USER MANUAL

Dental Claims - Fee for Service

Department of Medicaid

Table of Contents

Introduction

This user manual provides the steps and functions for submitting and searching for dental claims in the Provider Network Management (PNM) system. This document focuses on the submission of fee-for-service dental claims.

Fee-for-service dental claims can still be submitted through the same pathway used prior to the launch of this function in PNM (EDI). Additionally, if a predetermination or prior authorization is involved in the EDI submitted dental claim, the claim submission must go through the Managed Care dental claim vendor.

Currently, Managed Care claims can be submitted through the following:

- As direct data entry through the plan portal
- Through submissions of predeterminations claims via the plan's dental vendors (who will forward the claims to Medicaid)
- The OMES front door

The specific route of claims submissions is up to the provider or trading partner.

The information contained in this document does not apply to MyCare Ohio.

For a Provider Agent user to submit claims, the role/action *"Claim Submission"* must be assigned to the Agent by the Provider Administrator for the Medicaid ID under which the claims are submitted.

For a Provider Agent user to search for claims, the role/action *"Claim Search"* must be assigned to the Agent by the Provider Administrator for the Medicaid ID under which the claims were submitted.

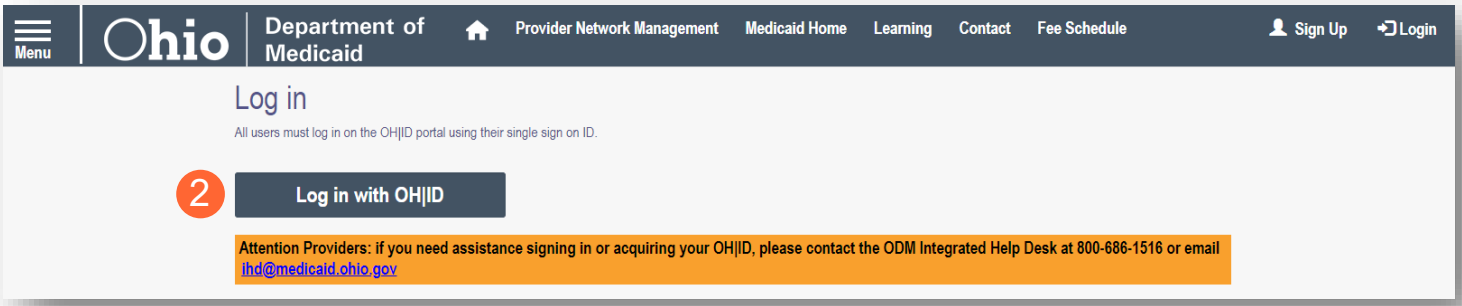
Decimals are not allowed on claim submissions. Be sure when entering codes (ex. diagnosis codes) that they are entered without decimals.

Provider User Initial Login

In this section of the user guide we will review the initial steps of logging into PNM. All users will log into the PNM system by using IOP (Innovate Ohio Platform).

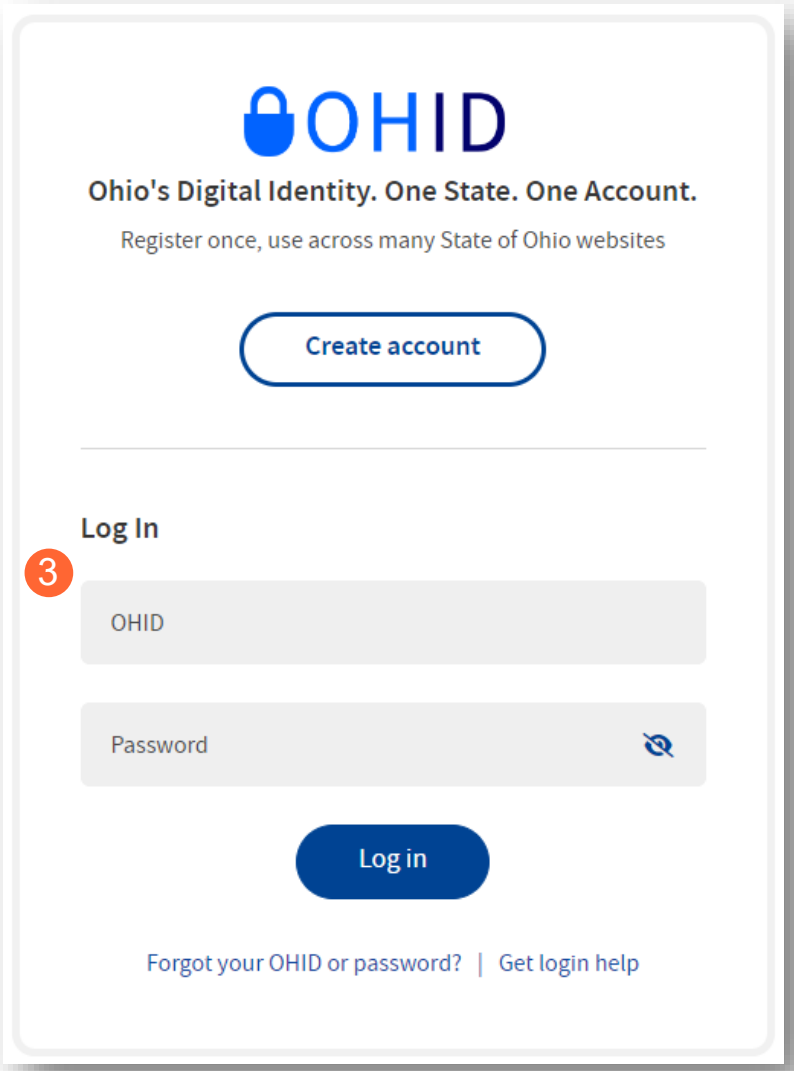
Step 1: Visit the PNM web address: https://ohpnm.omes.maximus.com/OH_PNM_PROD/Account/Login.aspx.

Step 2: Click **Log in with OH|ID**.

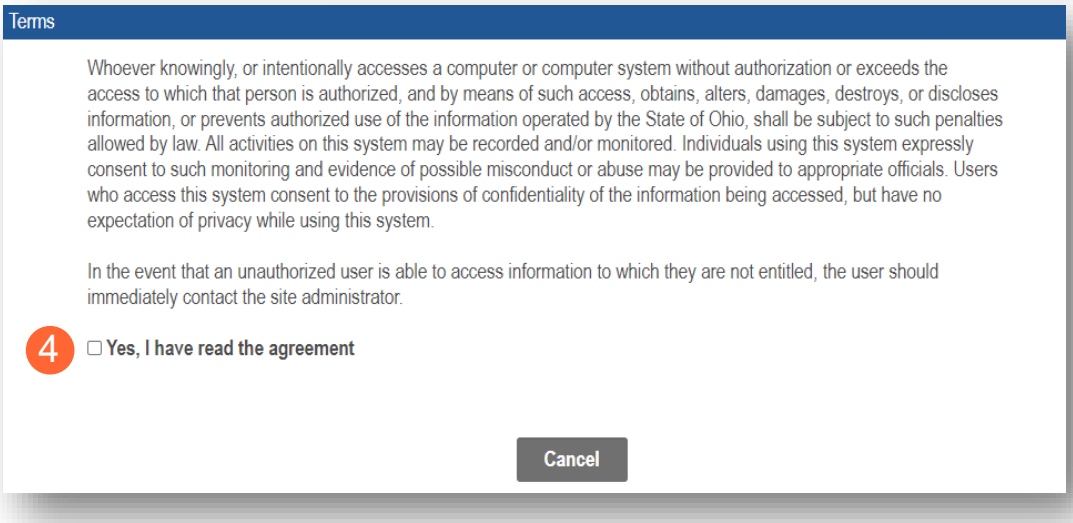


Step 3: The system will prompt you to enter your username and password on the IOP login screen. Once entered, click **Log in**.

- If you have not created an IOP account previously, you can click **Create Account** and follow the steps to create a new account.



Step 4: You will be redirected to the PNM system. Read the Terms of Use and click "Yes, I have read the agreement" to proceed into PNM.

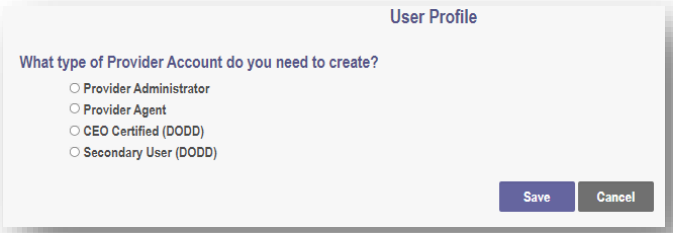


Provider Home Page

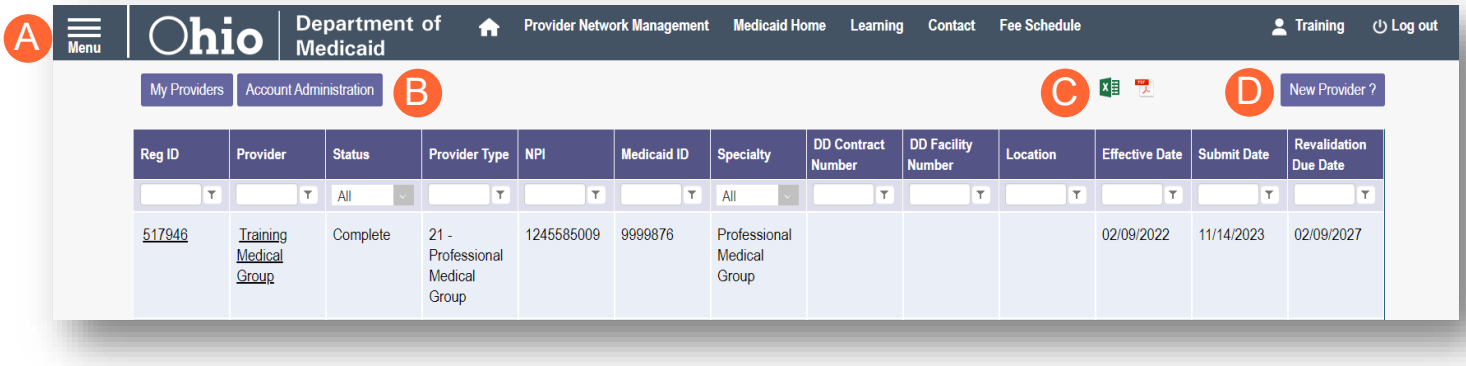
There are two provider roles in PNM:

- **Provider Administrator:** *(Also known as CEO Certified for DODD)* A role assigned to a user in PNM that allows that user to create new enrollment applications, update provider records, and complete revalidations among other tasks. The Administrator role will also be able to grant accesses/actions to other users in PNM, known as Agents.
    - There is one Administrator role per NPI/Medicaid ID. However, a single user with the Administrator role can administer to multiple providers (NPIs/Medicaid IDs).
- **Provider Agent:** *(Also known as Secondary User for DODD)* A role assigned to a user in PNM that allows that user to complete specific actions such as updating a provider record, revalidation, claims submission, prior authorization, the viewing of reports, etc. These actions are assigned to each Agent by the Administrator for the Medicaid ID.

A user must select a role the first time they log into PNM.



When you first login to the PNM system you will see a variety of buttons to help with administering providers. Some of the buttons, as indicated below, are only accessible to certain user roles.



Menu: The menu can be accessed by clicking on the three bars in the top left corner of the screen. The Menu provides a variety of key topics to choose from such as the Provider Directory, Learning Resources, and Contact Us (A).

Account Administration: This button allows a Provider Administrator to set up Agent users, assign them actions/roles, or transfer the Provider to another Provider Administrator user *(button only displays for users holding the Provider Administrator or CEO Certified role)* (B).

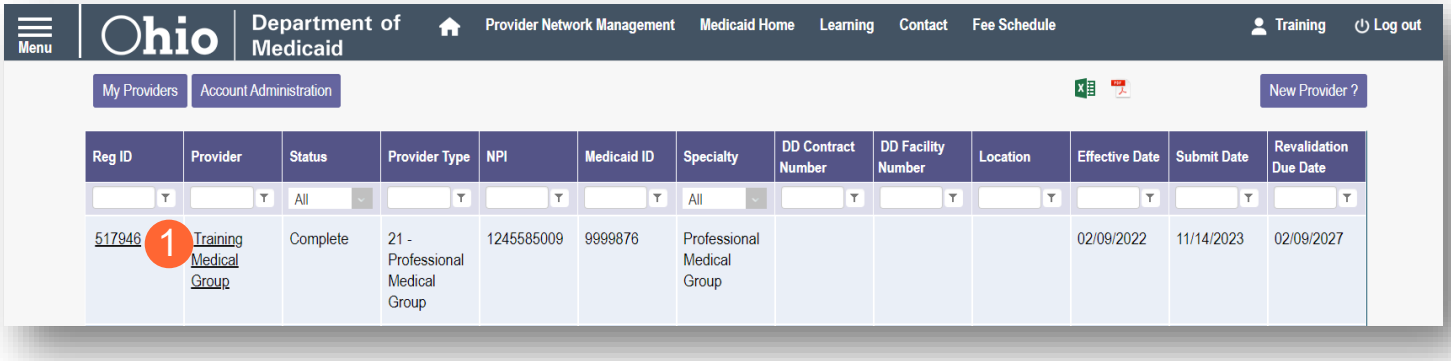
Excel and PDF Icons: These buttons allow you to export the list of providers appearing on your dashboard. Click the 'green' icon to export the list in an Excel format or the 'red' icon to export the list in a PDF format (C).

New Provider?: This button is used to start a New Enrollment Application (first time enrolling with ODM, ODA, or DODD) for any new Ohio Medicaid provider that you will be responsible for administering *(button only displays for users holding the Provider Administrator or CEO Certified role)* (D).

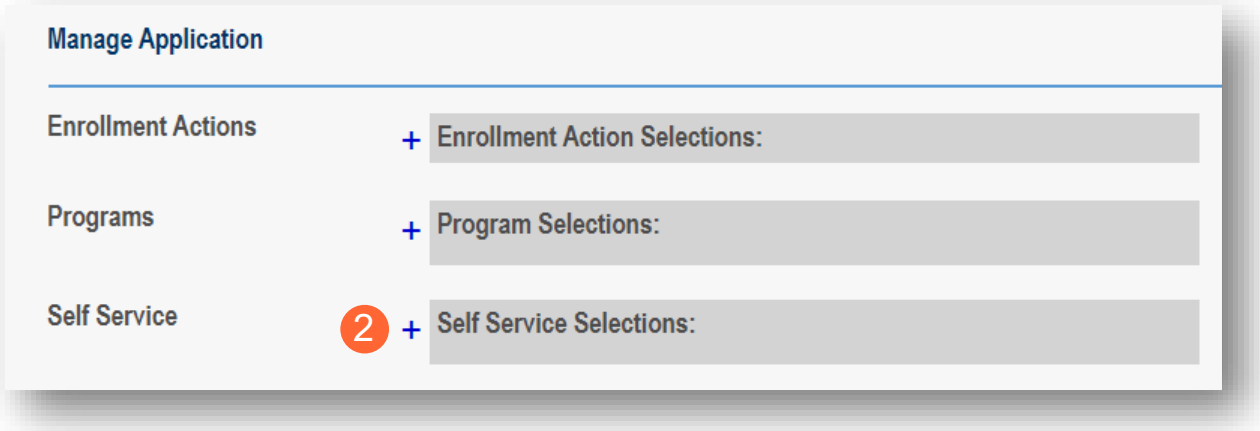
Accessing the Provider Self Service Panel

This section displays the necessary steps for accessing the Self Service functionalites for a provider file.

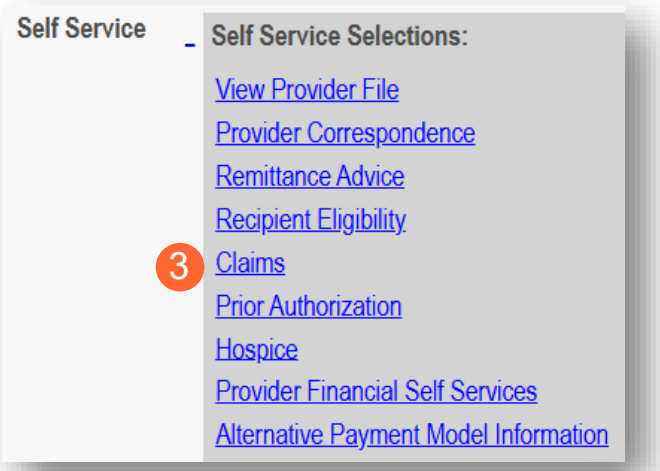
Step 1: From the Provider Homepage/Dashboard, click the hyperlink under Reg ID or Provider to manage the file of the Provider you wish to access.



Step 2: Under the Manage Application section, click the '+' icon to expand the Self Service Selections.



