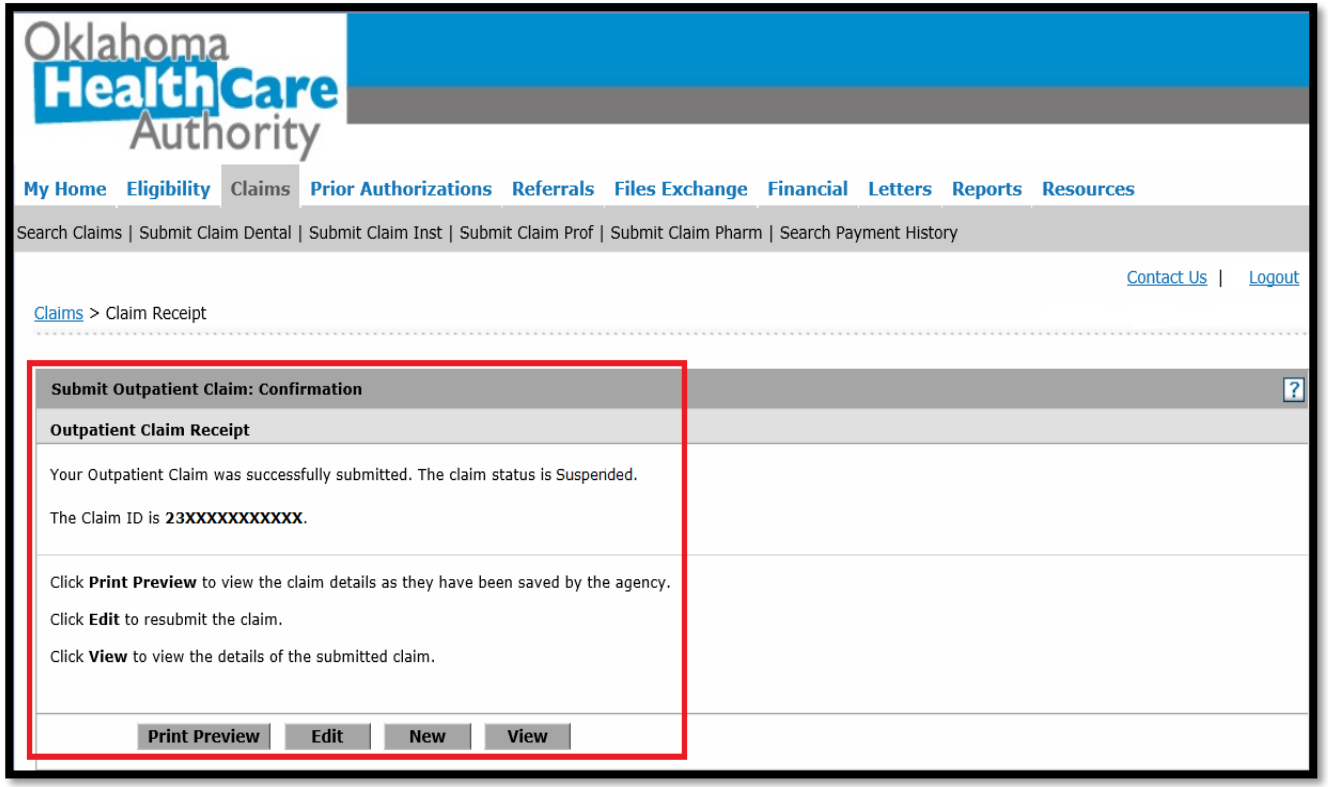
MEDICAID SECONDARY

- 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

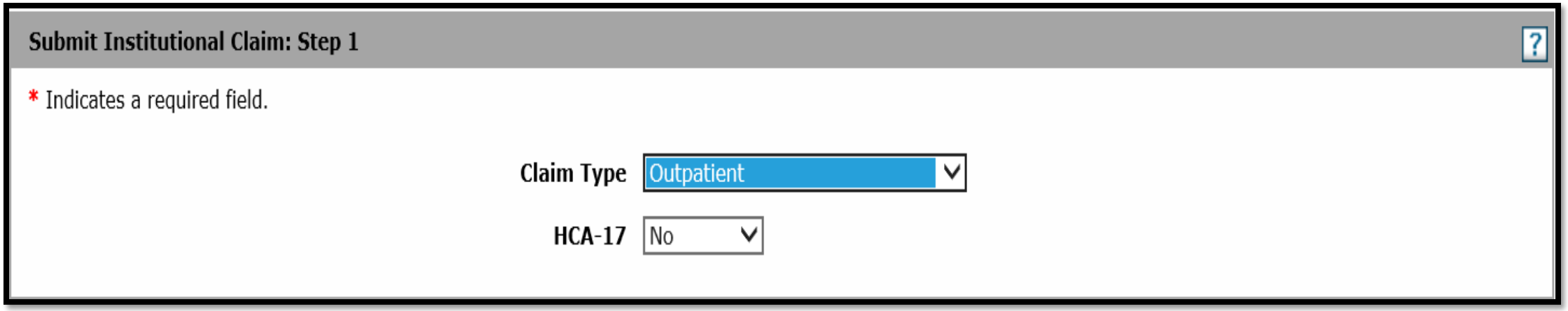
- Medicaid is considered secondary when the patient has a private Health Maintenance Organization (HMO) plan.

- 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.

HMO CO-PAY



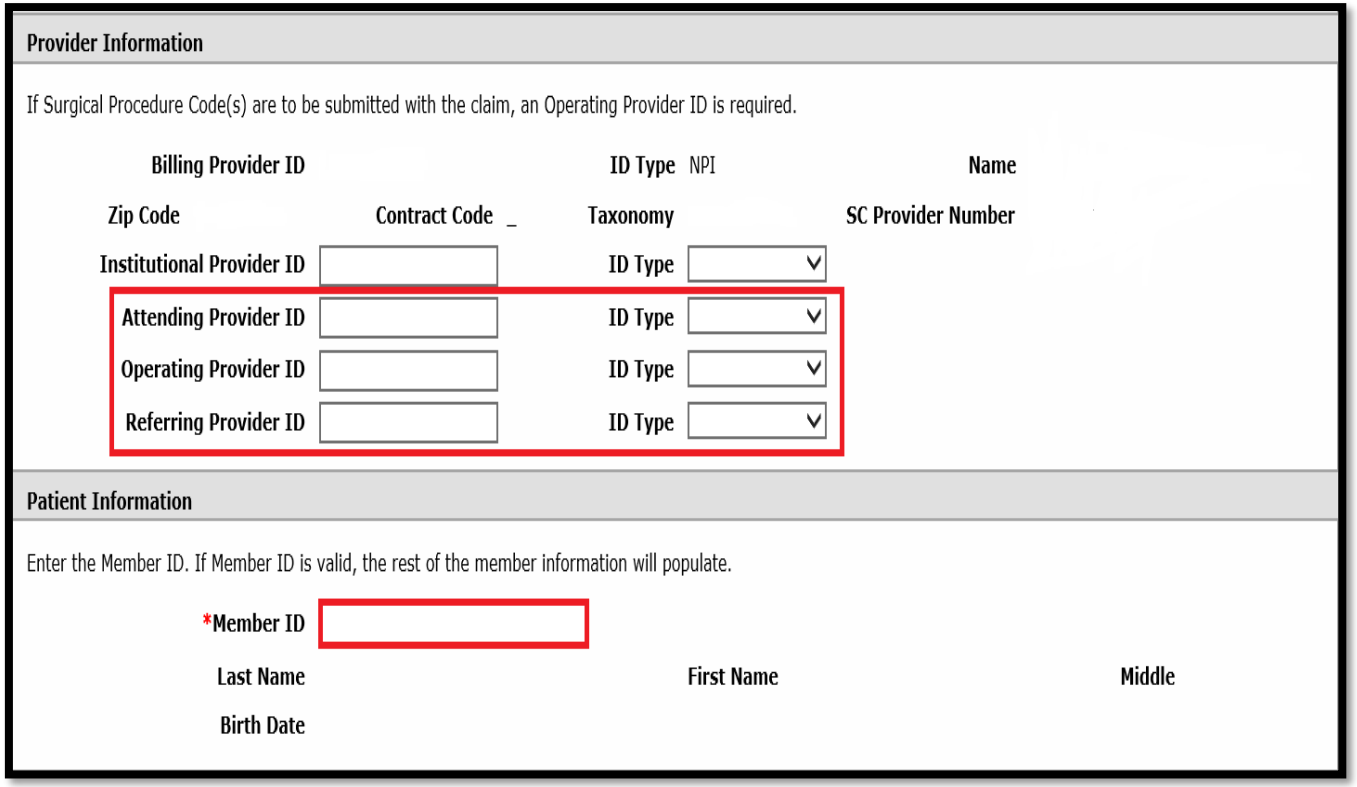
Choose the appropriate **Claim Type**.

HMO CO-PAY

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

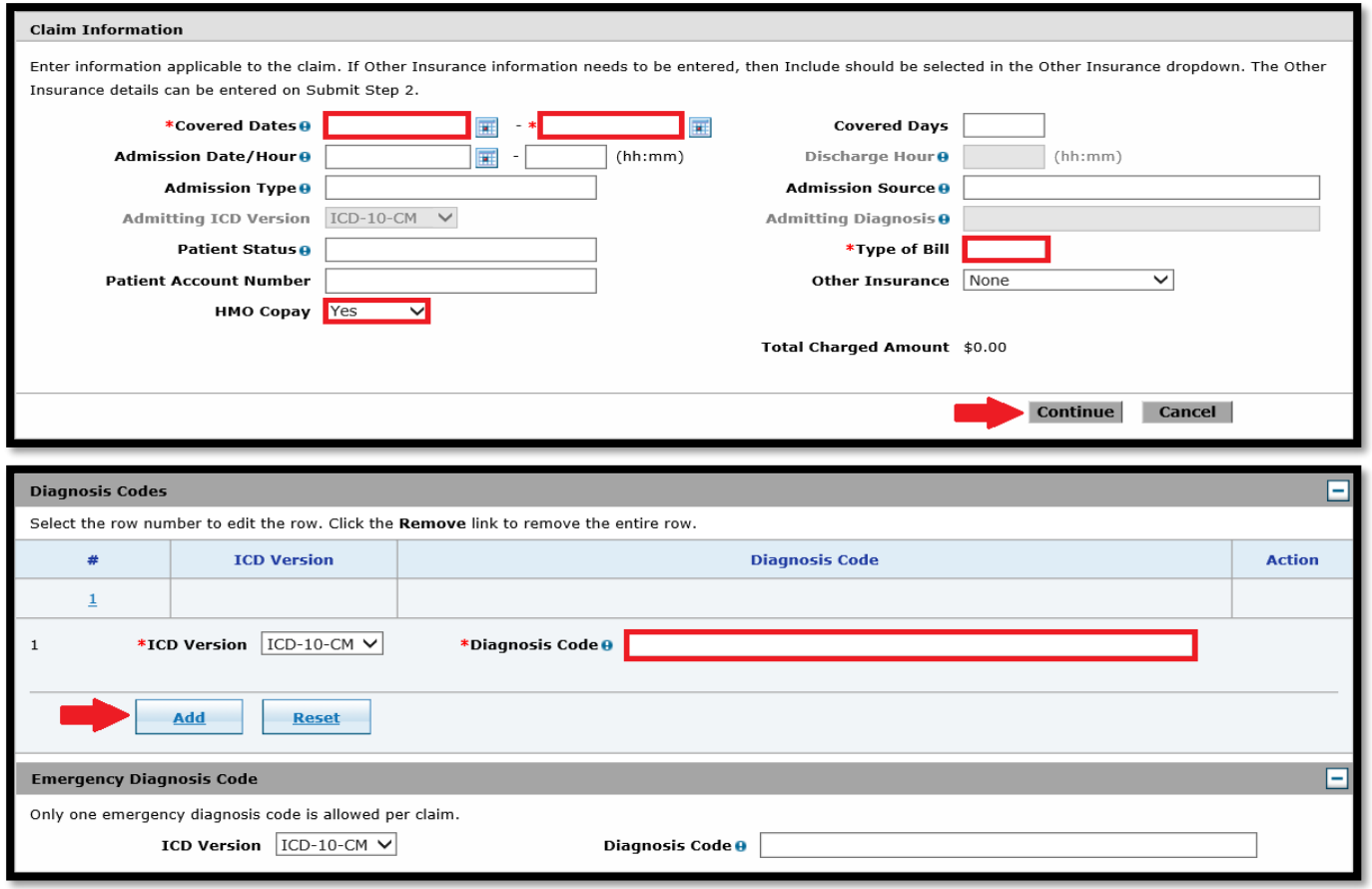
- Operating Provider is required when billing a surgical procedure.

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



HMO CO-PAY

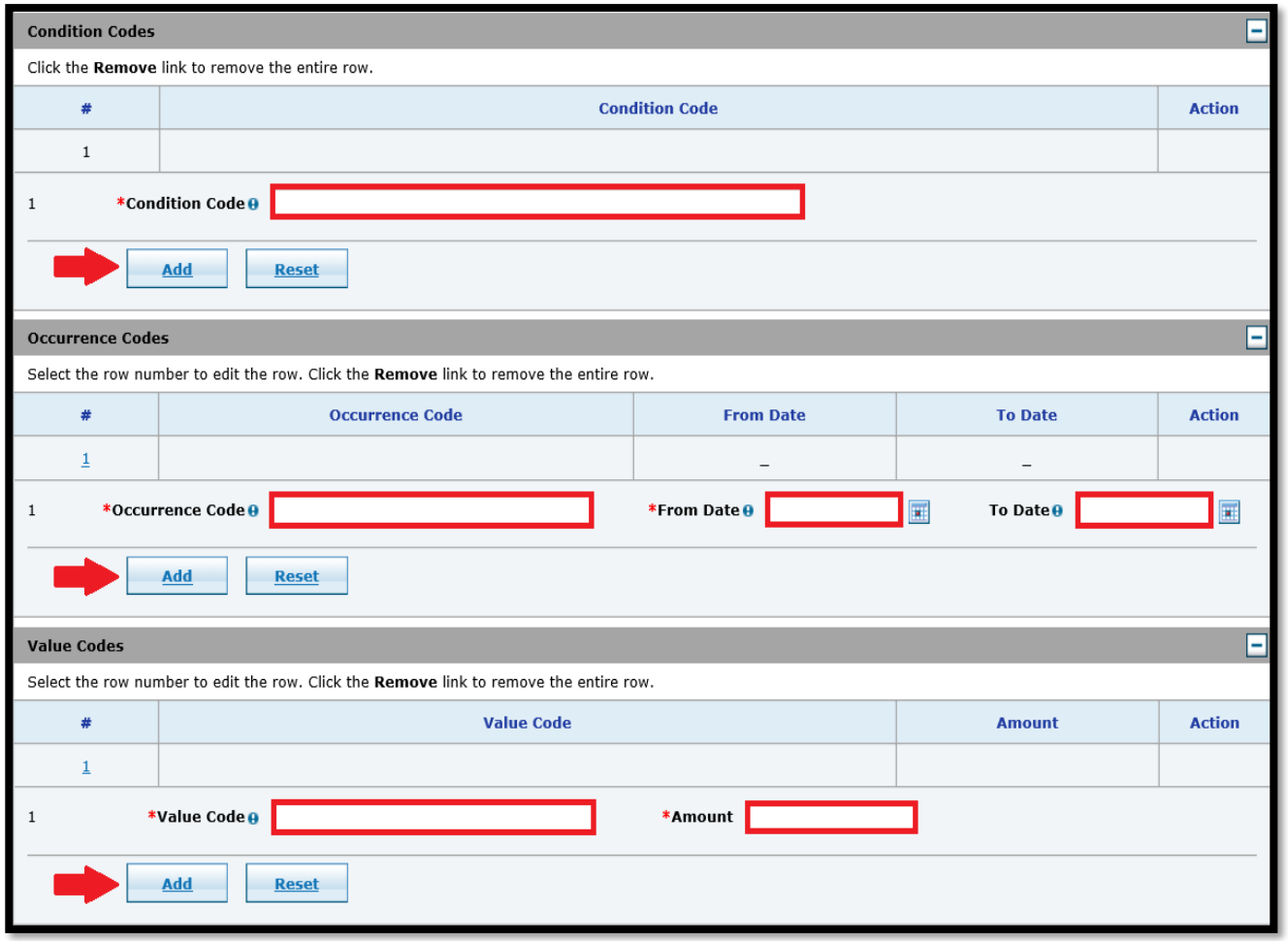
- Enter the required **Claim Information**.
- Leave **Other Insurance** at *None*.
- Change **HMO Copay** to *Yes*.
- Select **Continue** to enter diagnosis.
- **Diagnosis Code** field is required. Enter the diagnosis code without the decimal point and select the **Add** button after each diagnosis.