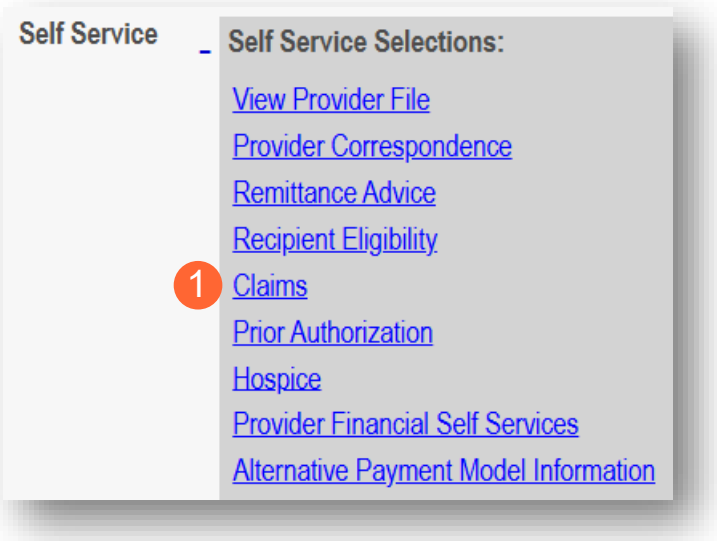
Step 3: Click the hyperlink for 'Claims.'



Search for a Previously Submitted Claim

This self-service functionality in PNM will allow for the search of fee-for-service claims previously submitted via PNM or EDI transaction.

Step 1: Click the 'Claims' hyperlink.



Step 2: The Claims search panel will appear. Enter any or all the following information:

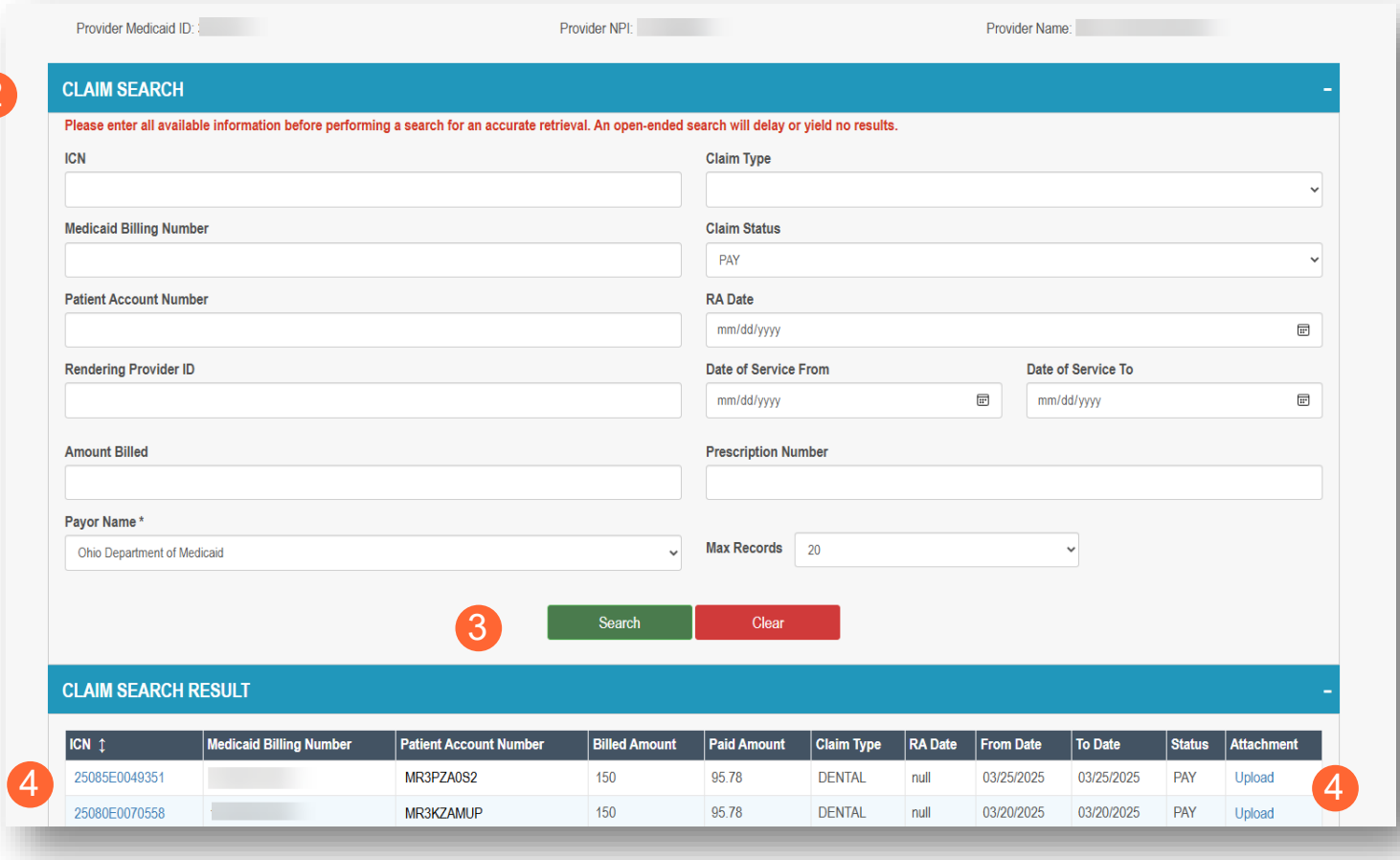
- Internal Control Number—ICN *(tracking number assigned to the claim)*
- Medicaid Billing Number
- Patient Account Number
- Rendering Provider ID
- Amount Billed
- Payor Name *(required field)*
  - Ohio Department of Medicaid
- Claim Type: Dental
- Claims Status
  - Pending Submission
  - Paid
  - Denied
  - Reversed
  - In Process
  - Open
  - Adjudicated
  - Pay
  - Void
  - RevSynch
  - Rev
  - WaitPay
  - WaitDeny
  - WaitRev
  - Deny
  - Pend

- Remittance Advice (RA) Date
- Date of Service From *(does not allow future date)*
- Date of Service To *(does not allow future date)*
- Prescription Number

Note: When searching by Claim Status for a claim in a 'Pending Submission' status, the Payor Name is not required.

Note: Please enter all available information before performing a search for an accurate retrieval. An open-ended search will delay or yield no results.

Step 3: When the criteria is entered, click **Search**.



Step 4: The ICN search results will be displayed at the bottom of the page. Click the '**ICN**' hyperlink to access claim details.

Note: The claim status and Attachments '**Upload**' hyperlink appear in the far-right columns. Attachments can be added to a claim in Adjudicated, Deny, Open, Pay, or Pend status using the 'Upload' hyperlink. This process is explained on page 45 in the section, Attachments to a Previously Submitted Claim.

Note: To clear search data and begin a new search, click **Clear**.

Step 5: Review the claim. Claim status and other information will appear in the section at the top-right.

- To expand a section, click the '+' icon.
- To collapse a section, click the '-' icon.

Note: For example, Reviewer Notes display in a collapsed section. To view, click the '+' icon.

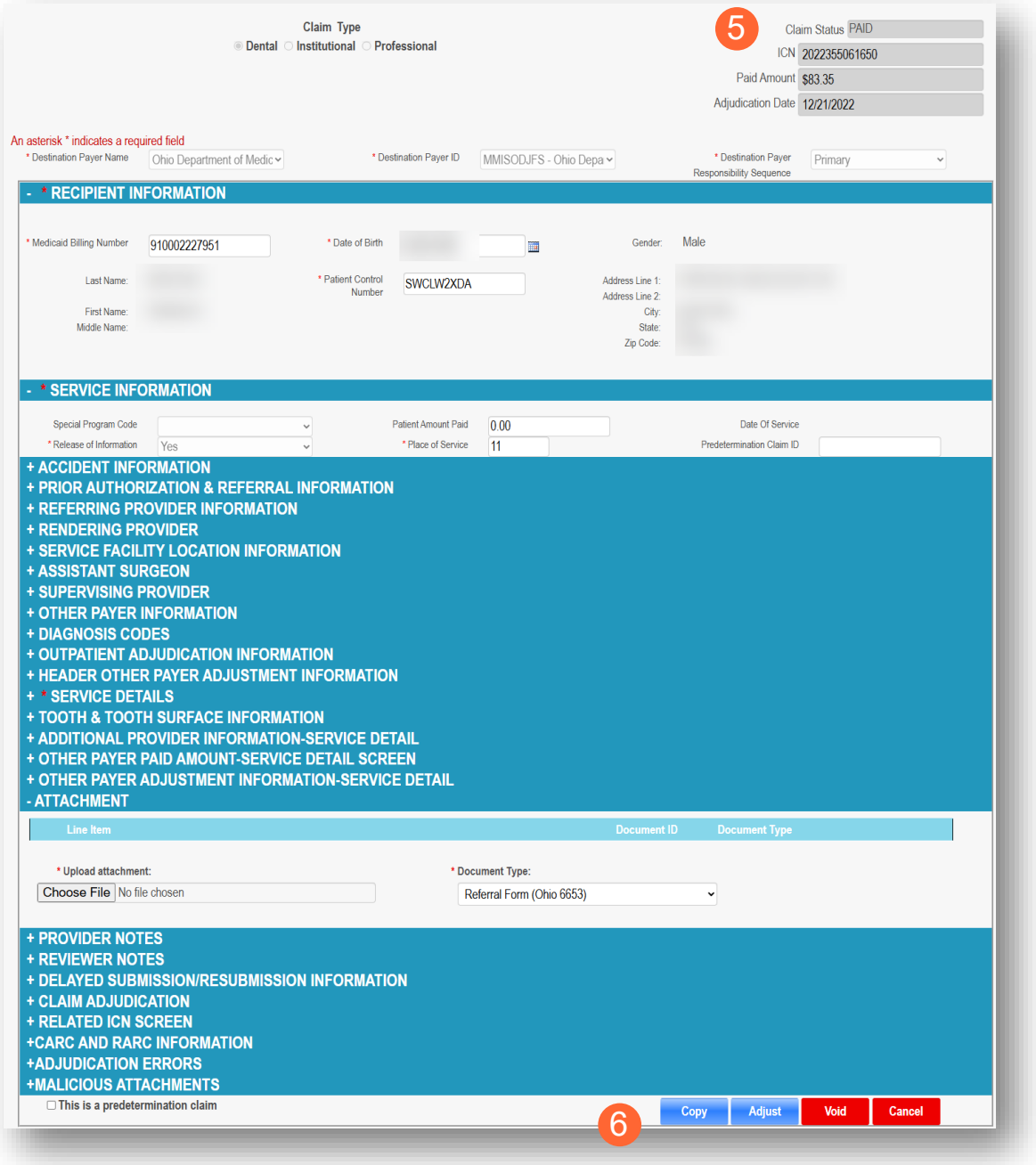
Step 6: Locate the available action buttons at the bottom of the screen for a claim in PAID status.

- **Copy**: Creates a new claim copying the data of the paid claim.
- **Adjust:** Allows data to be changed to submit claim.

Note: After clicking the '**Copy**' or '**Adjust**' buttons all field values become editable and claim adjudication information is deleted.

Note: Only claims in PAID status can be ADJUSTED. During a claims SEARCH, the user is expected to select the latest iteration of the claim for adjustment. If an earlier version of the claim is selected for adjustment and resubmitted, then it will be denied with the appropriate edit.

- **Void:** Lets provider void the previously paid claim.
- **Cancel:** Returns to the main menu.

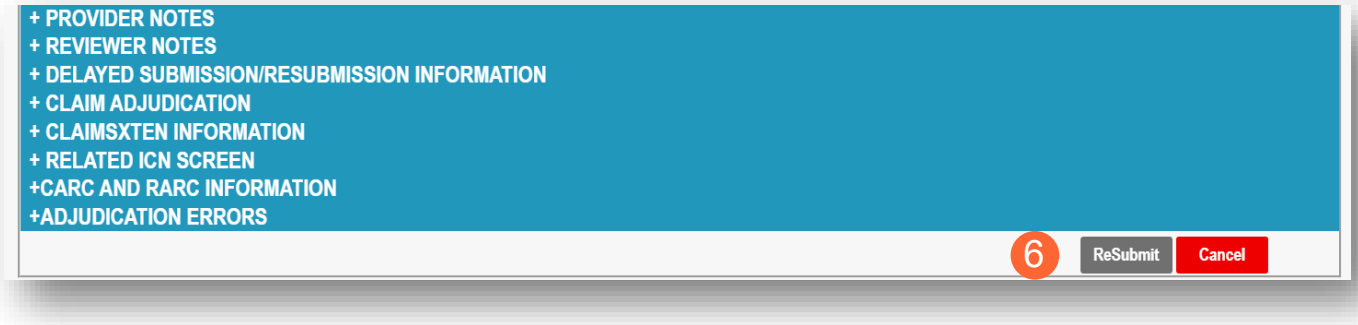


The action buttons available at the bottom of the screen for a claim in DENIED status are different than the action buttons available for a claim in PAID status.

- **Resubmit**: Available for claims in DENIED status and lets provider fix the data, resubmit the claim again, and create a NEW DAY claim with a new ICN for further claim processing.

Note: Only claims in a DENY/DENIED status can be RESUBMITTED. During a claims SEARCH, the user is expected to select the latest iteration of the claim for resubmittal. If an earlier version of the claim is selected for correction and resubmitted, then it will be denied with the appropriate edit.

Cancel: Returns to the main menu.



Note on Adjustment and Resubmission of Claims: Any action taken to Adjust or Resubmit a claim should be chosen carefully and what action needs to be performed depends on the latest status of the claim. If the latest status is PAID, then Provider is expected to ADJUST. If the latest status is DENY/DENIED, the Provider is expected to RESUBMIT.

Claim Statuses

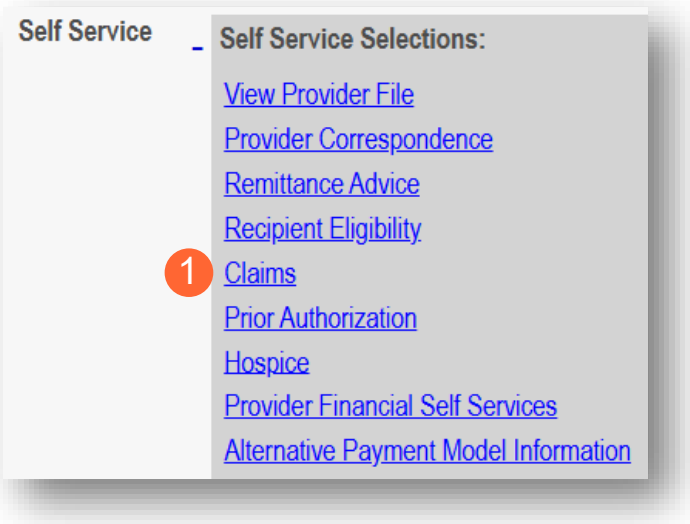
A summary of claim statuses and their definitions.

- **Adjudicated** – The claim has run through initial review of business rules and applied edits but has not gone through the payment process.
- **Denied** – The claim has failed business rules and has gone through the payment process.
- **Deny** – The claim has failed header and/or line-level business rules and has not been submitted to the payment process.
- **Open** – The claim has been received and is in process but has not been adjudicated.
- **Paid** – The claim has been finalized and has gone through the payment process.
- **Pay** – The claim has been adjudicated and all edits have been satisfied. It is now ready to go through the payment process.
- **Pend** – The claim has been set aside for review to determine if it should be paid or denied.
- **Pending Submission** - This is the status of a claim before submission.
- **Rev** – This is a real-time, non-finalized, financial status for a reversed/adjusted claim.
- **Reversed** – The claim has been finalized. Checks have been printed and the payment process is complete, but errors have been identified and a mirror image of the claim has been created to correct the errors.
- **RevSynch** – This is a real-time, non-finalized, financial status for a reversed claim that is synchronized to go through the payment cycle the same time as the adjustment claim.
- **Void** – This is a finalized status for a claim that has been voided. The claim has been canceled.
- **WaitDeny** – The claim has failed business rules and has been submitted for payment, but the payment process is not complete.
- **WaitPay** – The claim has been approved for payment and submitted to the payment process, but that process has not yet been completed.
- **WaitRev** – A reversal claim has been created and submitted to the payment process, but that process is not yet complete.
- **Warn** – An informational message that does not affect claim payment or denial.