HMO CO-PAY

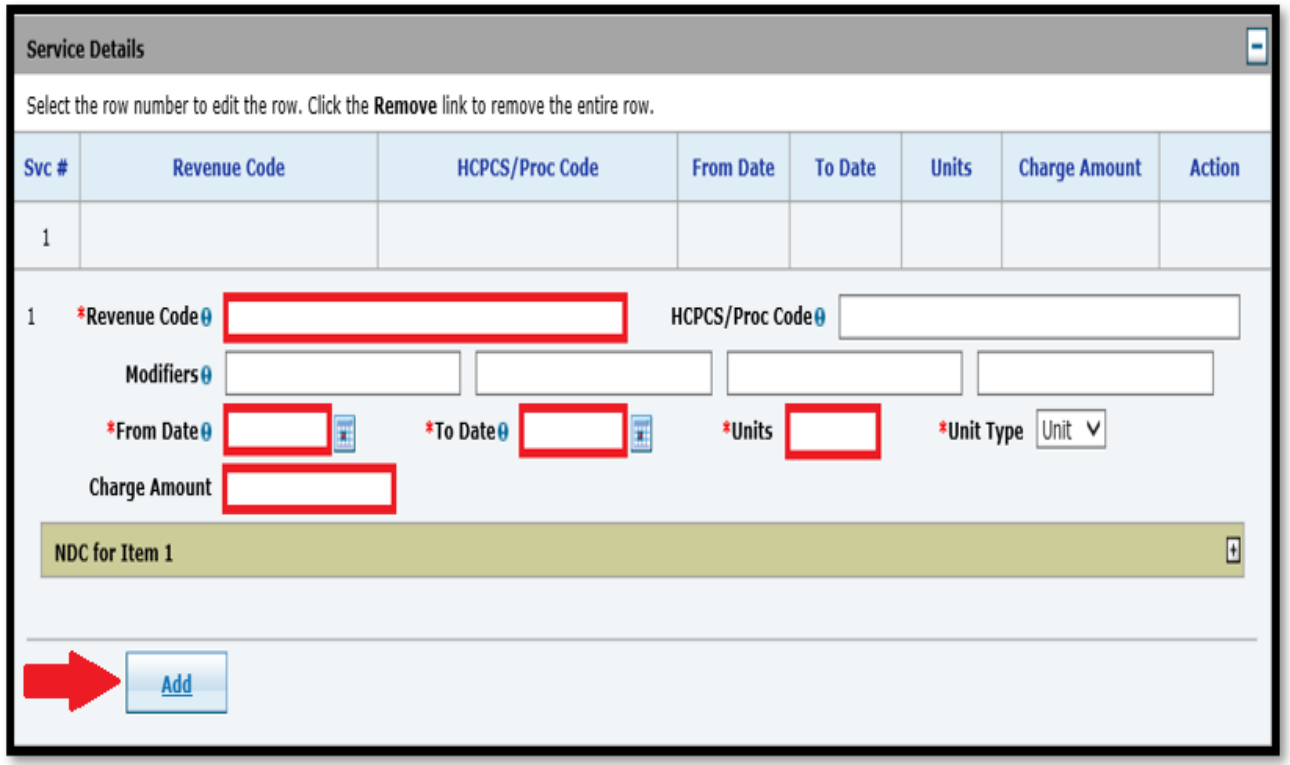
Condition Codes, Occurrence Codes and Value Codes are only required if applicable.

- 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.

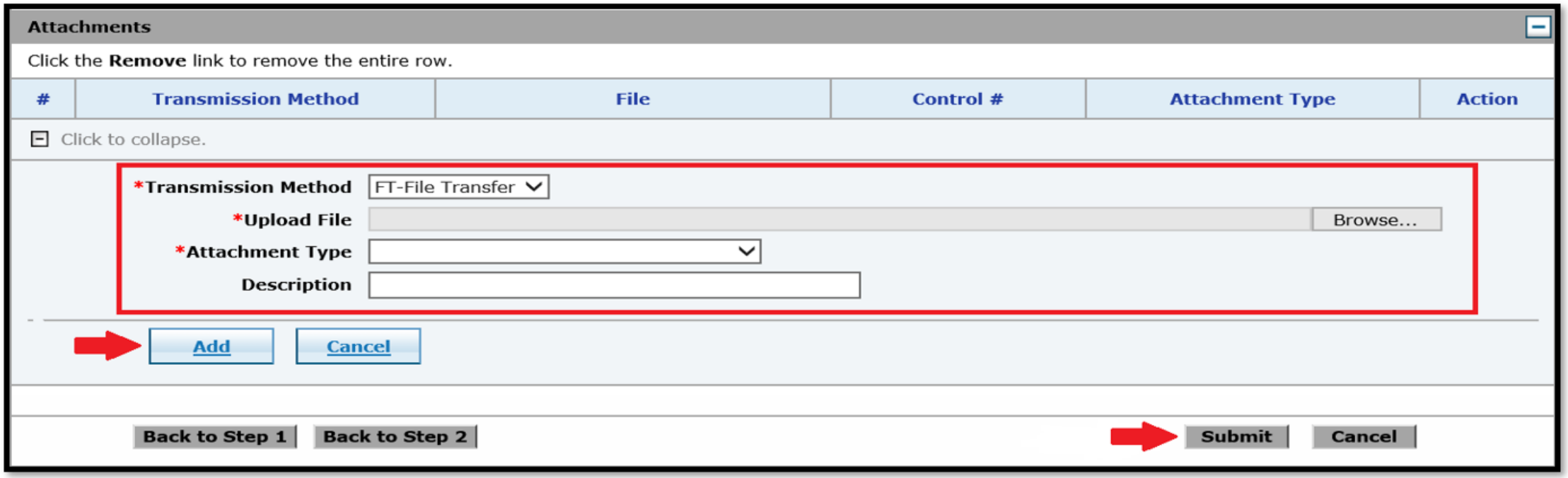


HMO CO-PAY

- 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.



HMO CO-PAY



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

Service Details

Svc #	Revenue Code	HCPCS/Proc Code	Mod	From Date	To Date	Units/Type	Charge Amount
1	424-PHYSICAL THERAPY/EVAL/RE-EVAL			12/08/2020	12/08/2020	1.00 Unit	$150.00

Attachments

#	Transmission Method	File	Control #	Attachment Type
1	FT-File Transfer	Sample EOB.pdf	20210108635341	EB-Explanation of Benefits

No Emergency Diagnosis Code exist for this claim

No Other Insurance Details 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

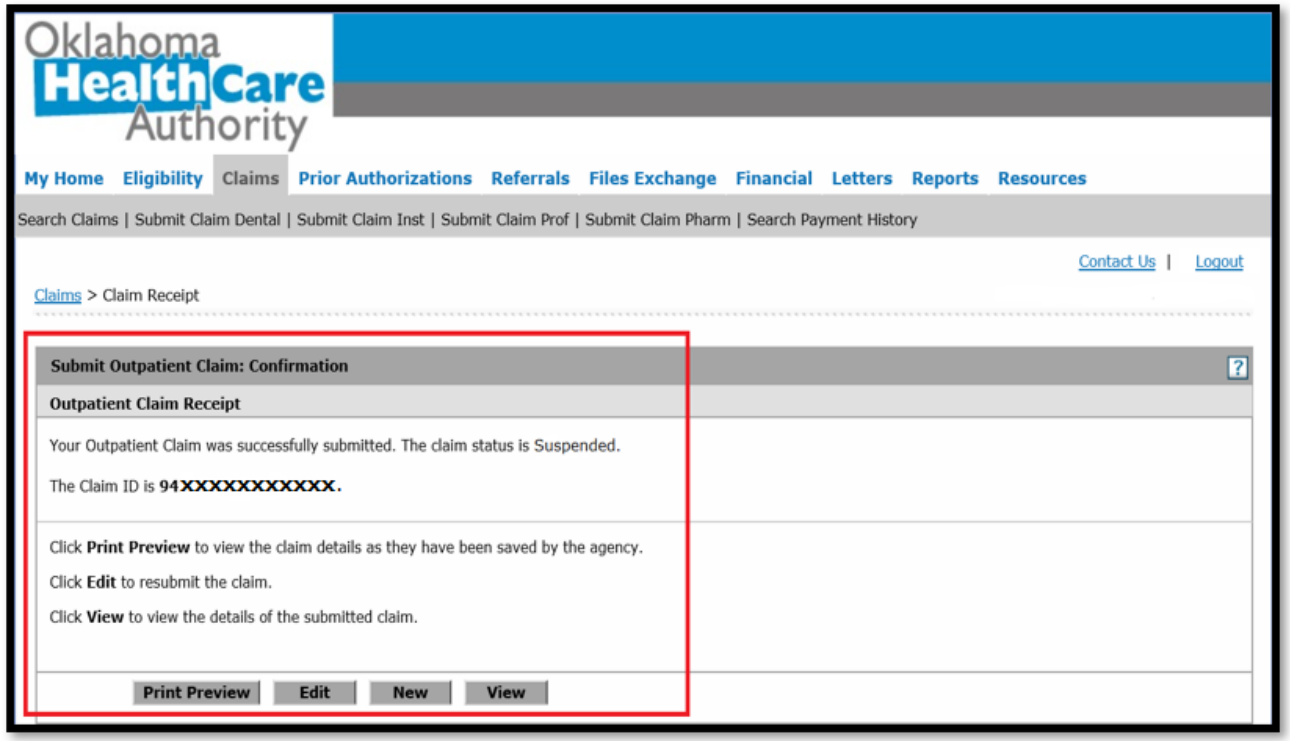
No Surgical Procedures exist for this claim

Back to Step 1 | Back to Step 2 | Back to Step 3 | Print Preview | Confirm | Cancel

- 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

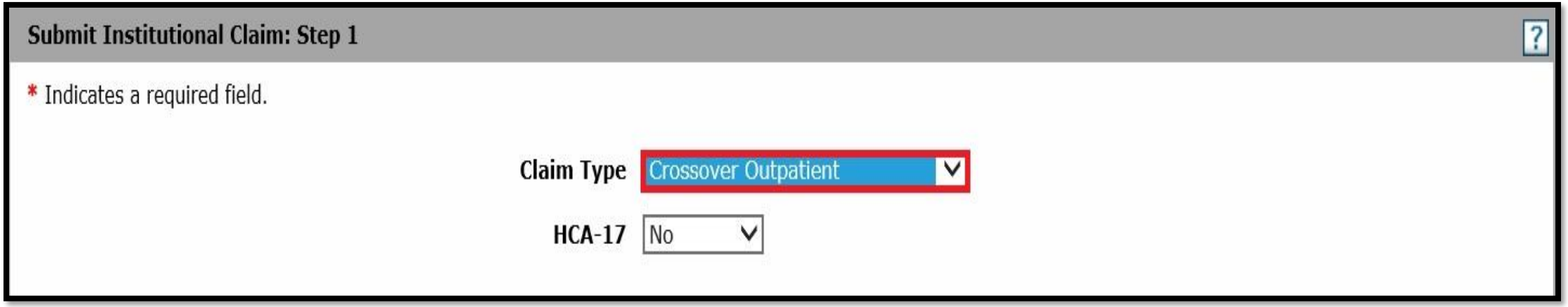
- OHCA reimburses the coinsurance and deductible of Medicare up to a certain percentage.
- The claim must be submitted as a crossover inpatient or crossover outpatient.
- Medicare coinsurance, deductible and paid date must be reported under the Crossover Details section of the claim.
  - The Explanation 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.

MEDICARE CROSSOVER



Two types of Medicare Crossover Claims:

- Crossover Inpatient
- Crossover Outpatient

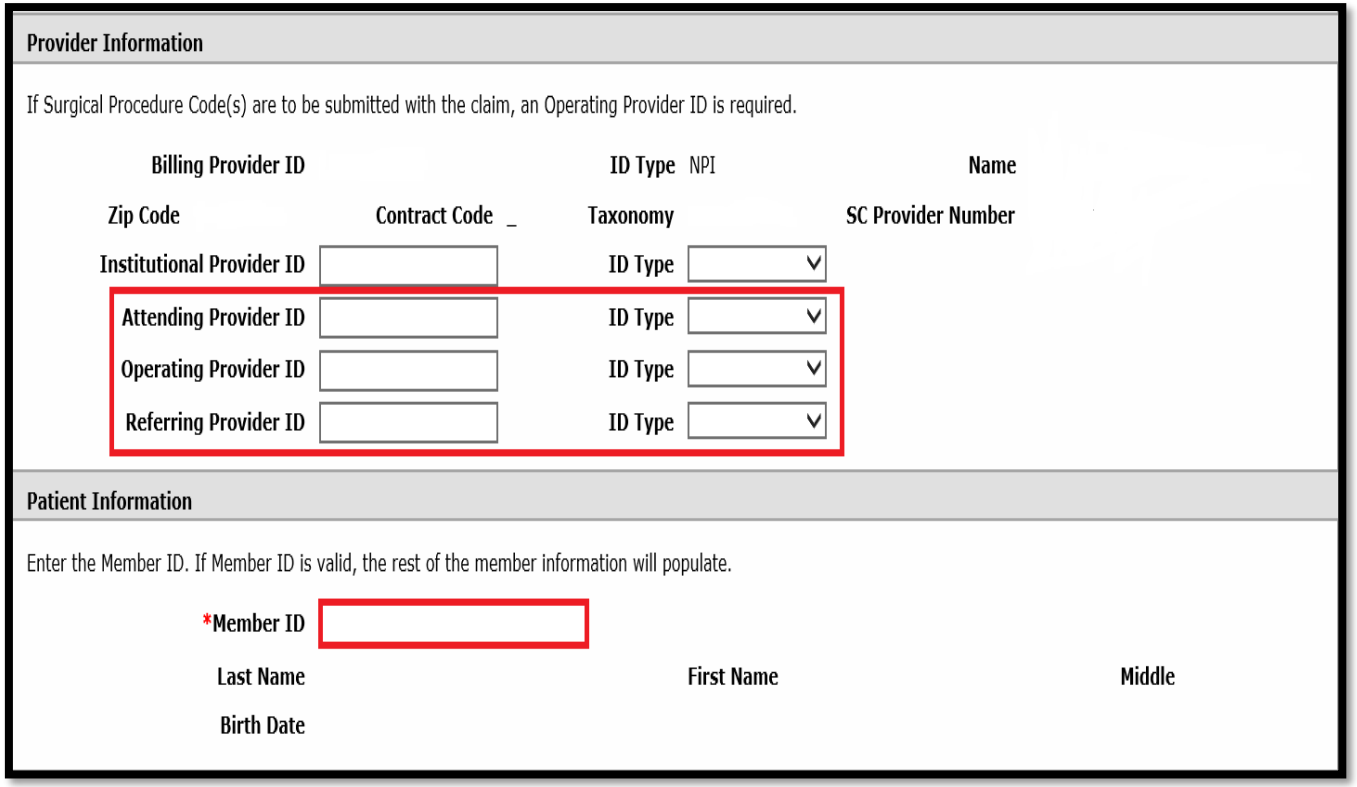
Choose the appropriate **Claim Type**.

MEDICARE CROSSOVER

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

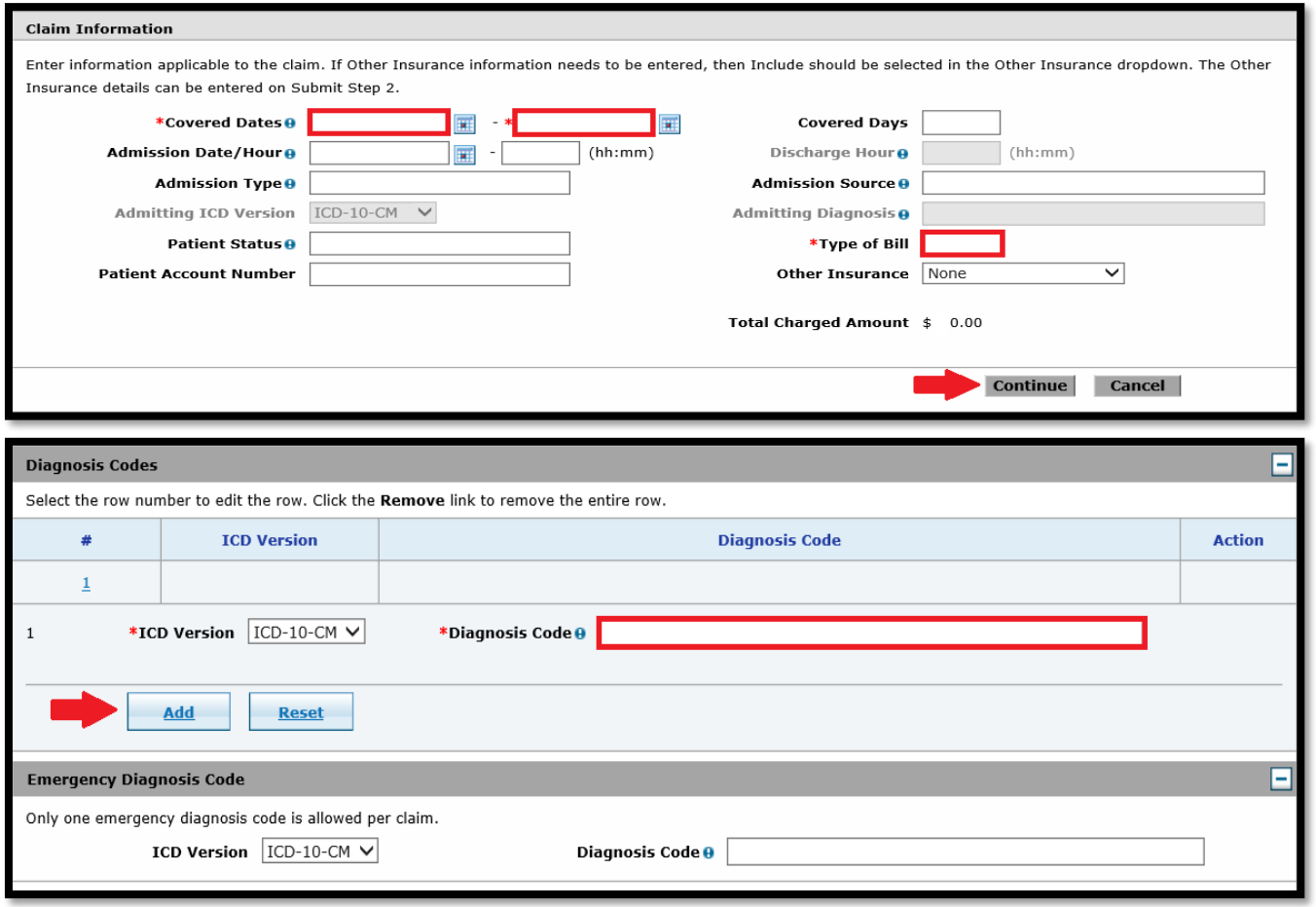
- Operating Provider is required when billing a surgical procedure.