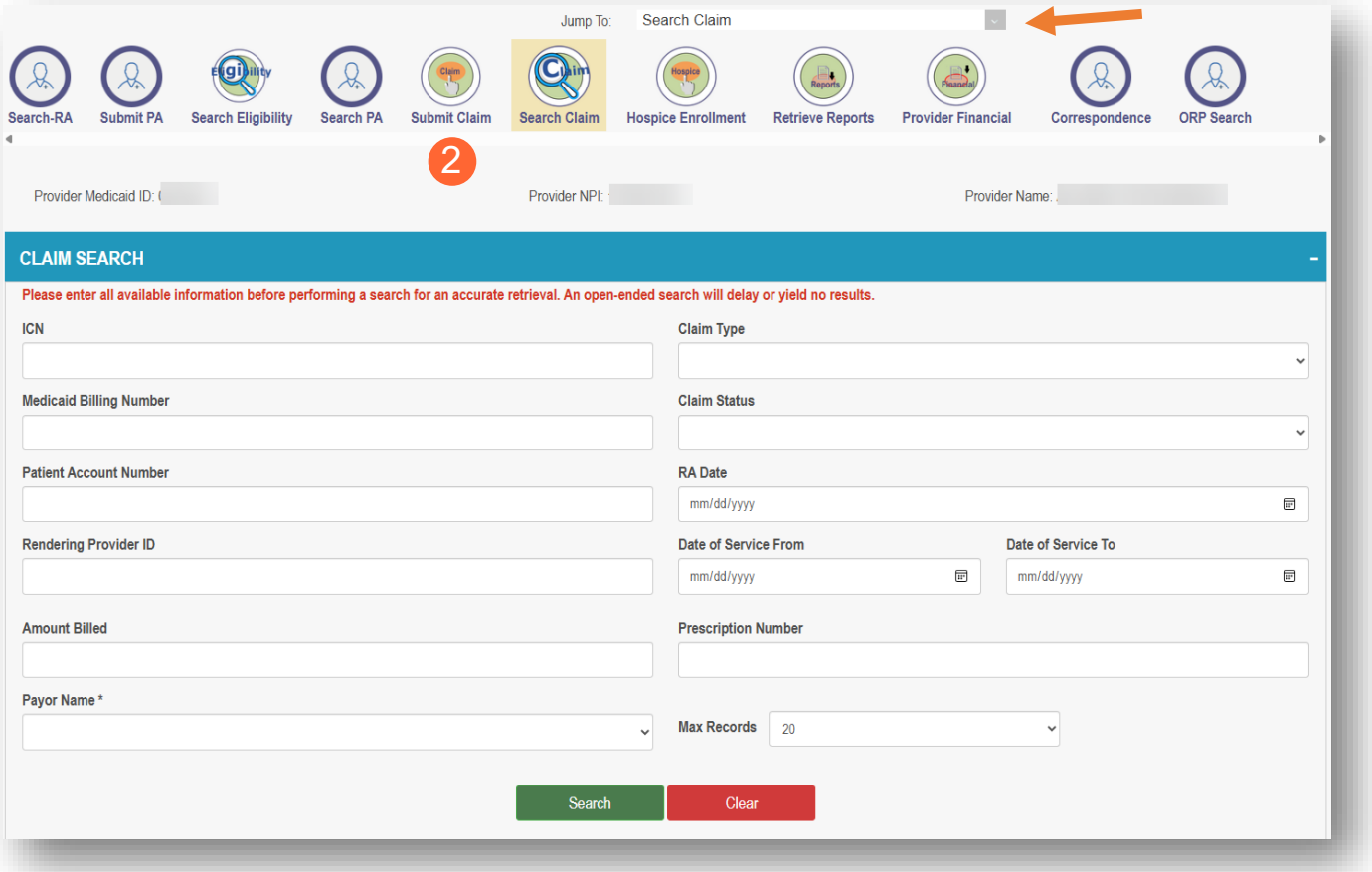
Submit a New Claim

Fee-for service Dental Claims can be submitted through PNM.

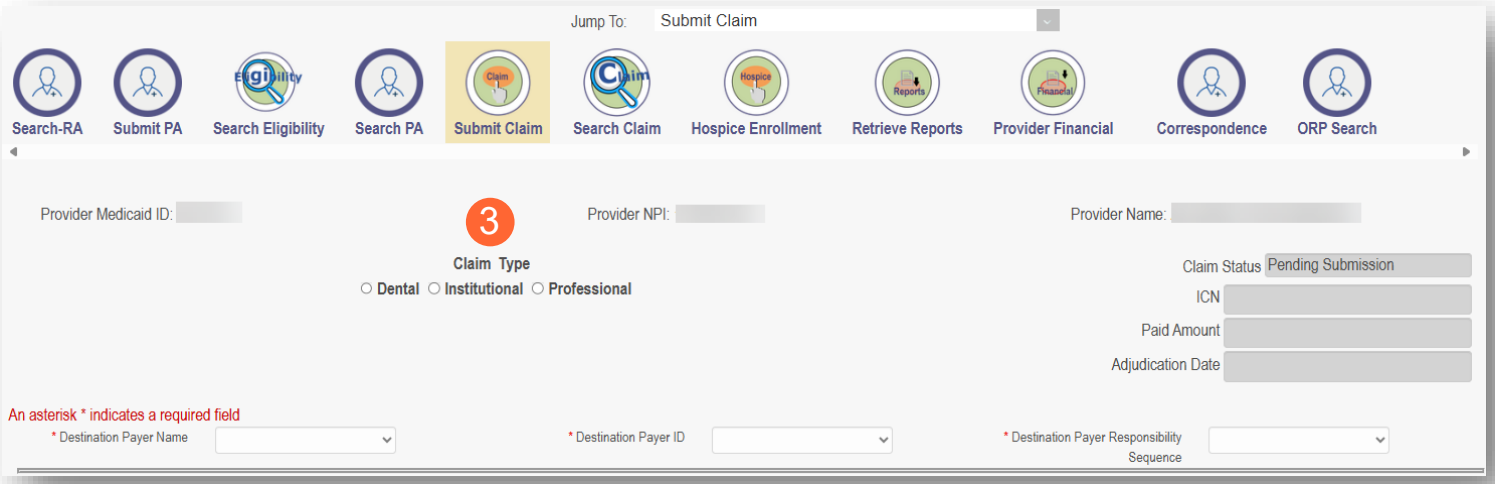
Step 1: Click the 'Claims' hyperlink.



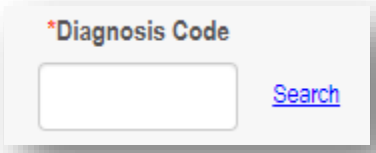
Step 2: To submit a Claim, click the 'Submit Claim' icon at the top of the page or select 'Submit Claim from the drop-down menu next to 'Jump to.'



Step 3: Under Claim Type, select 'Dental' by choosing the radio button.

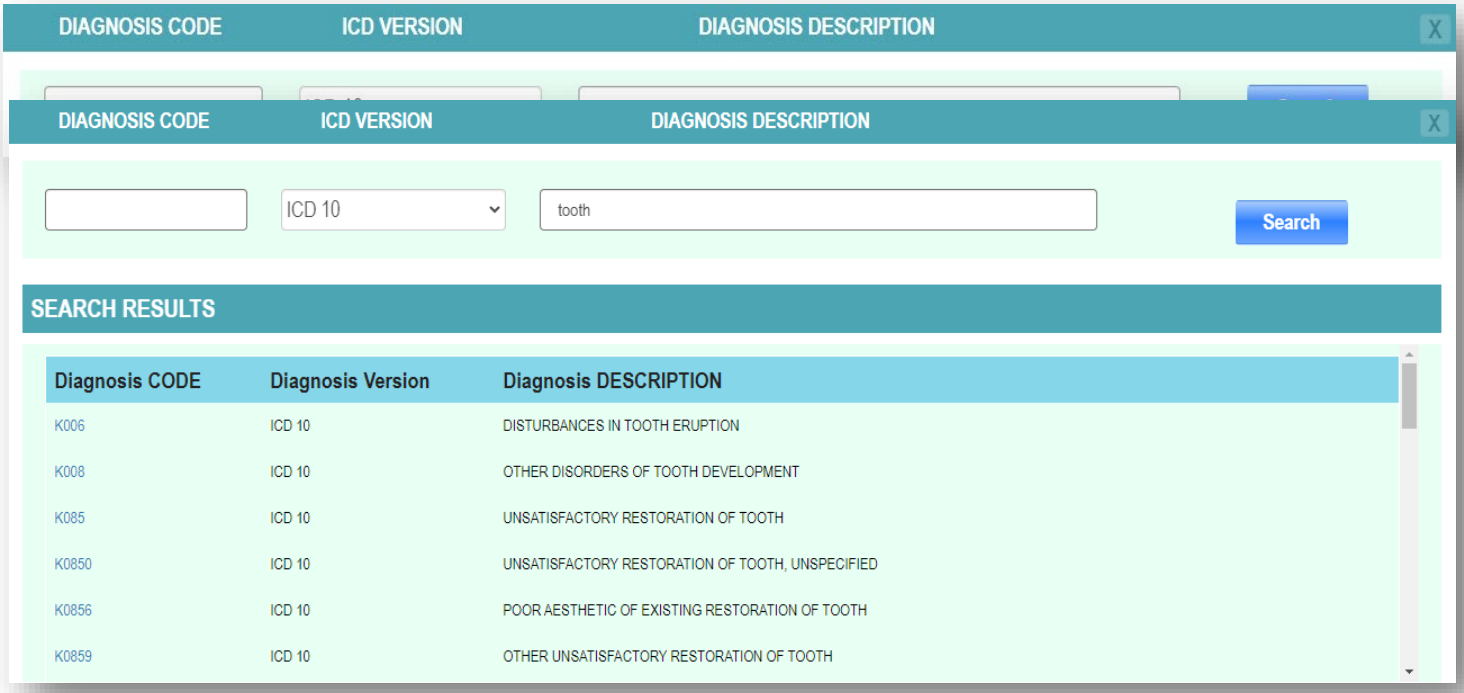


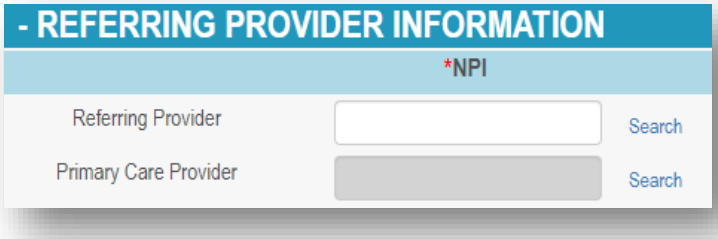
Note: If you select the incorrect claim type, fill out the Destination Payer information and then click **Cancel** at the bottom of the page. This will reset the claim submission page and allow for the correct type to be selected.

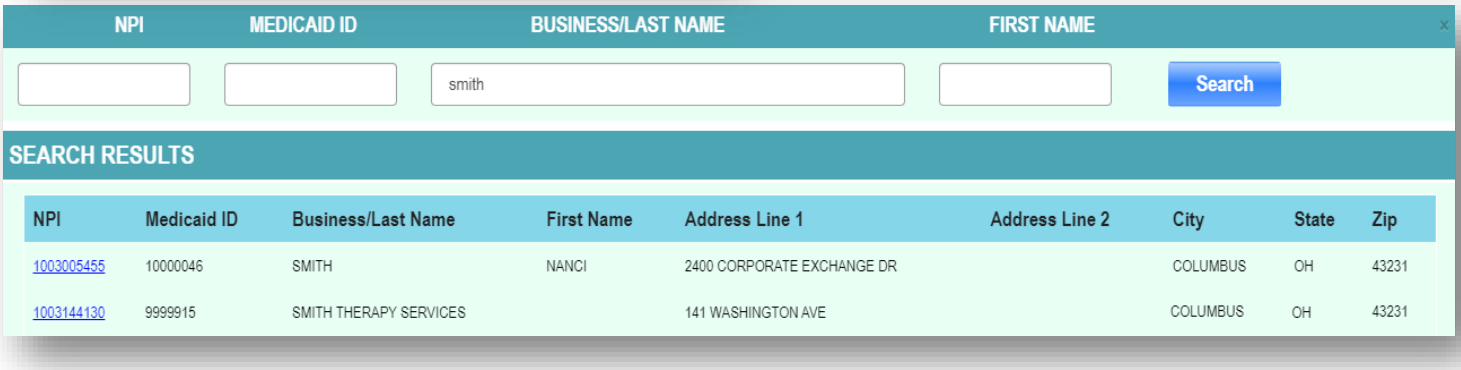


Note: Anytime a 'Search' hyperlink appears, clicking on the hyperlink will open a search panel to locate additional information, such as codes, or Provider information.

- Enter search criteria and click the 'Search' button.
- Search results will appear below the entered criteria.
- Click the hyperlink to add it to the proper field on the claim submission page.

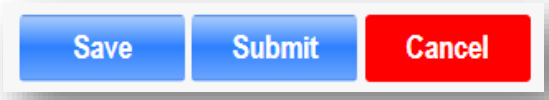






Note: The buttons below appear at the bottom of the Claims page.

- **Save**: Saves the Claim form and data entered.
    - Saved claim information will remain in PNM until the claim is submitted or until a 72-hour milestone is reached from the time of the save, whichever occurs first.
    - A saved claim can be retrieved from PNM system using claim search panel and searching for the status of “Submission Pending.”
- **Submit**: Sends the Claim for review.
- **Cancel**: Cancels the Claim and erases data entered.



Important Notes:

- A red asterisk appearing on the section header/title indicates that section is required to be completed.
    - The required fields within that section are marked with a red asterisk.
- If a section header/title does not display a red asterisk, it means that section is not required to be completed on all claim submissions.
    - These sections are situational and may need data entered depending on the claim being submitted.
    - Red asterisks listed for fields in these sections indicate that if information is filled out in these sections, at minimum, the asterisk marked fields are required to be completed.
- In the claim submission panels, to expand a section, click the ‘+’ icon or to collapse click ‘-’ icon.

Destination Payer Information

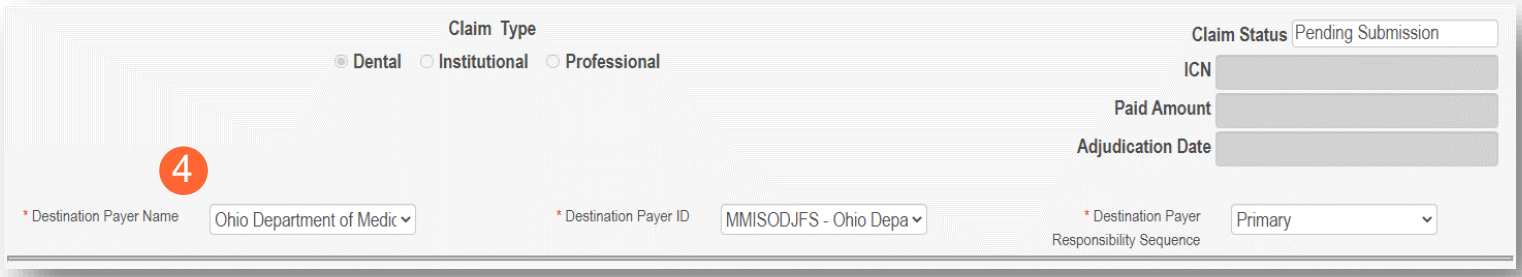
Step 4: After selecting a Dental Claim Type, select the following from the provided drop-down menus:

- Destination Payer Name
  - Ohio Department of Medicaid

- Destination Payer ID *(options dependent on what is selected for Destination Payer Name)*
  - *When selecting Ohio Department of Medicaid*
    - MMISODJFS - Ohio Department of Medicaid

- Destination Payer Responsibility Sequence
  - P – Primary
  - S – Secondary
  - T – Tertiary
  - A – Payer Responsibility Four
  - B – Payer Responsibility Five
  - C – Payer Responsibility Six
  - D – Payer Responsibility Seven
  - E – Payer Responsibility Eight
  - F – Payer Responsibility Nine
  - G – Payer Responsibility Ten
  - H – Payer Responsibility Eleven

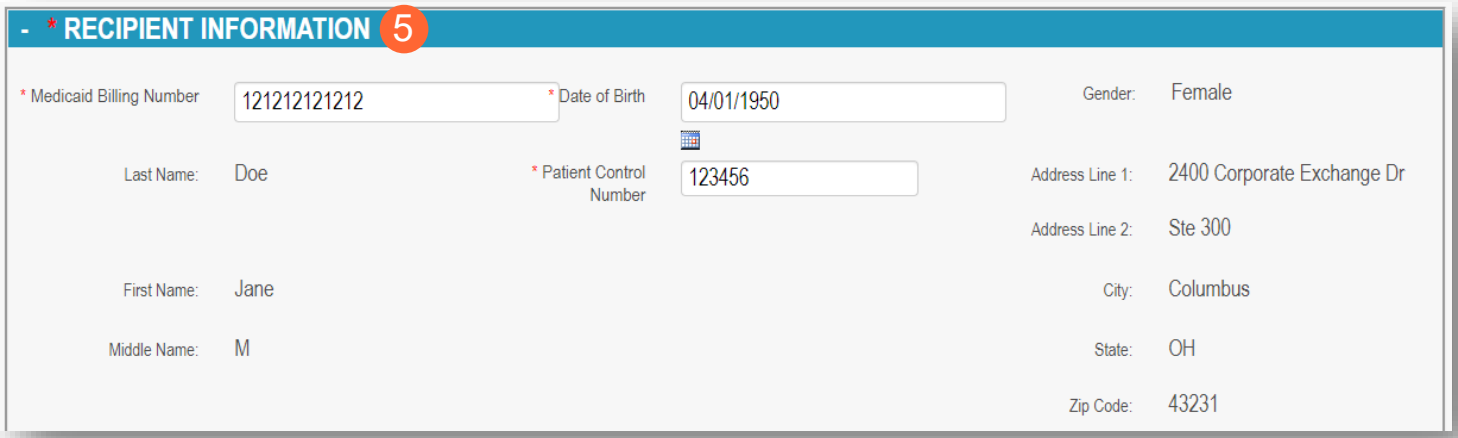
Note: If a Destination Payer Responsibility other than 'Primary' is chosen, Other Payer information will need to be completed during the claim submission.