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.



MEDICARE CROSSOVER

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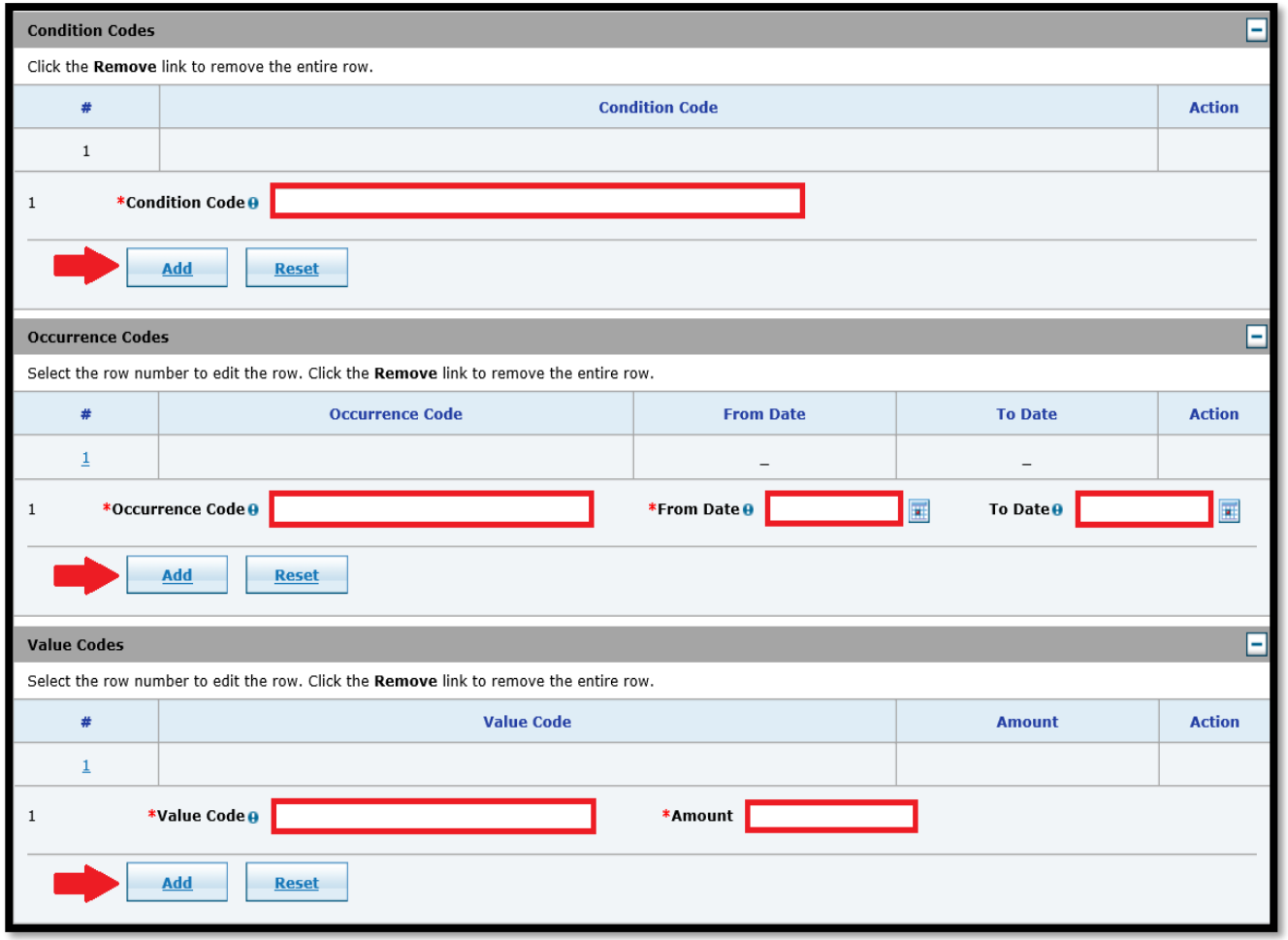
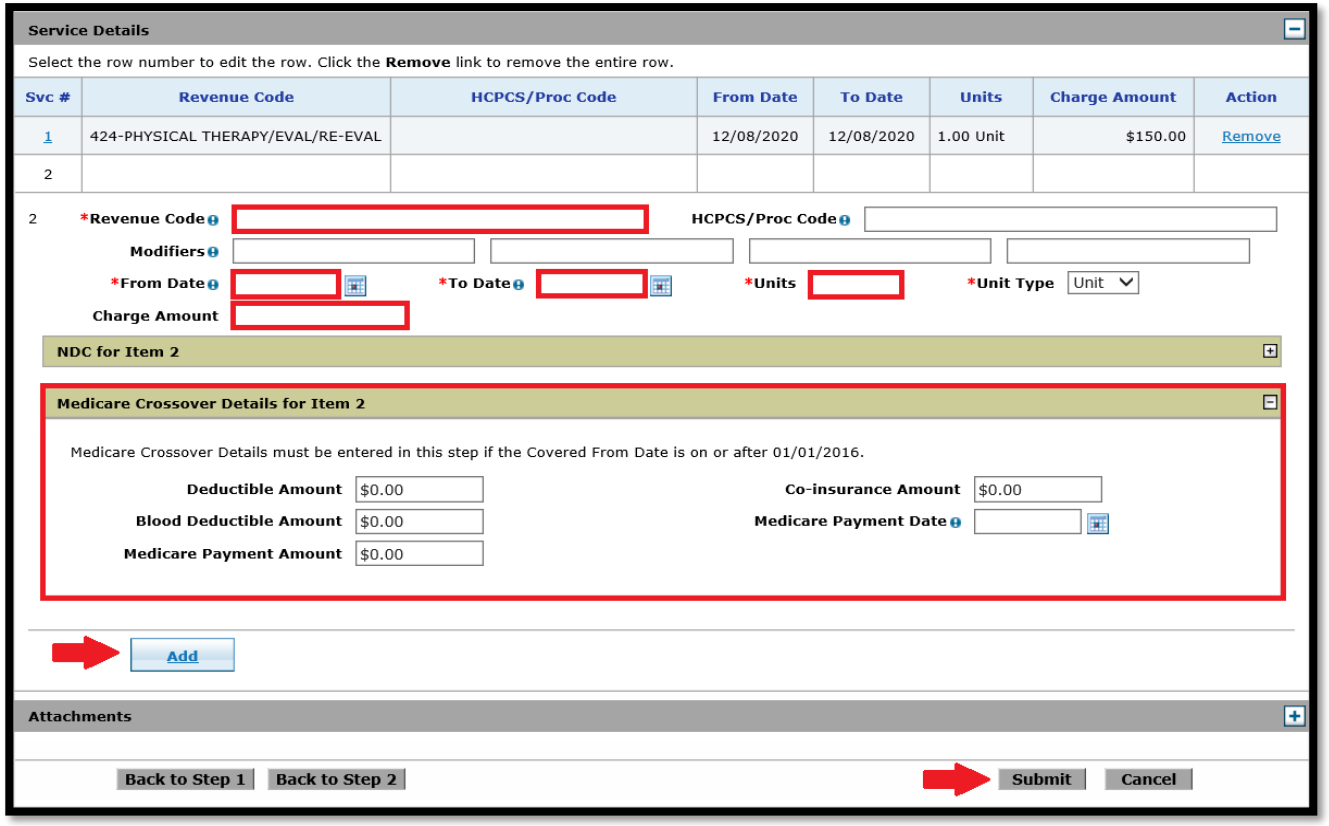


MEDICARE CROSSOVER

- 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.



MEDICARE CROSSOVER

- 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.