Recipient Information

Step 5: Enter recipient details:

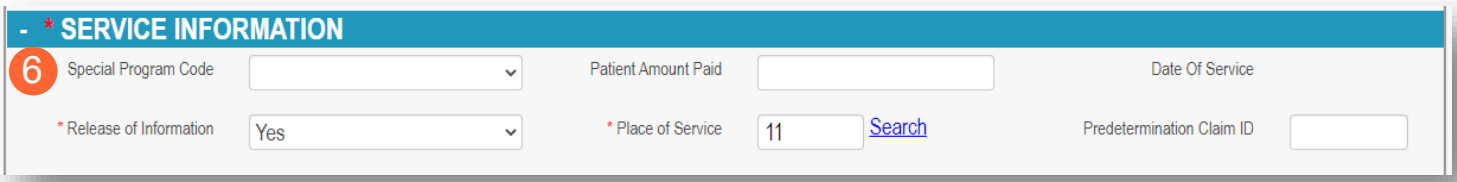
- Enter the Medicaid Billing Number for the recipient *(12-digit number).*
- Enter the recipient's Date of Birth *(must be in MM/DD/YYYY format).*
  - Once these are entered, the recipient's information (Last Name, First Name, Gender, Address) will auto-fill in the gray space.
- Enter the [Provider's] Patient Control Number *(Patient Account Number).*
  - This is the provider's internal tracking number for the patient/recipient in their record keeping system. This number can be used as a data point when completing a claim search in PNM.



Service Information

Step 6: Enter or select the following information:

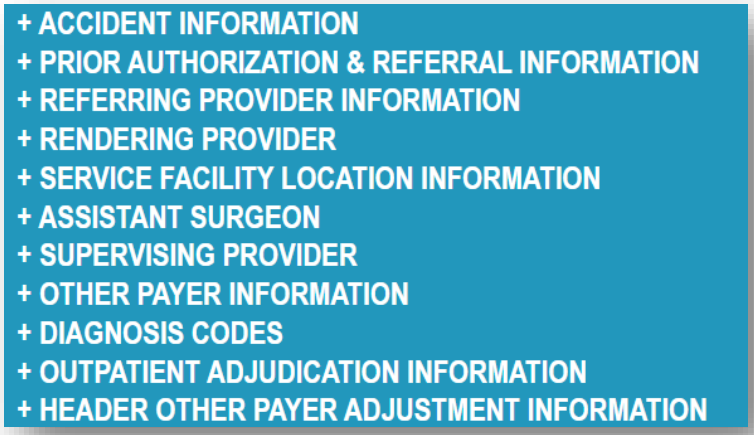
- Special Program Code *(as needed)*
  - Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) or CHAP
  - Physically Handicapped Children's Program
  - Special Federal Funding
  - Disability
- Patient Amount Paid *(as needed)*
- Release of Information *(required)*
  - Yes
  - No
- Place of Service *(required)*
  - Click 'Search' to look up Place of Service code.
- Predetermination Claim ID *(as needed)*



‘Situational’ Sections

To add information to any of the collapsed sections, click the ‘+’ icon to expand. When the section is expanded, enter any necessary information.

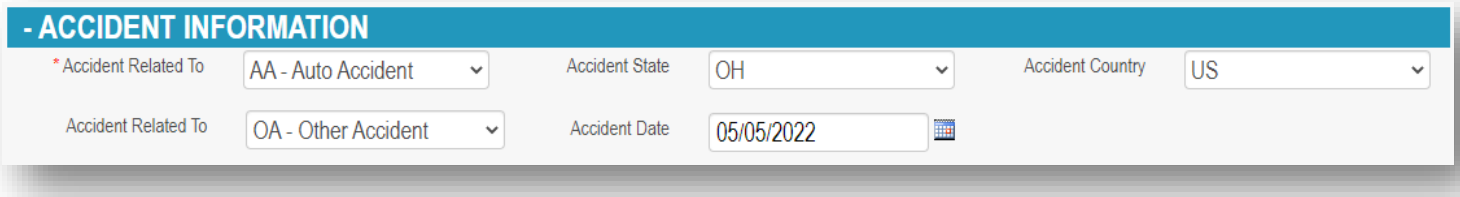
- Depending on the claim that is being entered, information may need to be listed in these sections. Policy requirements related to claim submissions should be followed when completing all sections within the claim.
- Situational fields that are not applicable to the claim submission should be left blank.



Accident Information

Enter or select the following information:

- Accident Related To (1st field) *(required to complete, only if information is added to this section)*
  - AA – Auto Accident
  - EM – Employment
  - OA – Other Accident
- Accident Related To (2nd field)
  - AA – Auto Accident
  - EM – Employment
  - OA – Other Accident
- Accident State
- Accident Date
  - Enter in MM/DD/YYYY format.
- Accident Country

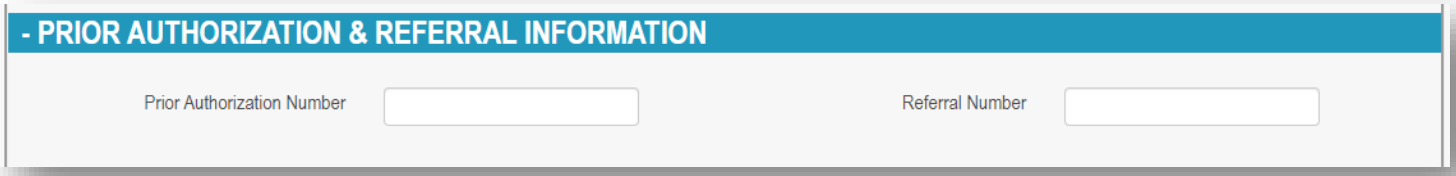


Prior Authorization & Referral Information

Enter the following information:

- Prior Authorization Number
- Referral Number *(leave blank if there is no patient referral between providers)*

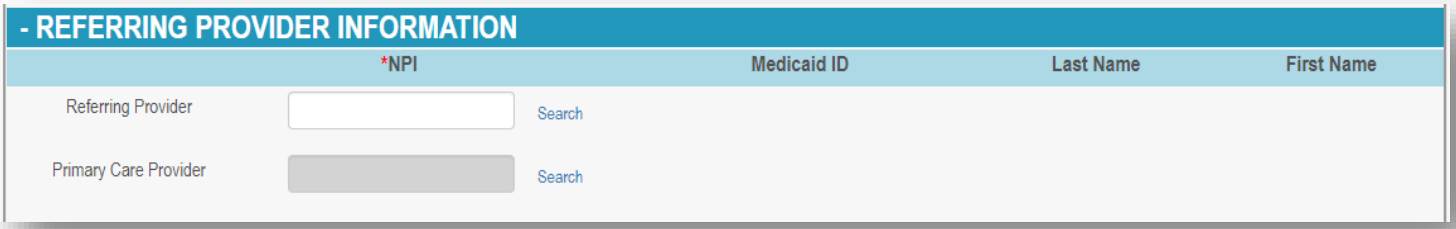
*A Prior Authorization Number needs to be added here if there is an approved prior authorization for the service on the claim.



Referring Provider Information

Enter the following information:

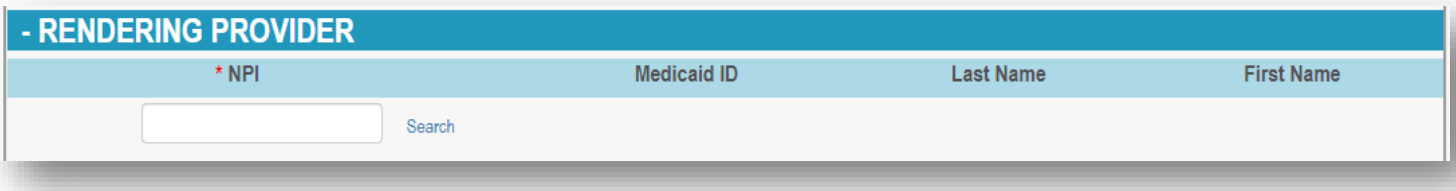
- Referring Provider National Provider Identifier (NPI)
  - If you do not know the provider's NPI, click 'Search' to lookup the provider.
  - Once the NPI is entered, the Medicaid ID, Last Name, and First Name will auto-populate.
- Primary Care Provider NPI
  - This field will be grayed out until a Referring Provider is entered.
  - If you do not know the provider's NPI, click 'Search' to lookup the provider.
  - Once the NPI is entered, the Last Name and First Name will auto-populate.
  - Note: Medicaid ID field will be populated only if NPI is not available.



Rendering Provider

Enter the following information:

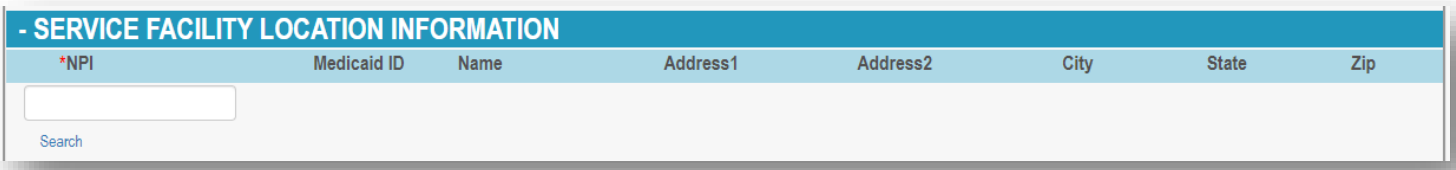
- Rendering Provider NPI
  - If you do not know the provider's NPI, click 'Search' to lookup the provider.
  - Once the NPI is entered, the Last Name and First Name will auto-populate.
  - Note: Medicaid ID field will be populated only if NPI is not available.



Service Facility Location Information

Enter the following information:

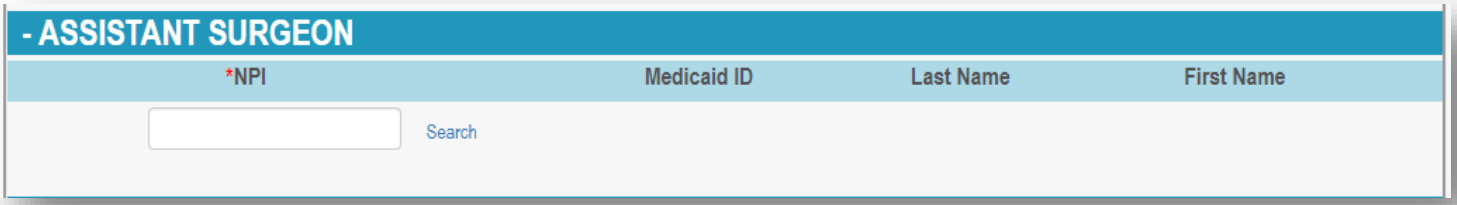
- Service Facility Location Information NPI
  - If you do not know the provider's NPI, click 'Search' to lookup the provider.
  - Once the NPI is entered, the Name, Address1, Address2, City, State, and Zip will auto-populate.
  - Note: Medicaid ID field will be populated only if NPI is not available.



Assistant Surgeon

Enter the following information:

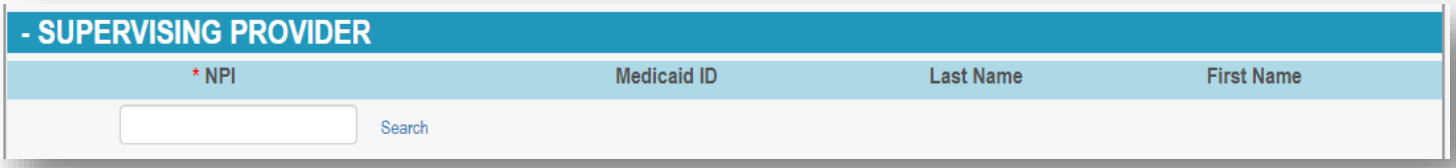
- Assistant Surgeon NPI
  - If you do not know the provider's NPI, click 'Search' to lookup the provider.
  - Once the NPI is entered, the Last Name and First Name will auto-populate.
  - Note: Medicaid ID field will be populated only if NPI is not available.



Supervising Provider

Enter the following information:

- Supervising Provider NPI
  - If you do not know the provider's NPI, click 'Search' to lookup the provider.
  - Once the NPI is entered, the Last Name and First Name will auto-populate.
  - Note: Medicaid ID field will be populated only if NPI is not available.



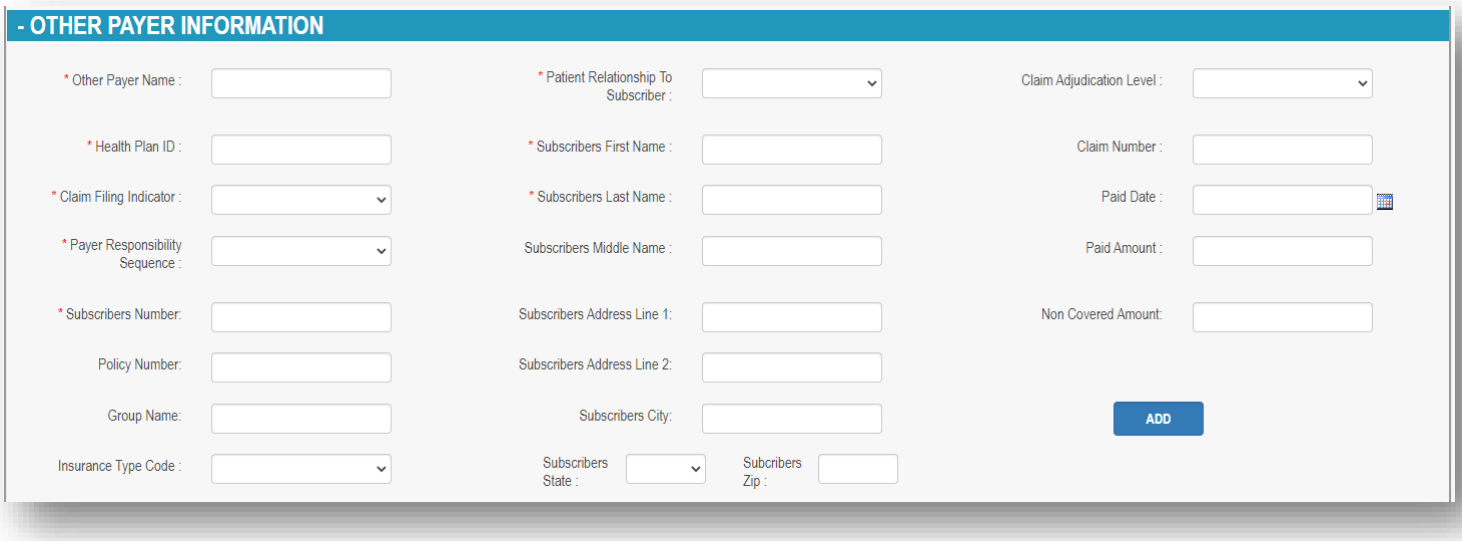
Other Payer Information

This section would need to be completed if the Destination Payer Responsibility Sequence selected earlier was anything other than 'Primary.'

Enter or select the following information:

- Other Payer Name
- Health Plan ID
- Claim Filing Indicator
  - 11 – Other Non-Federal Programs
  - 12 – Preferred Provider Organization (PPO)
  - 13 – Point of Service (POS)
  - 14 – Exclusive Provider Organization (EPO)
  - 15 – Indemnity Insurance
  - 16 – Health Maintenance Organization (HMO) Medicare Risk
  - 17 – Dental Maintenance Organization
  - AM – Automobile Medical
  - BL – Blue Cross/Blue Shield
  - CH – Champus
  - CI – Commercial Insurance Co.
  - DS – Disability
  - FI – Federal Employees Program
  - HM – Health Maintenance Organization
  - LM – Liability Medical
  - MA – Medicare Part A
  - MB – Medicare Part B
  - MC – Medicaid
  - OF – Other Federal Program
  - TV – Title V
  - VA – Veterans Affairs Plan
  - WC – Workers' Compensation Health Claim
  - ZZ – Mutually Defined
- Payer Responsibility Sequence
  - P – Primary
  - S – Secondary
  - T – Tertiary
  - A – Payer Responsibility Four
  - B – Payer Responsibility Five
  - C – Payer Responsibility Six
  - D – Payer Responsibility Seven
  - E – Payer Responsibility Eight
  - F – Payer Responsibility Nine
  - G – Payer Responsibility Ten
  - H – Payer Responsibility Eleven
  - U – Unknown
- Subscriber Number
- Policy Number
- Group Name

- Insurance Type Code
  - 12 – Medicare Secondary Working Aged Beneficiary or Spouse with Employer Group Health Plan
  - 13 – Medicare Secondary End-Stage Renal Disease Beneficiary in the Mandated Coordination Period with an Employer s Group Health Plan
  - 14 – Medicare Secondary, No-fault Insurance including Auto is Primary
  - 15 – Medicare Secondary Worker's Compensation
  - 16 – Medicare Secondary Public Health Service (PHS)or Other Federal Agency
  - 41 – Medicare Secondary Black Lung
  - 42 – Medicare Secondary Veteran's Administration
  - 43 – Medicare Secondary Disabled Beneficiary Under Age 65 with Large Group Health Plan (LGHP)
  - 47 – Medicare Secondary, Other Liability Insurance is Primary
- Patient's Relationship to Subscriber
  - 01 – Spouse
  - 18 – Self
  - 19 – Child
  - 20 – Employee
  - 21 – Unknown
  - 39 – Organ Donor
  - 40 – Cadaver Donor
  - 53 – Life Partner
  - G8 – Other Relationship
- Subscriber's (Cardholder's) First Name
- Subscriber's (Cardholder's) Last Name
- Subscriber's (Cardholder's) Middle Name
- Subscriber's (Cardholder's) Address Line 1
- Subscriber's (Cardholder's) Address Line 2
- Subscriber's (Cardholder's) City
- Subscriber's (Cardholder's) State
- Subscriber's (Cardholder's) Zip
- Claim Adjudication Level
  - PNM grays out this field if the other payer responsibility sequence is greater than the destination payer responsibly sequence:
    - Header
    - Detail
- Claim Number
- Paid Date
- Paid Amount
- [Total] Non-Covered Amount
  - PNM grays out this field if other payer responsibility sequence is greater than the destination payer responsibility sequence or claim adjudication level is 'Detail.'
  - If destination or other payer responsibility sequence is unknown, this field will be optional and available to report when claim adjudication level is 'Header.'