MEDICARE CROSSOVER

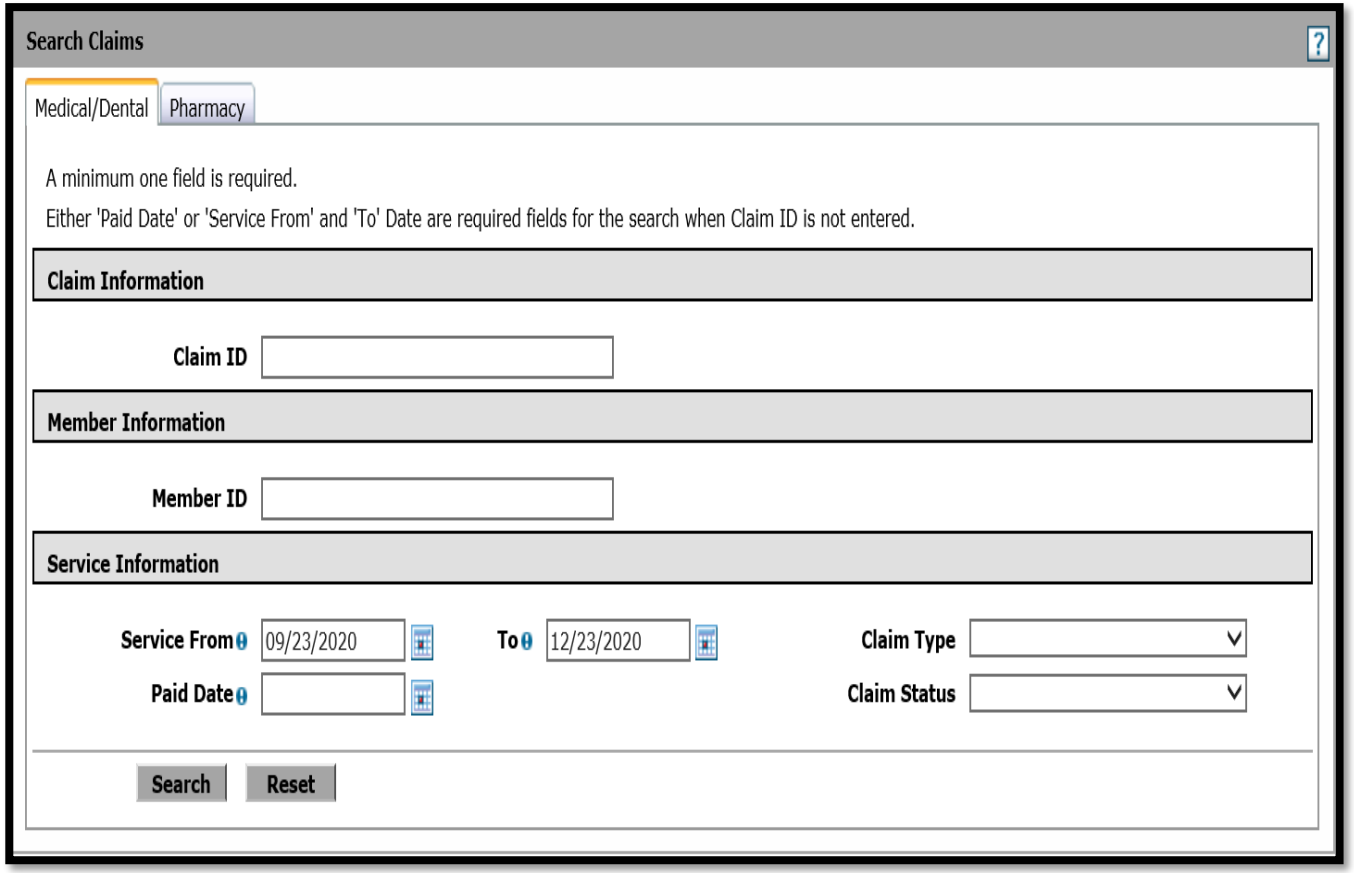
- Upon confirmation the claim will adjudicate and claim ID will populate.
- Claim ID beginning with 22 region code indicates an internet claim with no attachments.

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.

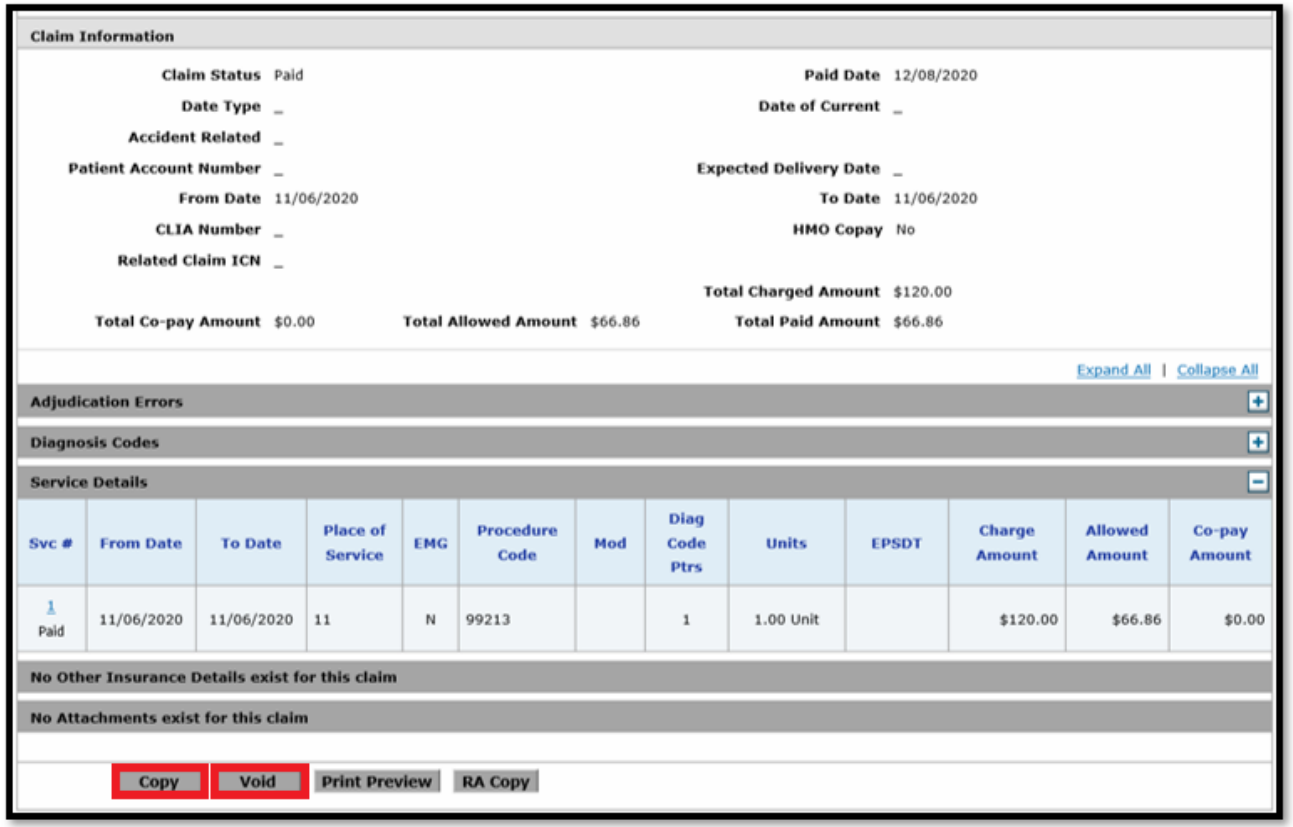
Total Records: 6

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



PAID CLAIM FUNCTIONS

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

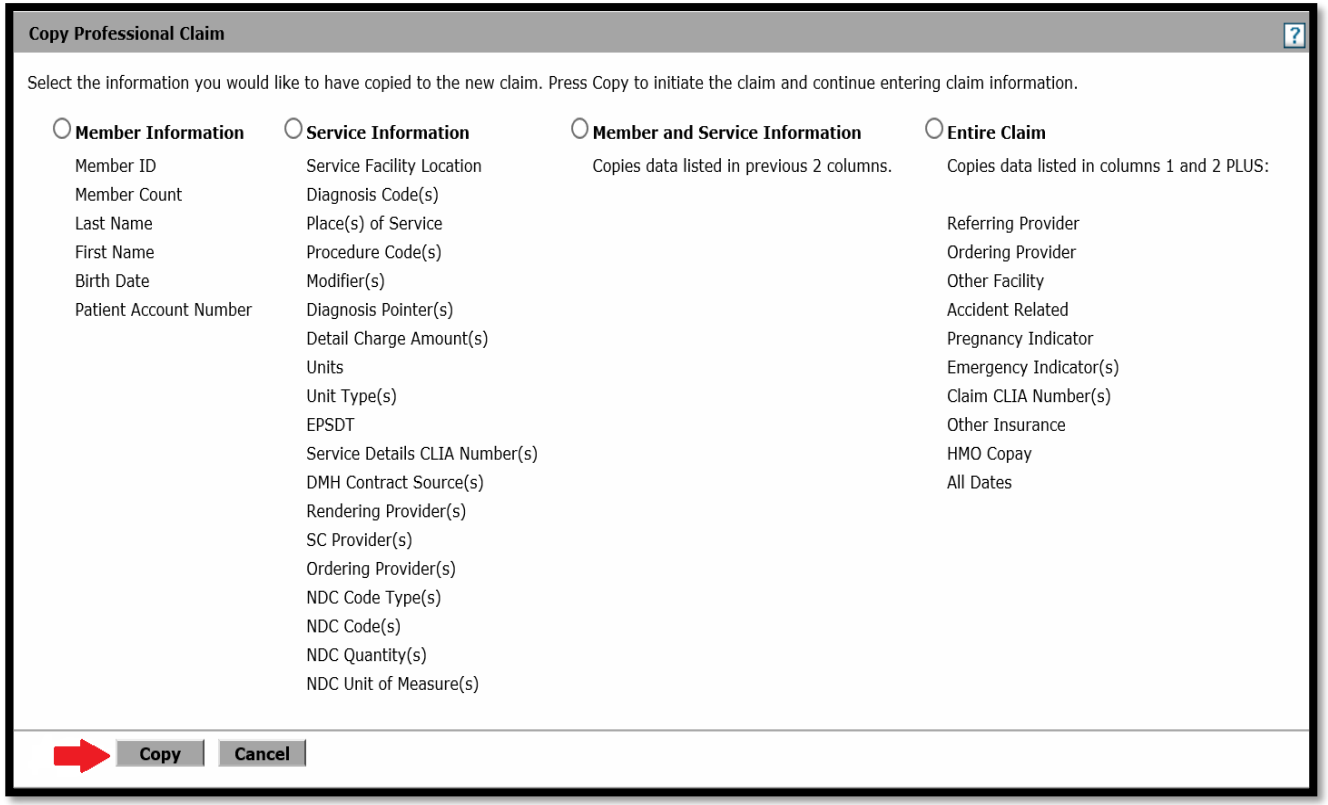
- Claims voided after six months from the date of service are subject to timely filing limitations.

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

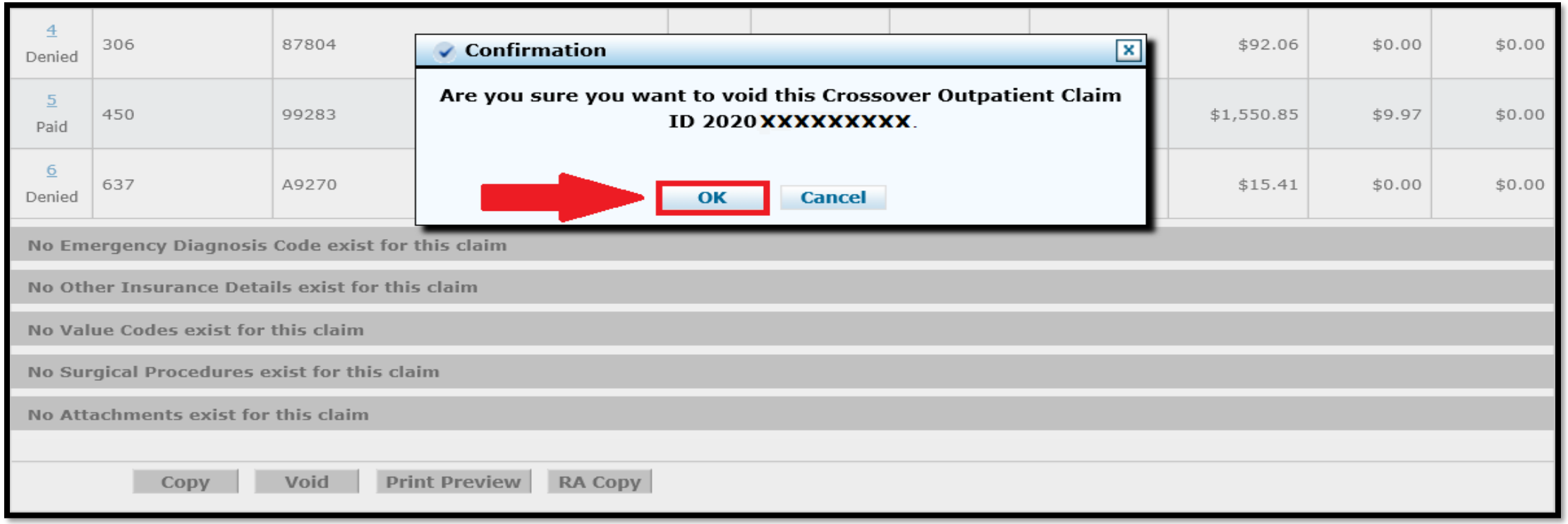
PAID CLAIM FUNCTIONS

Copy claim:

- Select the information to copy.



PAID CLAIM FUNCTIONS



Void claim:

- Select OK to confirm.

DENIED CLAIM FUNCTIONS

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

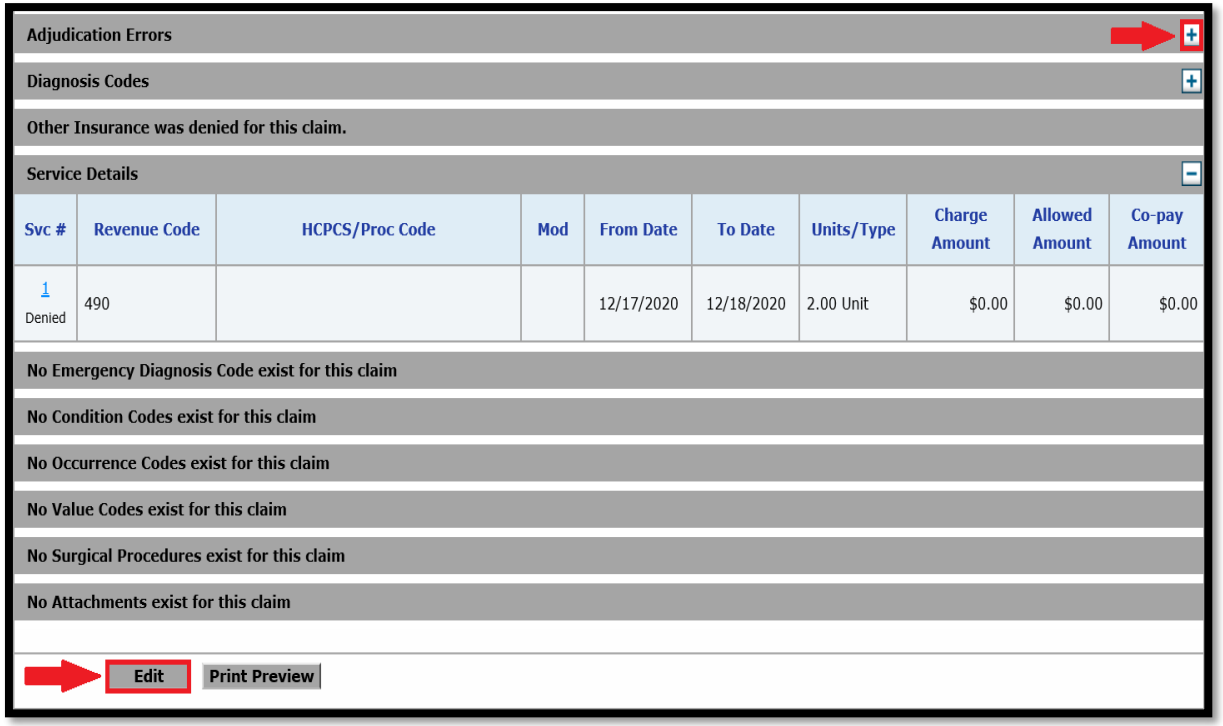
- Header: Contains information about the member and provider but not about the services performed.
  - The system will verify member's eligibility and provider's contract information, causing the entire claim to deny.
- Detail: Contains information specific to the services performed.
  - The system verifies coverage of services, policy limitations or program restrictions which will cause specific service lines to deny and not the entire claim.