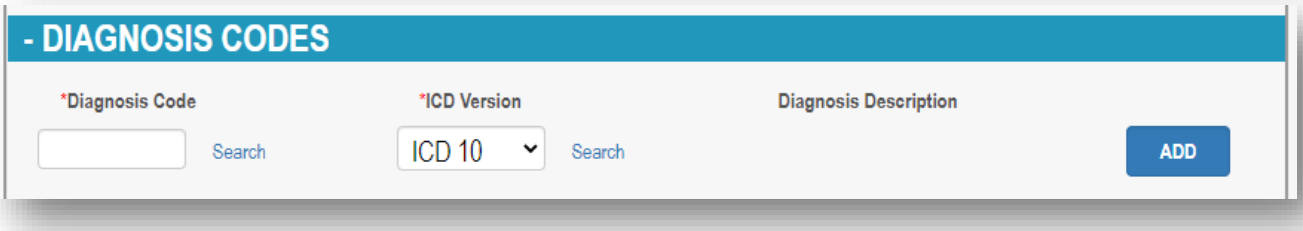
- Click **Add** to add the other payer information.
- Repeat the process to add other payers.
- A maximum of 10 payers can be reported.

Diagnosis Codes

Decimals are not allowed on claim submissions. Be sure to enter the diagnosis code without decimals.

Enter or select the following information:

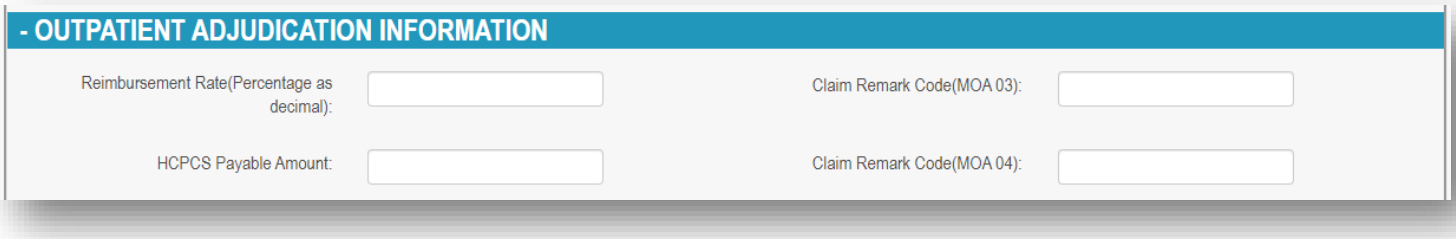
- Diagnosis Code
  - If you do not know the Diagnosis Code, click 'Search' to lookup the code.
    - PNM defaults to the ICD 10 code, but this can be changed if needed.
  - The Diagnosis Description auto-populates after the Diagnosis Code is selected.
- Click **Add** to add the diagnosis code to the claim submission.
  - Repeat the process to add.
  - A maximum of 4 diagnosis codes can be added.



Outpatient Adjudication Information

Enter the following information:

- Reimbursement Rate
  - Listed in percentage as a decimal.
- Healthcare Common Procedure Coding System (HCPCS) Payable Amount
- Claim Remark Code (MOA 03)
- Claim Remark Code (MOA 04)



Header Other Payer Adjustment Information

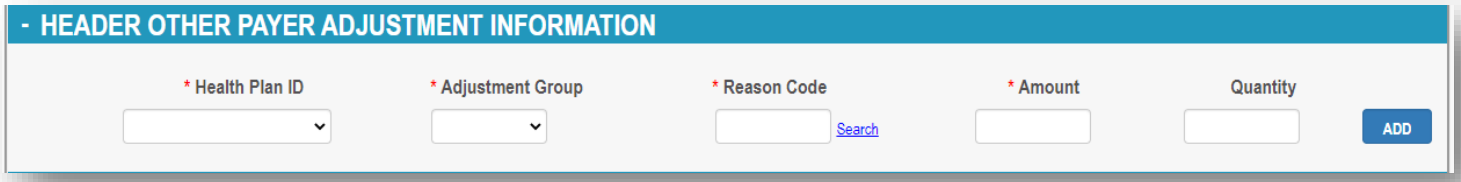
Information only needs to be added in this section if the Other Payer Information section is filled out and the Other Payer Adjudication Level is 'Header.'

Enter the following information:

- Heath Plan ID
  - A Health Plan ID will be available in the drop-down only if the claim adjudication level is listed as 'Header' and other payer responsibly sequence is prior to the destination payer.
- Adjustment Group
  - *Required when an adjustment amount is reported
  - Each Adjustment Group can be repeated up to 6 times for one other payer.
    - CO – Contractual Obligations
    - CR – Correction and Reversals
    - OA – Other adjustments
    - PI – Payor Initiated Reductions
    - PR – Patient Responsibility
- Reason Code
  - If you do not know the Reason Code, click 'Search' to lookup the code.
- Amount
- Quantity
  - The quantity adjusted by the other payer.

- Click **Add** to add the information.
- A maximum of 30 records are allowed.

Reminder: *Enter the ARC information provided by the other payer in this panel.*



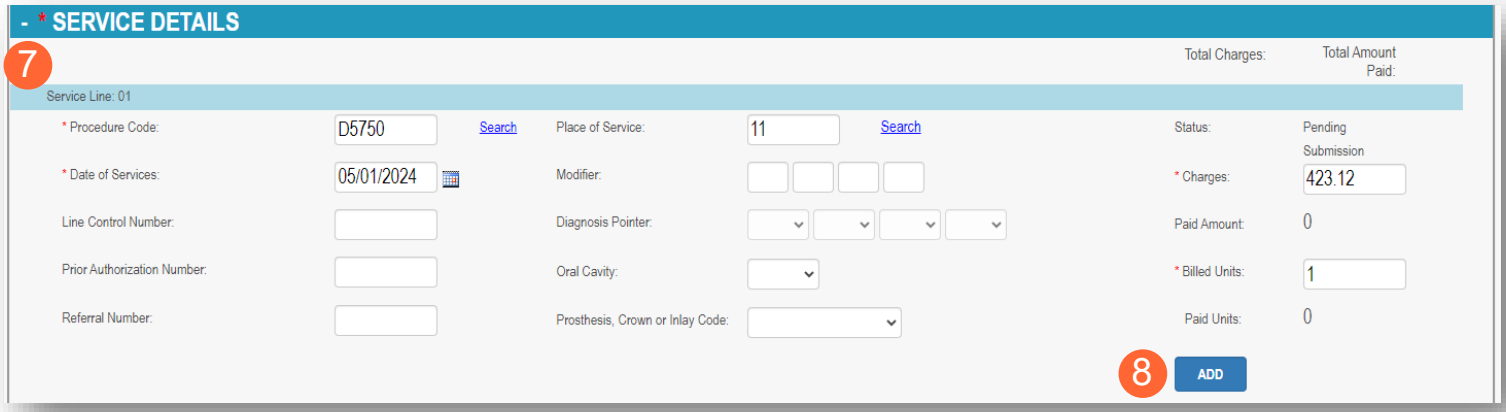
Service Details

Step 7: Enter or select the following information:

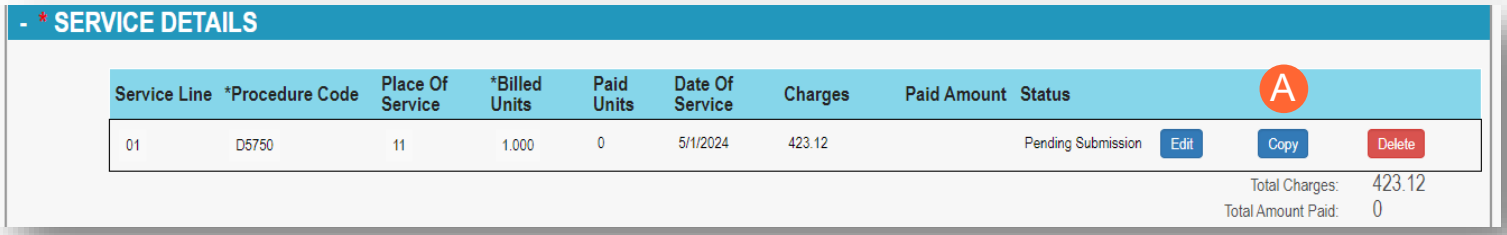
Note: At least one (1) service detail needs to be entered.

- Procedure Code *(required)*
  - If you do not know the Procedure Code, click 'Search' to lookup the code.
- Date of Services *(required)*
- Line Control Number *(as needed)*
- Prior Authorization Number *(as needed)*
- Referral Number *(as needed)*
- Place of Service *(as needed – should auto-fill from Service Information section)*
  - If you do not know the Place of Service, click 'Search' to lookup the code.
- Modifier *(as needed)*
  - Up to 4 values allowed.
- Diagnosis Pointer *(as needed)*
  - A maximum of 4 values per procedure.
- Oral Cavity *(as needed)*
  - 00 – Entire Oral Cavity
  - 01 – Maxillary arch
  - 02 – Mandibular arch
  - 10 – Upper right quadrant
  - 20 – Upper left quadrant
  - 30 – Lower left quadrant
  - 40 – Lower right quadrant
- Prothesis, Crown or Inlay Code *(as needed)*
  - Initial Placement
  - Replacement
- Charges *(required)*
  - The billed amount for the procedure.
- Billed Units *(required)*
  - The number of the units billed for the dental claim.

Step 8: Click the **Add** button.



- The added service appears on a list. The line can be edited, copied, or deleted by clicking the corresponding button (A).
- Repeat the process above to add other services.
- A maximum of 50 service lines can be added.

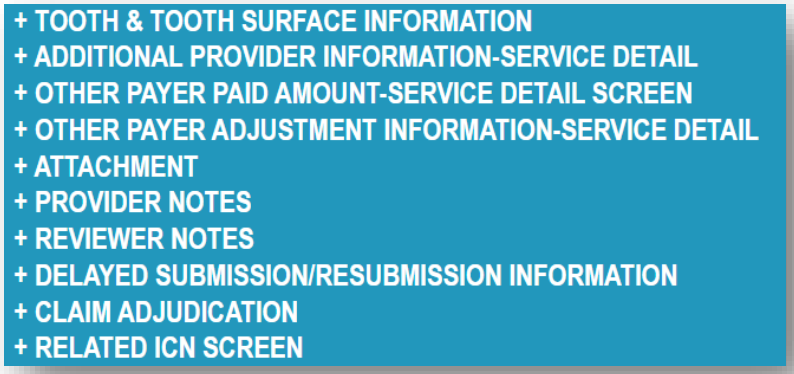


Additional 'Situational' Sections

To add information to any of the collapsed sections, click the '+' icon to expand. When the section is expanded, enter any necessary information.

- Depending on the claim that is being entered, information may need to be listed in these sections. Policy requirements related to claim submissions should be followed when completing all sections within the claim.

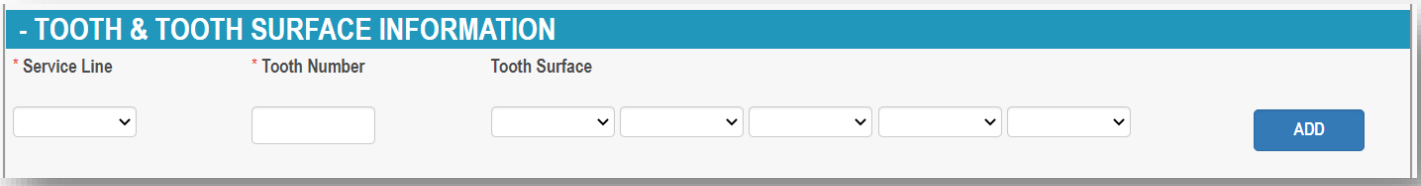
- Situational fields that are not applicable to the claim submission should be left blank.



Tooth & Tooth Surface Information

Enter or select the following information:

- Service Line *(required to complete, only if information is added to this section)*
  - The line as it relates to the service detail information entered above.
- Tooth Number *(required to complete, only if information is added to this section)*
  - 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 51, 52, 53, 54, 55, 56, 57,58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 99, A, AS, B, BS, C, CS, D, DS, E, ES, F, FS, G, GS, H, HS, I, IS, J, JS, K, KS, L, LS, M, MS, N, NS, O, OS, P, PS, Q, QS, R, RS, S, SS, T, TS
- Tooth Surface
  - Up to 5 values can be added:
    - B – Buccal
    - D – Distal
    - F – Facial
    - I – Incisal
    - L – Lingual
    - M – Mesial
    - O – Occlusal
- Click **Add** to add the information.
- A maximum of 50 records can be added.

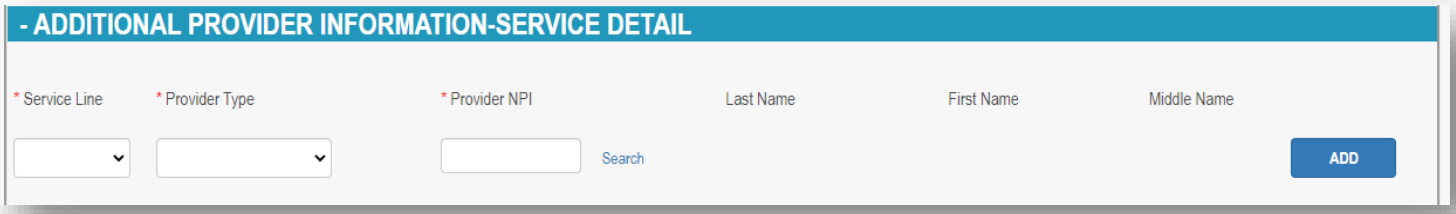


Additional Provider Information – Service Detail

Enter or select the following information:

- Service Line *(required to complete, only if information is added to this section)*
  - The line as it relates to the service detail information entered above.
- Provider Type *(required to complete, only if information is added to this section)*
  - Rendering Provider
  - Assistant Surgeon
  - Supervising Provider
  - Service Facility
- Provider NPI *(required to complete, only if information is added to this section)*
  - If you do not know the provider's NPI, click 'Search' to lookup the provider.
  - Once the NPI is entered, the Medicaid ID, Last Name, and First Name will auto-populate.

- Click **Add** to add the information.



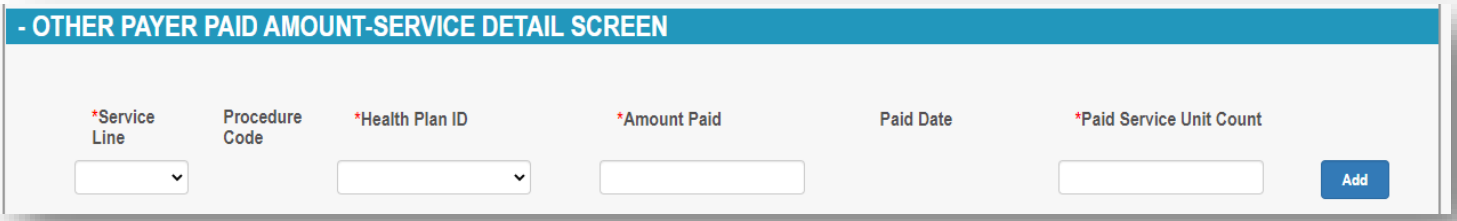
Other Payer Paid Amount – Service Detail Screen

This panel is required if other payer exists, and other payer adjudication level is 'Detail.' PNM will display an error message of "Other payer payment information is required" if it is not reported, but the other payer adjudication level is 'Detail', and the service line payment record is not reported for the service line.

Enter or select the following information:

- Service Line *(required to complete, only if information is added to this section)*
  - The line as it relates to the service detail information entered above.
- Health Plan ID *(required to complete, only if information is added to this section)*
- Amount Paid *(required to complete, only if information is added to this section)*
- Paid Service Unit Count *(required to complete, only if information is added to this section)*
  - The number of units paid by the other payer.

- Click **Add** to add the information.

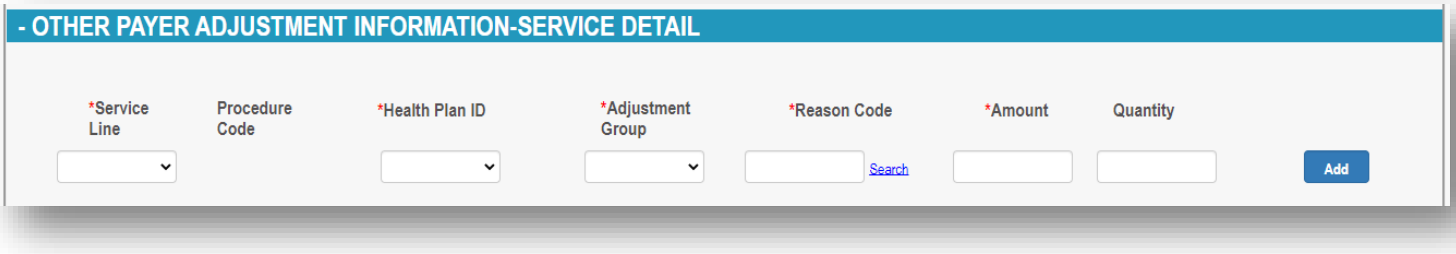


Other Payer Adjustment Information – Service Detail

Enter the following information:

- Service Line *(required to complete, only if information is added to this section)*
  - The line as it relates to the service detail information entered above.
- Health Plan ID *(required to complete, only if information is added to this section)*
- Adjustment Group *(required to complete, only if information is added to this section)*
  - Each Adjustment Group can be repeated up to 6 times for one other payer.
    - CO – Contractual Obligations
    - CR – Correction and Reversals
    - OA – Other adjustments
    - PI – Payor Initiated Reductions
    - PR – Patient Responsibility
- Reason Code *(required to complete, only if information is added to this section)*
  - If you do not know the Reason Code, click 'Search' to lookup the code.
- Amount *(required to complete, only if information is added to this section)*
- Quantity
  - The quantity adjusted by the other payer.

- Click **Add** to add the information.
- A maximum of 30 records can be added.



Attachment

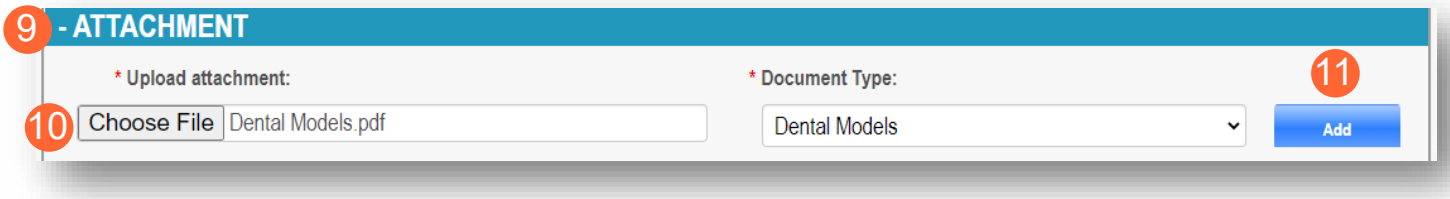
Step 9: Prior to submitting the claim, make sure to add any necessary attachments by expanding the Attachment section.

Note: The maximum file upload size is 10 MB.

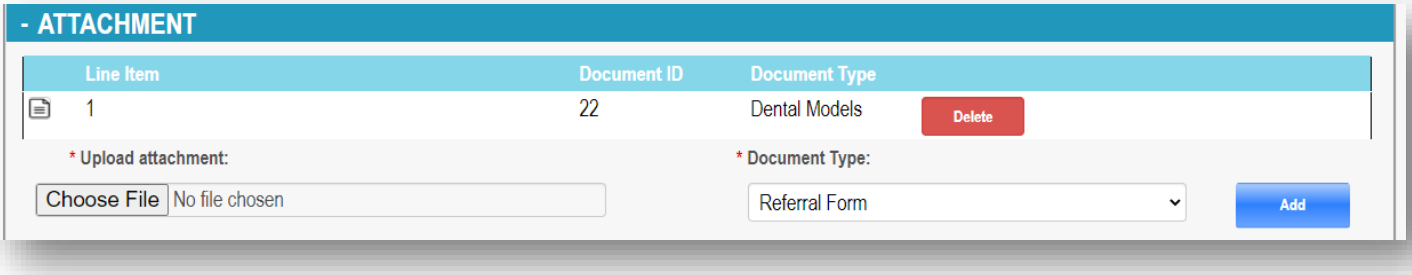
Step 10: Click **Choose File**, locate the file on your computer you wish to upload and select the Document Type from the drop-down menu.

- Admission Summary
- Certification
- Completed Referral Form
- Dental Models
- Diagnostic Report
- Discharge Summary
- Explanation of Benefits
- Models
- Nursing Notes
- Operative Note
- Physical Therapy Certification
- Physical Therapy Notes
- Physician Order
- Prescription
- Prosthetics or Orthotic Certification
- Radiology Films
- Radiology Reports
- Referral Form (Ohio 6653)
- Report of Tests and Analysis Report
- Support Data for Claim

Step 11: Click the **Add** button.



- The added attachment appears on a list. Repeat the process above to add other attachments.
- A maximum of 10 documents can be uploaded for each claim submission.



Acceptable File Types:

- Word: doc, docx
- Excel: xls, xlsx, xlsm, xlsx
- Image: mdi, jpe, jpeg, jpg, png, gif, bmp, tif, tiff
- PDF: pdf
- Other: pi, ec, zip, csv, acrbak, msg

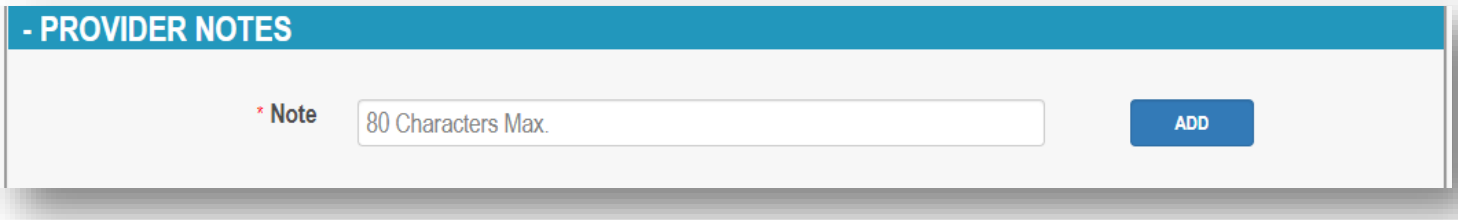
Provider Notes

Prior to submitting the claim, PNM does provide a space to add a note for the claim reviewer.

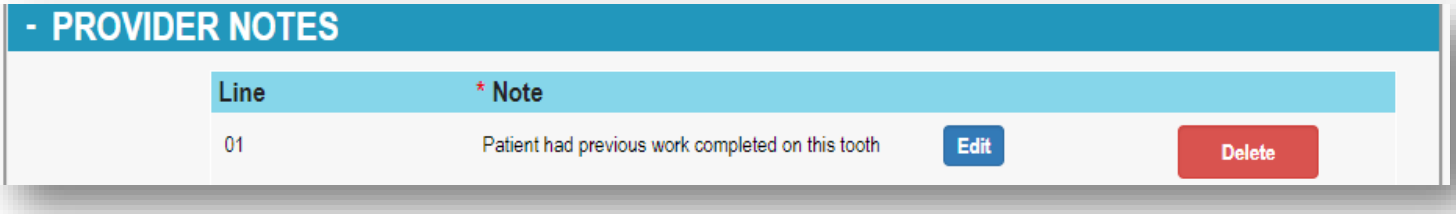
Enter any note(s) that you wish to provide:

- A maximum of 80 characters can be typed per note.
- A maximum of 5 notes can be added to the submission.

Enter the note and click **Add**.



The saved note will appear. To make changes, click **Edit**.

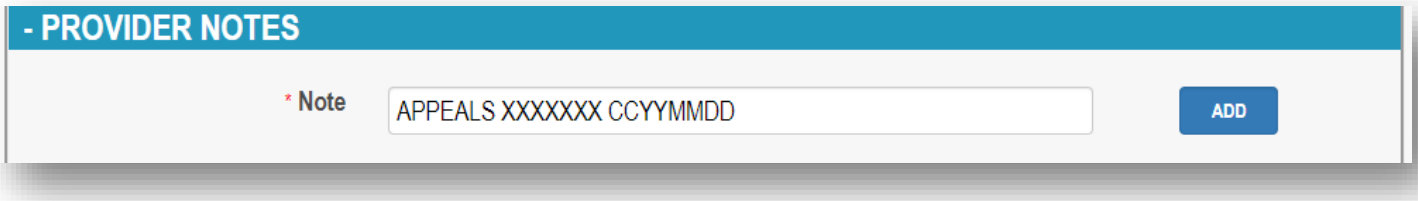


Notes to Bypass a Timely Filing

Below are instructions for notes to list when submitting a claim over 365 days old to Ohio Medicaid due to an eligibility determination or a hearing decision.

Hearing Decision *(Claim must be submitted within 180 days of the hearing decision)*

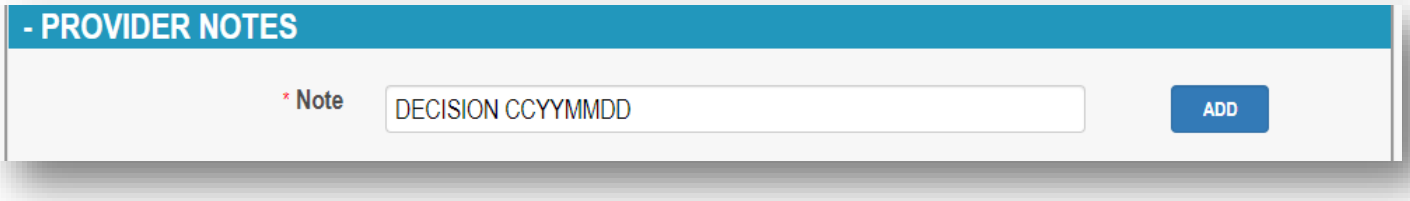
To denote a hearing decision, enter “APPEALS XXXXXXX CCYYMMDD” for the Note and click **Add**. *(XXXXXXX is the hearing number and CCYYMMDD is the date on the hearing decision letter.)*



Delay in Eligibility Decision *(Claim must be submitted within 180 days of the eligibility determination date)*

To denote a delay in an eligibility decision, enter “DECISION CCYYMMDD” for the Note and click **Add**. *(CCYYMMDD is the date on the eligibility determination notice from the county department of job and family services.)*

Ex. If there was a delay in eligibility and eligibility was determined April 1, 2024, the Note would need to display “DECISION 20240401”.

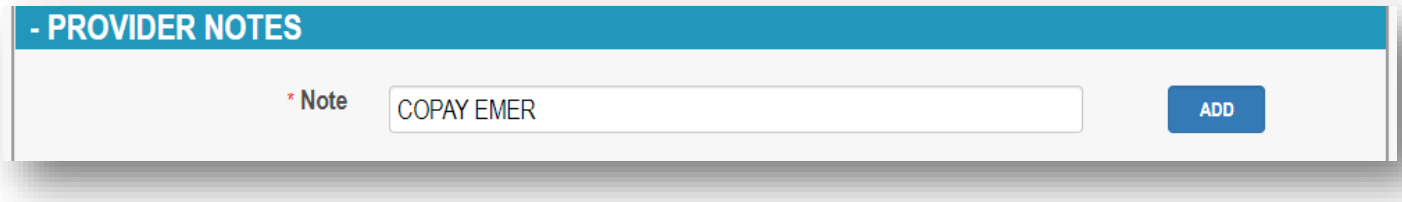


Medicaid Co-Payment Exclusion

Below are instructions for notes to list when submitting a claim when a Medicaid co-payment exclusion applies.

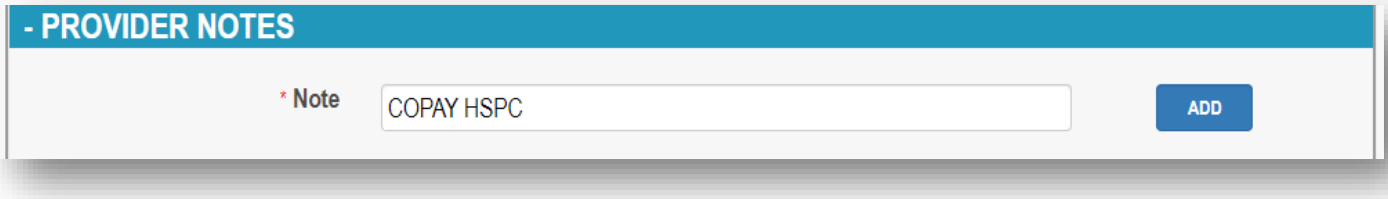
Emergency Exclusion

To denote a Medicaid co-payment emergency exclusion, enter “COPAY EMER” for the Note and click **Add**. (There must be a space after the word 'COPAY'.)



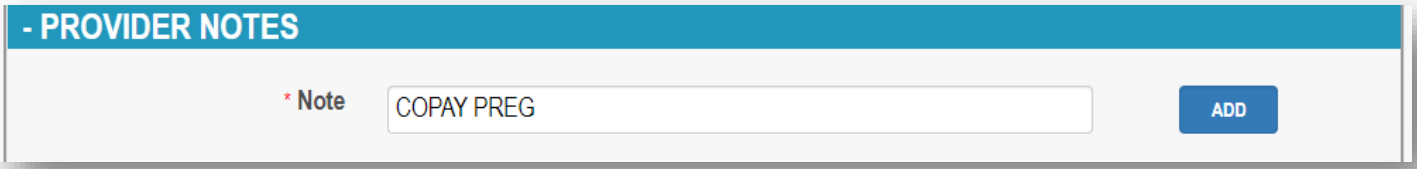
Hospice Exclusion

To denote a Medicaid co-payment hospice exclusion, enter “COPAY HSPC” for the Note and click **Add**. (There must be a space after the word 'COPAY'.)



Pregnancy Exclusion

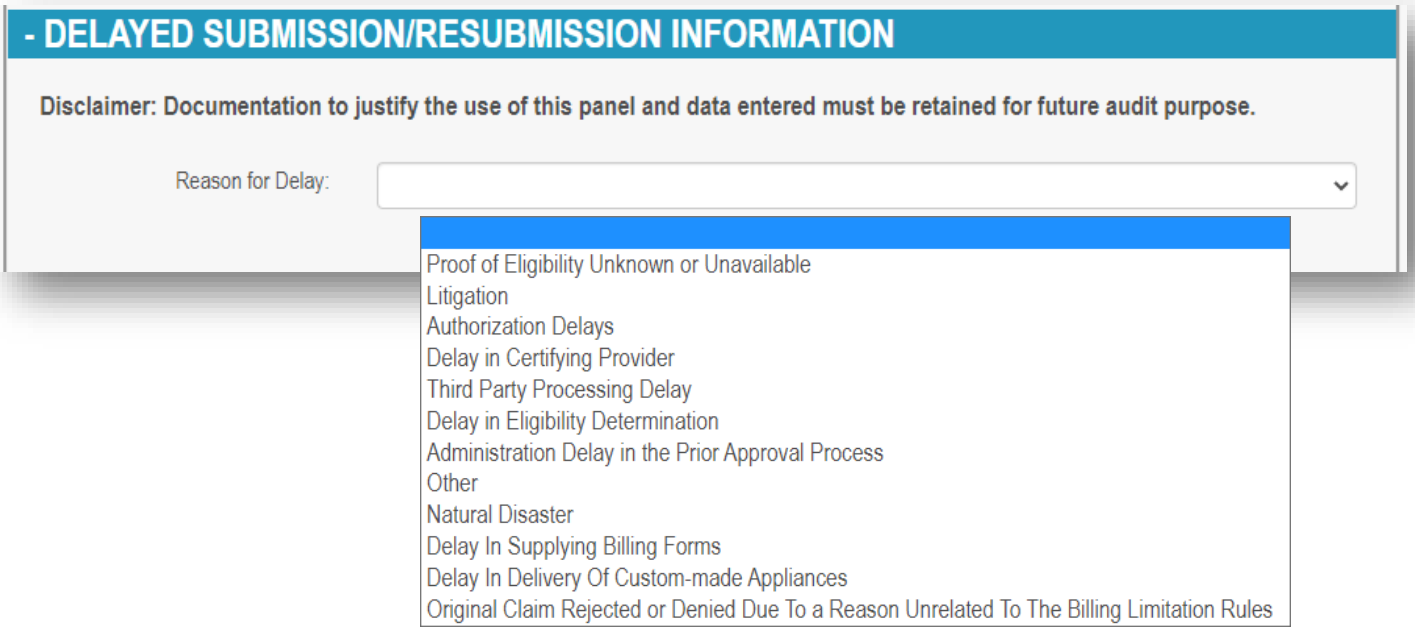
To denote a Medicaid co-payment pregnancy exclusion, enter “COPAY PREG” for the Note and click **Add**. (There must be a space after the word 'COPAY'.)