DENIED CLAIM FUNCTIONS

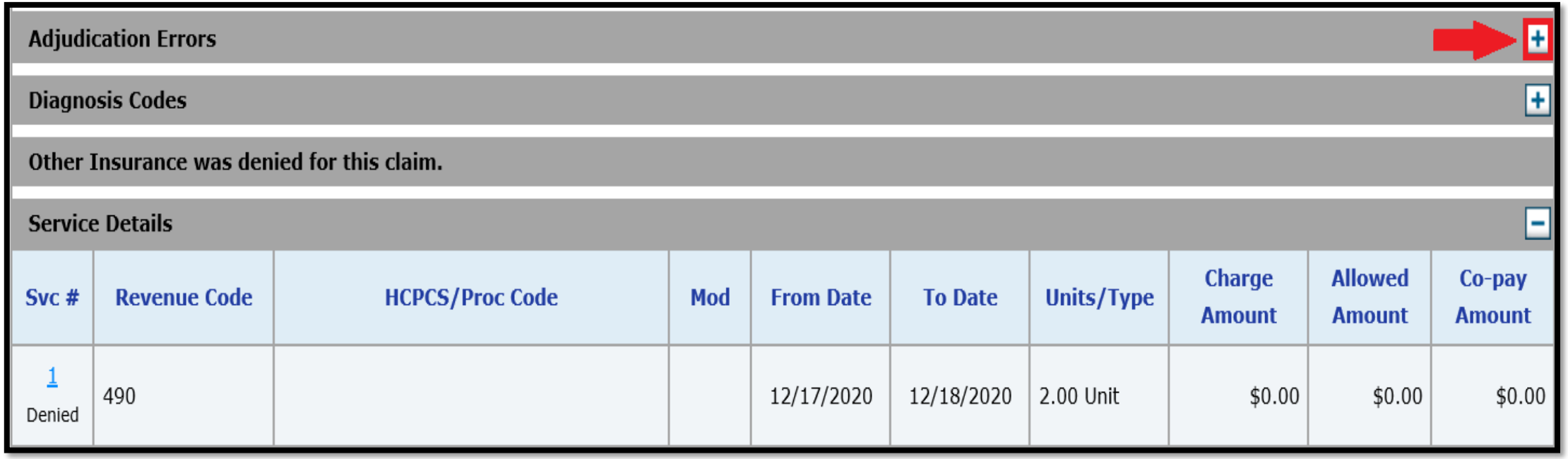
- The OHCA secure provider portal provides HIPAA and EOB remark codes for the denial reason.
- Denied claims can be edited for changes and resubmitted through the provider portal.
- Claims in a denied status cannot be voided.

DENIED CLAIM FUNCTIONS

Claims in a denied status allows the user to view **Adjudication Errors** or **Edit** the claim.



DENIED CLAIM FUNCTIONS



Adjudication Errors

Diagnosis Codes

Other Insurance was denied for this claim.

Service Details

Svc #	Revenue Code	HCPCS/Proc Code	Mod	From Date	To Date	Units/Type	Charge Amount	Allowed Amount	Co-pay Amount
1 Denied	490			12/17/2020	12/18/2020	2.00 Unit	$0.00	$0.00	$0.00

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

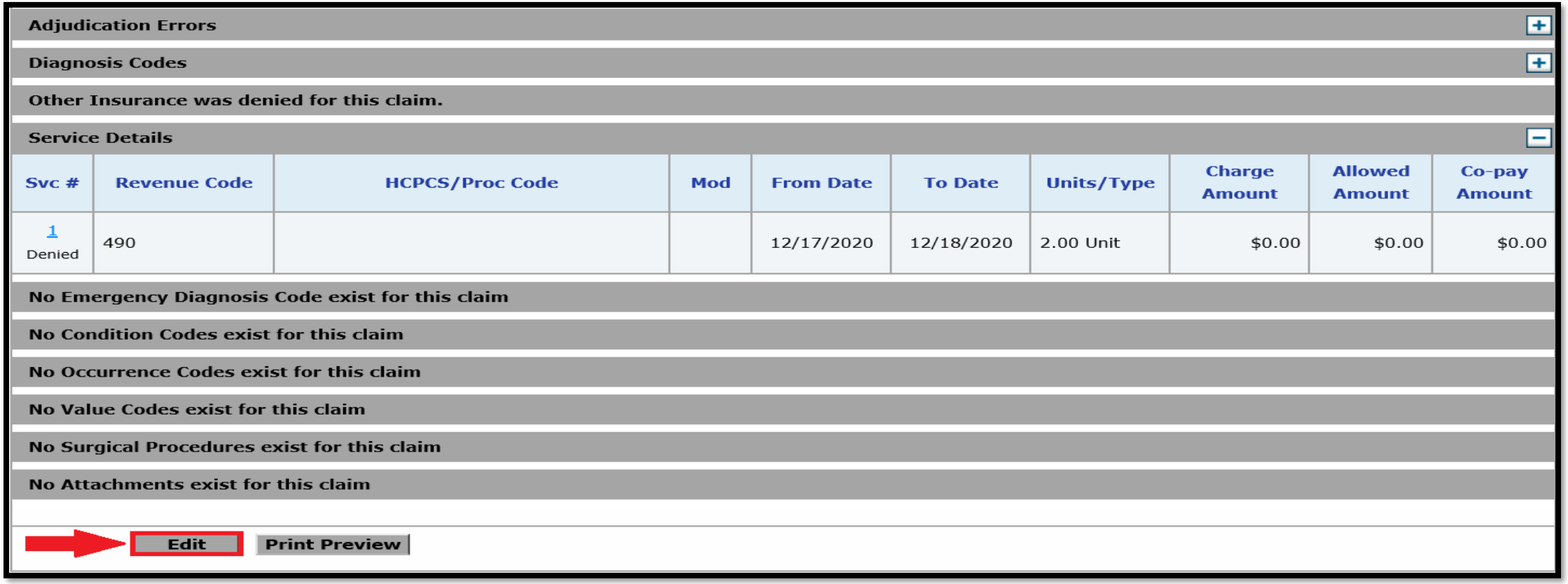
DENIED CLAIM FUNCTIONS

Adjudication Errors

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

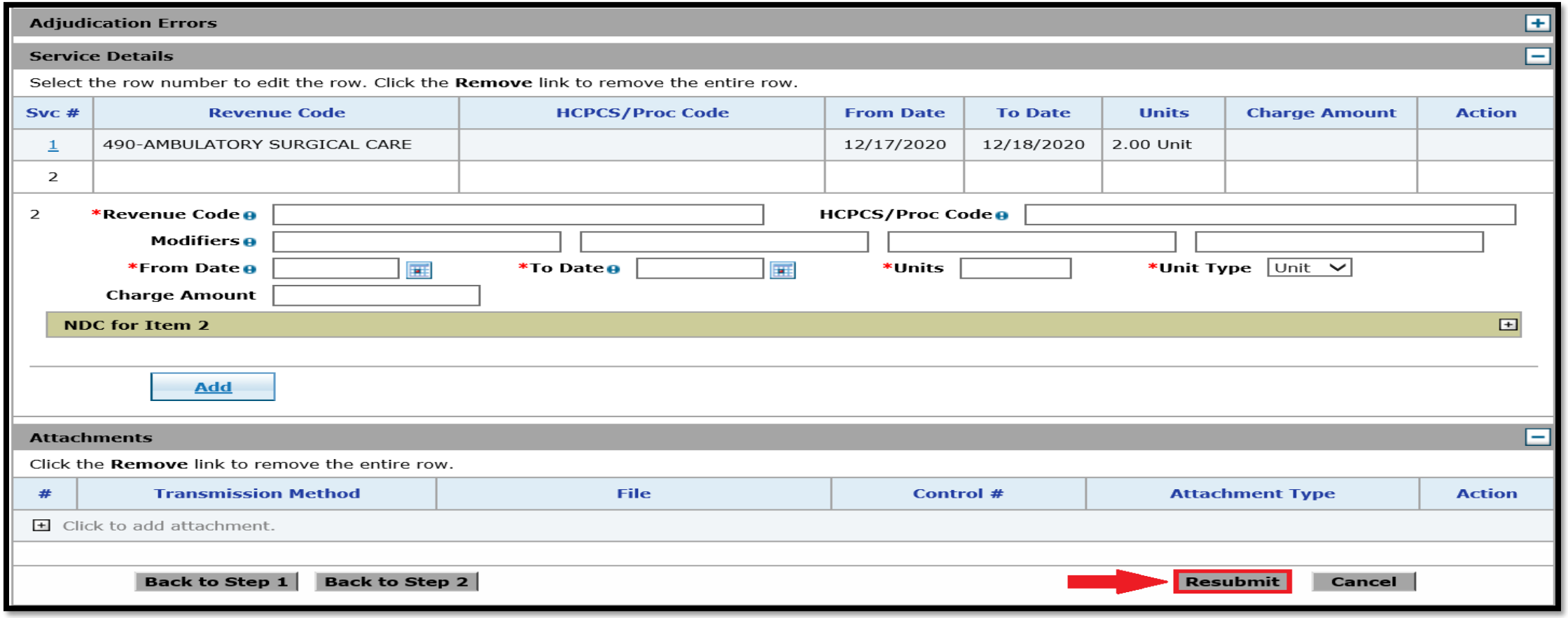
The EOB description remarks provide a more detailed explanation of why the claim denied.

DENIED CLAIM FUNCTIONS



Select **Edit** to modify the claim.

DENIED CLAIM FUNCTIONS



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.

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 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:

- 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