Delayed Submission/Resubmission Information

Indicate a reason for a delayed submission or resubmission for the claim.

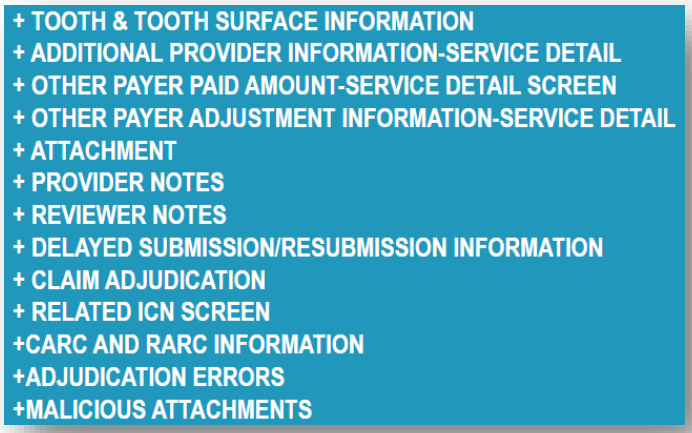
The reasons listed are from the Electronic Data Interchange (EDI) and may relate to delayed in Managed Care claim submissions. Fee-for-service claims usually indicate delays in the provider notes.



Returned Data Panels

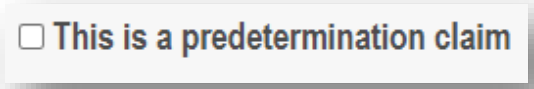
During the claim submission process, no data is entered in the following sections, but upon a claim review and return, data will populate in these sections and can be reviewed.

- Reviewer Notes
- Claim Adjudication
- Related ICN (Internal Control Number) Screen
- CARC and RARC Information
- Adjudication Errors
- Malicious Attachments



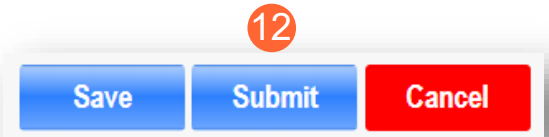
Pre-Determination Claim Checkbox

Select the checkbox at the bottom of the page if the claim being submitted is a predetermination claim.



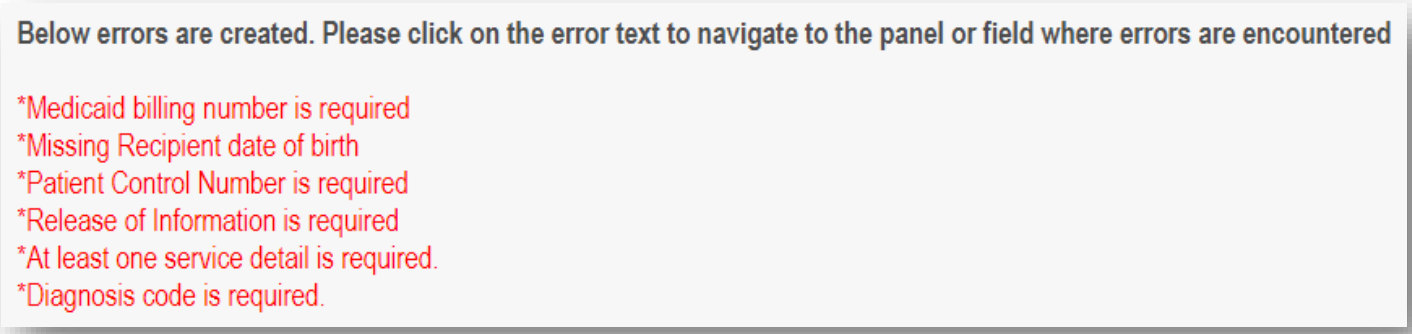
Submit the Claim

Step 12: When all data has been entered, click **Submit** at the bottom of the page.



Note: If there are any entry errors in PNM preventing submission, error messages will display at the top of the page.

Click on the error message text and PNM will direct you to the section that needs to be reviewed/corrected.

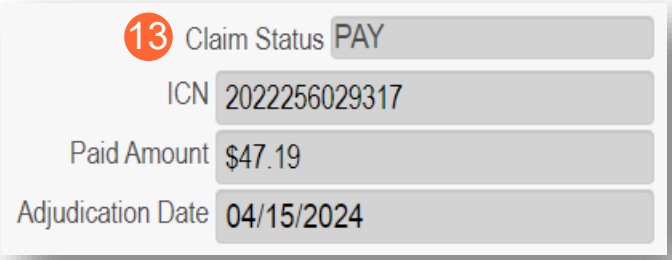


Note: Messages that appear in pop-up windows are from the Fiscal Intermediary (FI). Error messages or informational messages may be received from FI.

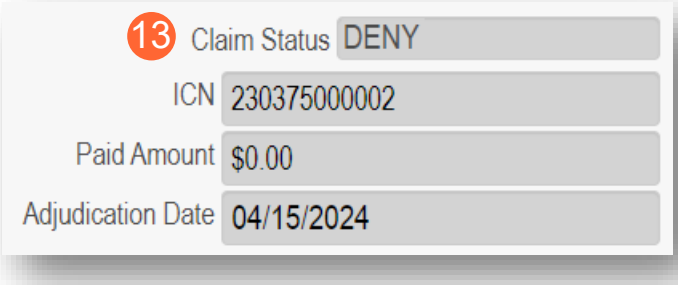
If error messages are received, please work to correct, or reach out to the contact information provided for assistance.

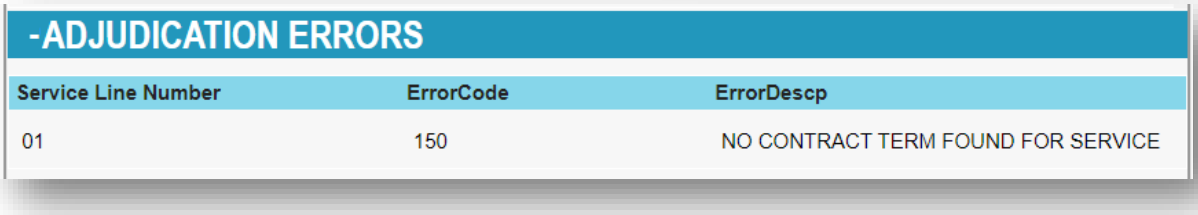
Step 13: If no errors are present, verify the submission was successful by reviewing the claim status at the top of the page.

- If the claim displays a status other than a 'Pending Submission' status, the transaction was successfully completed.



- Claim adjudication may happen instantly. If a claim receives a 'Deny' status, review the Adjudication Errors section/panel or the CARC and RARC Information section/panel to obtain additional details.





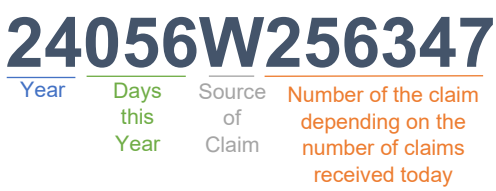
Fiscal Intermediary (FI) ICN Logic

After the claim is submitted, an Internal Control Number (ICN) will be created for the claim. Below outlines the process for how the ICN is created for the claim.

Date Format	Source
YYJJJP	SPBM incoming pharmacy claims
YYJJJX	FI incoming CHC FFS pharmacy claims
YYJJJM	FI MyCare and Managed Care run-out incoming Encounter pharmacy
YYJJJE	FI FFS incoming EDI claims
YYJJJW	FI FFS incoming web portal claims
YYJJJB	FFS incoming Partner State Agency claims
EYYJJJ	FI incoming encounter claim
MYYJJJ	FI Managed Care incoming routed claims

Example:

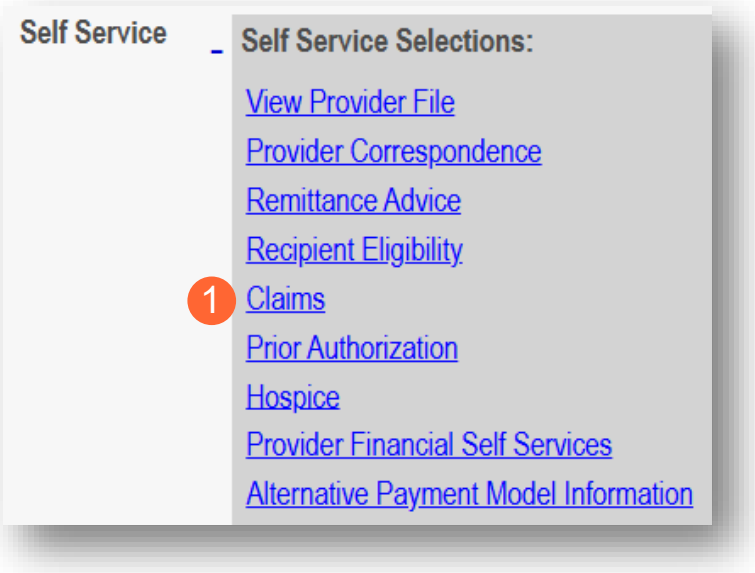
If today were 2/25/2024 and the claim received came from the Provider Portal, the ICN would be the following:



Attachments to a Previously Submitted Claim

This process allows for the upload of attachments to previously submitted claims in Adjudicated, Deny, Open, Pay, or Pend status.

Step 1: Click the 'Claims' hyperlink.

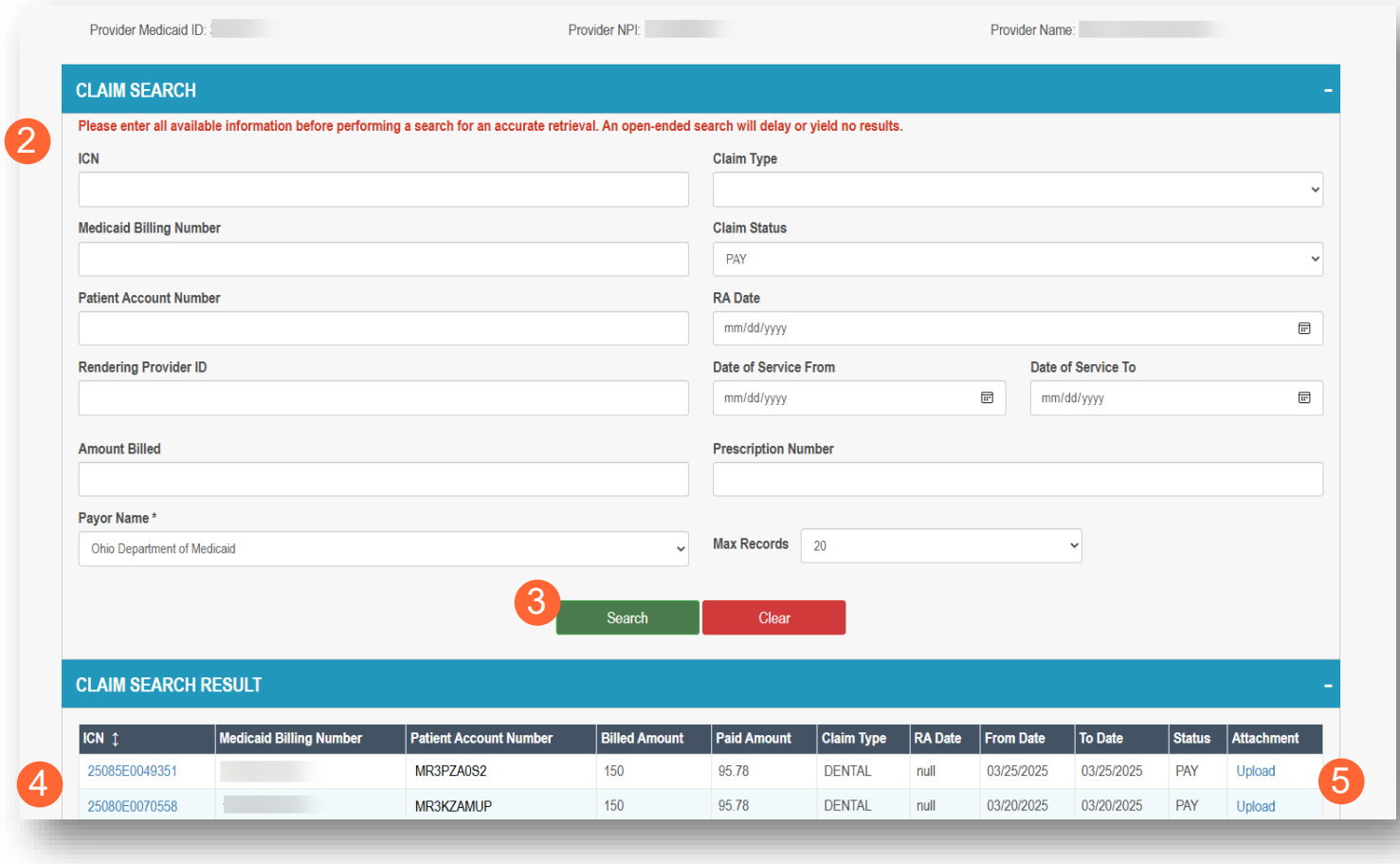


Step 2: The Claims search panel will appear. Enter any or all the following information:

- Internal Control Number—ICN *(tracking number assigned to the claim)*
- Medicaid Billing Number
- Patient Account Number
- Rendering Provider ID
- Amount Billed
- Payor Name *(required field)*
  - Ohio Department of Medicaid
- Claim Type: Professional
- **Claims Status**
  - **Adjudicated**
  - **Pay**
  - **Open**
  - **Deny**
  - **Pend**
- Remittance Advice (RA) Date
- Date of Service From *(does not allow future date)*
- Date of Service To *(does not allow future date)*
- Prescription Number

Step 3: When the criteria is entered, click **Search**.

Note: To clear search data and begin a new search, click **Clear**.

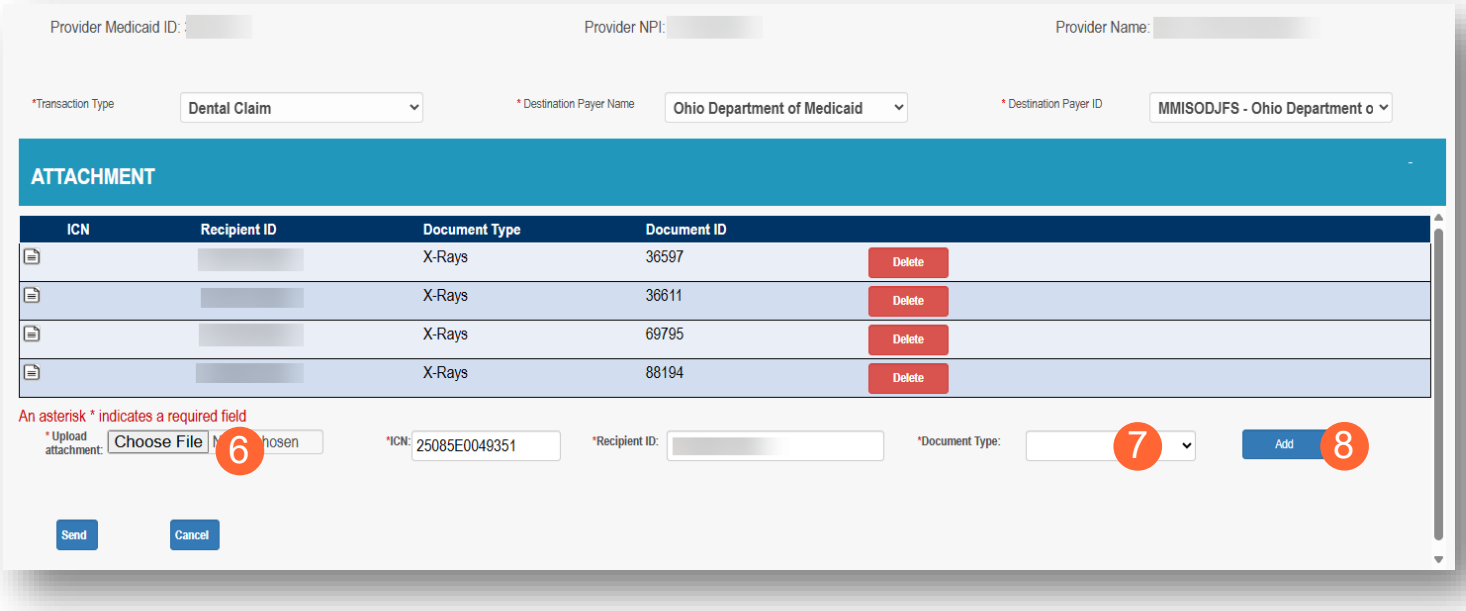


Step 4: View the ICN claim search results displayed at the bottom of the page.

Note: For claims in Adjudicated, Deny, Open, Pay, or Pend status, the 'Upload' hyperlink appears in the Attachment column.

Step 5: Identify which ICN needs an attachment and click its corresponding '**Upload**' hyperlink.

Note: Any attachments already listed in the claim will appear and can remain or be deleted by clicking the red Delete button.



Step 6: Click 'Choose File' in the **Upload Attachment** area, locate the file on your computer.

Step 7: Select **Document Type** from the drop-down menu.

Note: The ICN and Recipient ID fields are non-editable.

Step 8: Click the blue **Add** button.

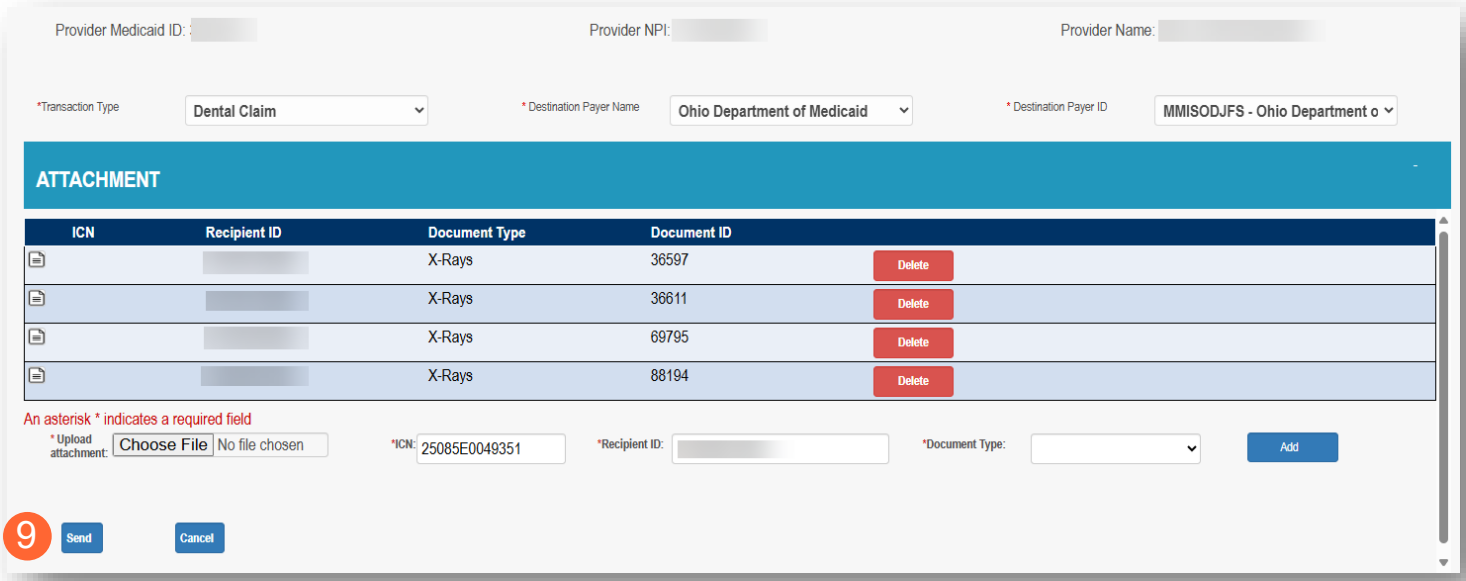
Note: Document attachments and uploads are subject to certain constraints:

- A maximum of 10 documents can be sent to the Destination Payer at a time.
- The maximum file size per document upload is 10 MB.
- The following document types are acceptable:
  - Word: doc, docx
  - Excel: xls, xlsx, xlsm, xlsx
  - Image: mdi, jpe, jpeg, jpg, png, gif, bmp, tif, tiff
  - PDF: pdf
  - Other: pi, ec, zip, csv, acrbak, msg

Step 9: After verifying the attachment details, click the '**Send**' button to submit the files for further processing.

- The added attachment appears on a list. Repeat the process above to add other attachments.

Note: If the user clicks 'Cancel', no attachments will be sent and will be redirected to the 'Search' page.

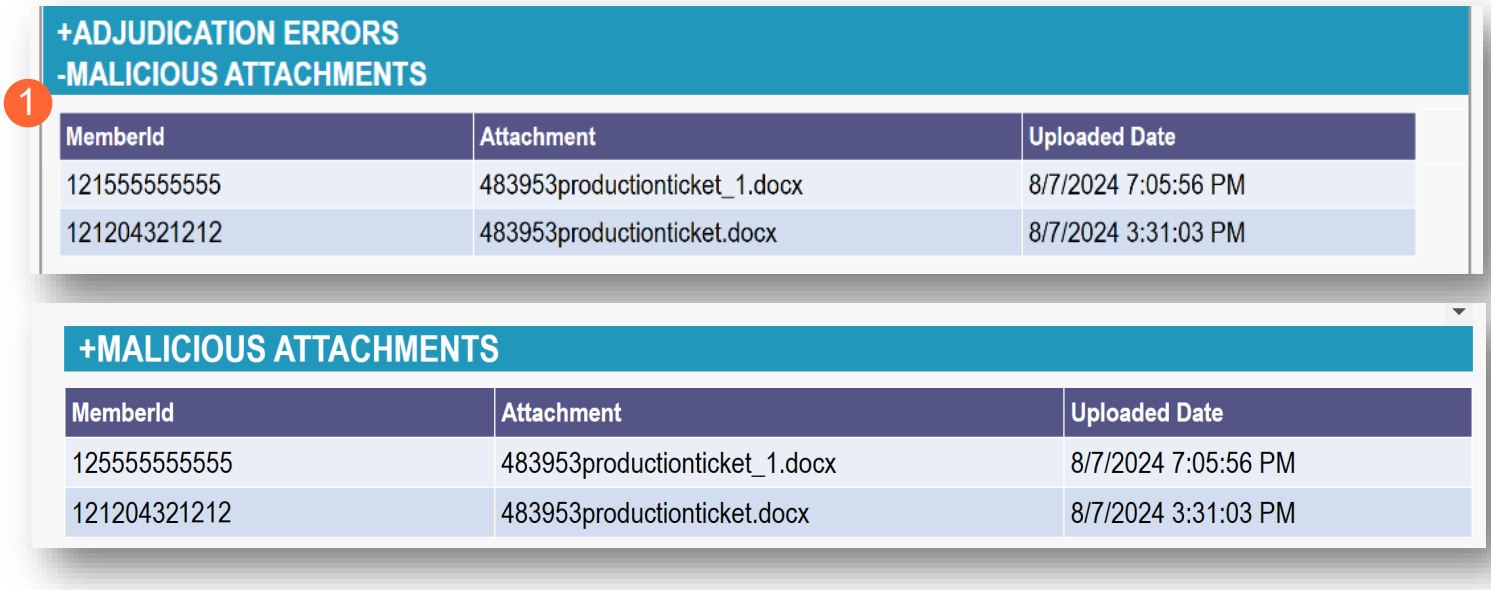


Malicious Attachments

If a document uploaded during claim submission is found to contain damaging macros, it will be flagged as a 'malicious attachment'. Any flagged malicious attachments will be listed on the claim submission page in the 'Malicious Attachments' section.

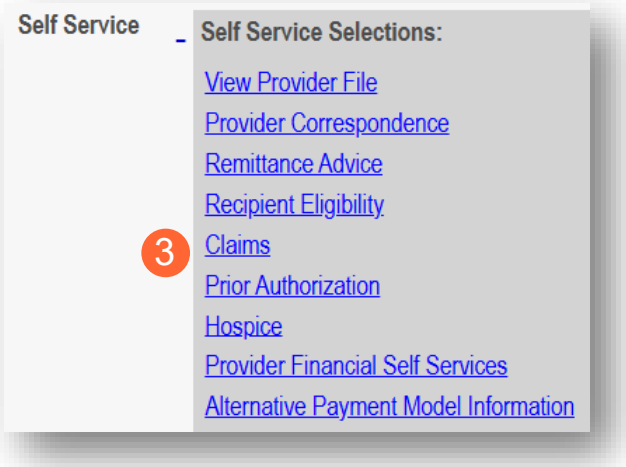
Note: Notifications regarding malicious attachments are not sent from PNM.

Step 1: Review the malicious attachments list on the claim submission page in the 'Malicious Attachment' section.



Step 2: Use virus scanning software on your computer to review the document for any malicious data.

Step 3: Upload a 'clean' version of the document by clicking the 'Claims' hyperlink.



Step 4: The Claims search panel will appear. Enter any or all the following information:

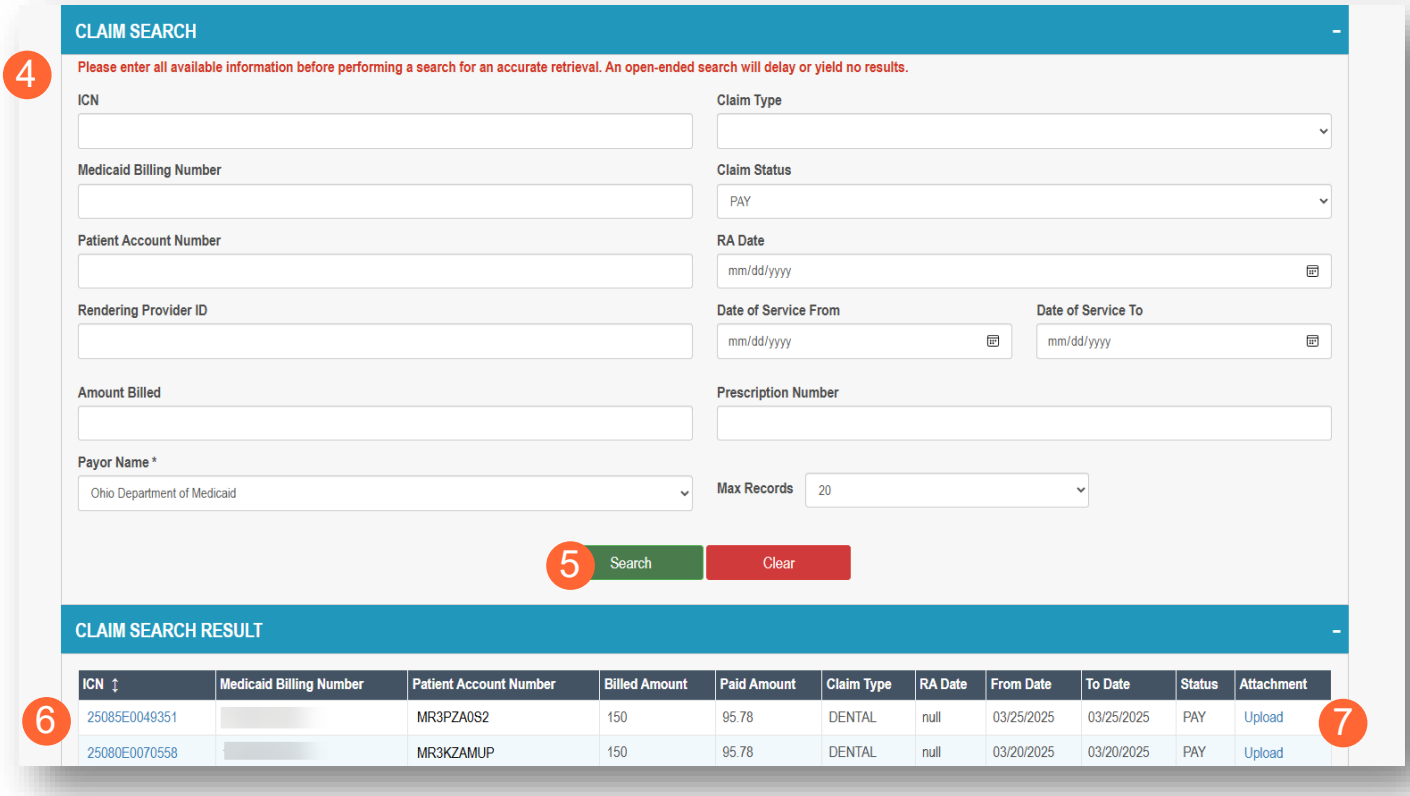
- Internal Control Number—ICN *(tracking number assigned to the claim)*
- Medicaid Billing Number
- Patient Account Number
- Rendering Provider ID
- Amount Billed
- Payor Name *(required field)*
  - Ohio Department of Medicaid
- Claim Type: Professional
- Claims Status
  - Adjudicated
  - Pay
  - Open
  - Deny
  - Pend
- Remittance Advice (RA) Date
- Date of Service From *(does not allow future date)*
- Date of Service To *(does not allow future date)*
- Prescription Number

Step 5: When the criteria is entered, click **Search**.

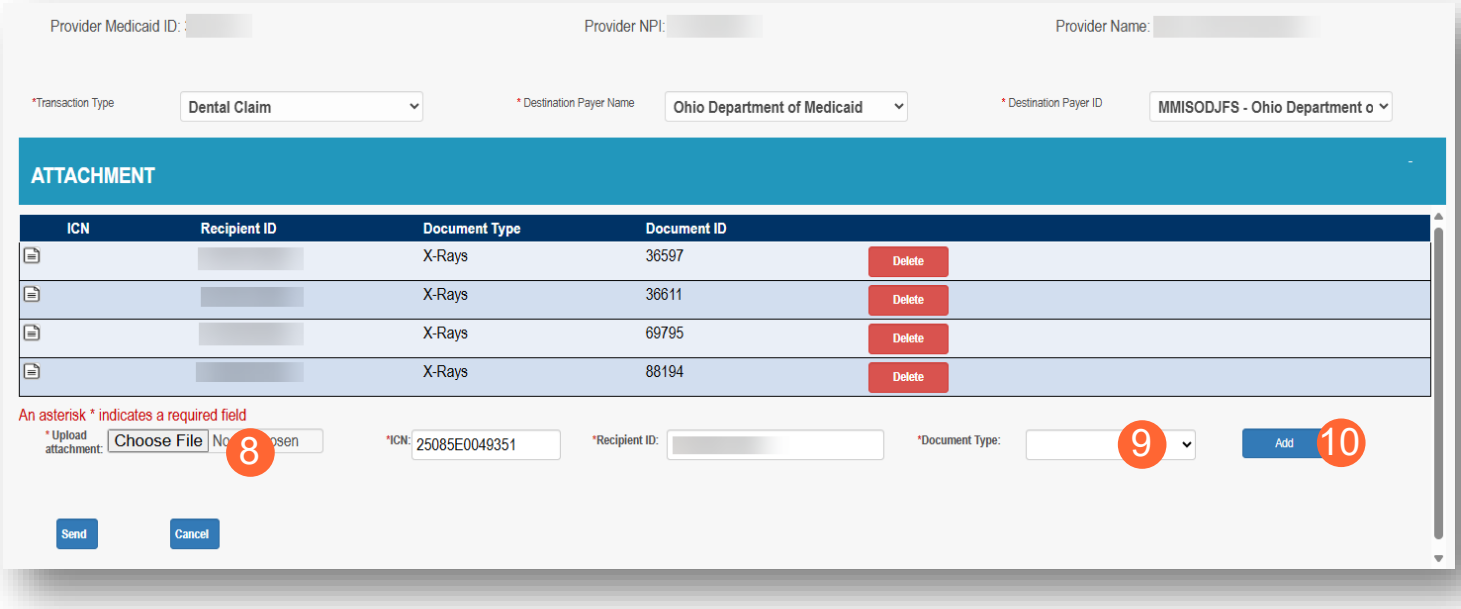
Note: To clear search data and begin a new search, click **Clear**.

Step 6: View the ICN search results displayed at the bottom of the page. For claims in Adjudicated, Deny, Open, Pay, or Pend status, the 'Upload' hyperlink appears in the **Attachment** column.

Step 7: Identify which ICN needs an attachment and click its corresponding '**Upload**' hyperlink.



Note: Any attachments already listed in the claim will appear and can remain or be deleted by clicking the red Delete button.



Step 8: Click 'Choose File' in the **Upload Attachment** area, locate the file on your computer.

Step 9: Select **Document Type** from the drop-down menu.

Note: Recipient ID is the recipient's Medicaid number.

Note: The ICN and Recipient ID fields are non-editable.

Step 10: Click the blue **Add** button.

Note: Document attachments and uploads are subject to certain constraints:

- A maximum of 10 documents can be sent to the Destination Payer at a time.
- The maximum file size per document upload is 10 MB.
- The following document types are acceptable:
  - Word: doc, docx
  - Excel: xls, xlsx, xlsm, xlsx
  - Image: mdi, jpe, jpeg, jpg, png, gif, bmp, tif, tiff
  - PDF: pdf
  - Other: pi, ec, zip, csv, acrbak, msg

Step 11: After verifying the attachment details, click the '**Send**' button to submit the files for further processing.

- The added attachment appears on a list. Repeat the process above to add other attachments.

Note: If the user clicks 'Cancel', no attachments will be sent and will be redirected to the 'Search' page.