PNM Billing Guide for Institutional Claims

For full step-by-step guidance of how to enter an institutional claim in the Provider Network Management (PNM) system, access the Institutional Claims User Guide by selecting the 'Learning' page from the PNM homepage/dashboard.

Fields marked with an asterisk (*) require an entry. Sections/panels marked with an asterisk, indicate that a field within that section/panel requires entry. Sections/panels that are situational, may not display an asterisk (*) but can be expanded by clicking (+) in the section/panel header. Fields with an asterisk (*) listed under a section/panel without an asterisk, are only required if data is entered within that section/panel.

Information entered in a field must be 'recorded' before the PNM system can accept and use it. (This is a similar concept to clicking <Enter> after entering information in a cell on a spreadsheet for the data to be accepted). After typing in information in a field, and clicking outside of that field, the data entered will be 'locked' into that field.

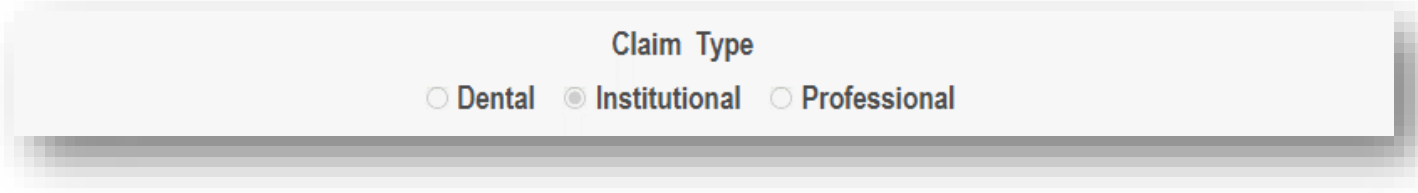
Certain fields have a "Search" hyperlink located next to this. This search function allows the user to look up information if they do not know it at the time of submission. Some examples of this include provider NPIs and diagnosis codes, among others.

Within certain sections/panels, there is an 'Add' button that needs to be selected to add new information. This occurs in sections/panels where multiple lines of data can be entered. Select a display row and click "Edit" to update/change information, "Copy" to copy the line details or "Delete" to remove the information for an existing line item.

Once all data points for the claim submission are entered, the "Submit" button needs to be selected. If there is missing information in any section or panel, PNM displays error messages in red text at the top of the page. If there are errors in the adjudication process with the Fiscal Intermediary (FI), the error messages display in a pop-up message.

After a claim is submitted, information relating to the claim including the Claim Status, ICN, Paid Amount, and Adjudication date appear in an area at the top-right of the claim submission page in PNM.

Ohio Department of Medicaid



*PAYER INFORMATION

*Destination Payer Name

<Blank> (default)
Ohio Department of Medicaid

- Select the payer entity to receive the claim.

*Destination Payer ID

<Blank> (default)
MMISODJFS – Ohio Department of Medicaid

- Select the Destination Payer identification code.
- NOTE: Some Destination Payers only have a single ID. When those Destination Payers are selected, PNM will automatically list the ID in this field.

*Destination Payer Responsibility Sequence

<Blank> (default)
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

- Select a code to indicate the Destination Payer's level of responsibility for the payment of the claim being submitted.

Once these 3 selections are made, the rest of the claim submission page will populate with the panel/sections listed below.

*RECIPIENT INFORMATION

***Medicaid Billing Number**

- Enter the 12-digit Billing Number from the recipient's medical card or the online eligibility system.
- NOTE: For a recipient who is a Qualified Medicare Beneficiary (QMB) on the date(s) of service, Medicare coverage is primary, and the Medicaid benefit is limited to Medicare cost-sharing (payment of coinsurance, copays, and deductibles.)

***Date of Birth**

- Enter the Medicaid recipient's date of birth in the following format (MM/DD/YYYY).
- The date of birth must match the birth date on file for the recipient's Medicaid Billing Number entered in the previous field. Make sure that both the recipient's Medicaid Billing Number and date of birth are entered correctly; if they do not correspond, you will not be able to proceed.

Last Name *(populated automatically from FI)*

First Name *(populated automatically from FI)*

Middle Name *(populated automatically from FI if one is part of the recipient's record)*

***Patient Control Number**

- Enter the patient control number/account number assigned by the provider to identify the individual. If a control/account number is not available, enter '0' in this field.

Medical Record Number

- Enter a medical record number assigned by the provider, if applicable. This optional field is meant to assist providers in maintaining medical records.

Gender *(populated automatically from FI)*

Address Line 1 *(populated automatically from FI)*

City *(populated automatically from FI)*

State *(populated automatically from FI)*

Zip Code *(populated automatically from FI)*

*SERVICE INFORMATION

*Type of Bill

- Enter (or use the [Search] function to select) the code indicating the specific type of bill. The code must be four characters long; use a leading zero where needed. The characters represent the kind of facility, service (inpatient or outpatient), and frequency.
- NOTE: For inpatient hospital Medicare Part B crossover claims, only type of bill 012X will be accepted. For inpatient hospital stays paid under Medicare Part B (where the patient does not have Medicare Part A or it exhausts before admission), the claim type assigned will be outpatient cross over. For nursing facility (NF) claims, type of bill 021X will be accepted. For Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs-IID) claims, type of bill 061X will be accepted. The Type of Bill code set is definite by the National Uniform Billing Committee (NUBC).

*Release of Information

<Blank> (default)
Yes
No

- This field indicates whether the provider has the authorization for the release of medical data.

*From Date

- Enter the From Date of Service (the date cannot be greater than today's date).

*To Date

- Enter the To Date of Service (must be greater than the 'From Date' but not a future date).

*Patient Status

<Blank> (default)
1 – Discharged to Home or Self Care (Routine Discharge)
2 – Discharged/Transferred to a Short-Term General Hospital for Inpatient Care
3 – Discharged/Transferred to Skilled Nursing Facility (SNF) with Medicare Certification in Anticipation of Skilled Care
4 – Discharged/Transferred to a Facility That Provides Custodial or Supportive Care
5 – Discharged/Transferred to a Designated Cancer Center or Children's Hospital

6 – Discharged/Transferred to Home under Care of an Organized Home Health Service Organization in Anticipation of Covered Skilled Care
7 – Left Against Medical Advice or Discontinued Care
9 – Admitted as an Inpatient to This Hospital
20 – Expired
21 – Discharged/Transferred to Court/Law Enforcement
30 – Still Patient
40 – Expired at Home
41 – Expired in a Medical Facility (E.G. Hospital, SNF, ICF, or Free Standing Hospice)
42 – Expired - Place Unknown
43 – Discharged/Transferred to a Federal Health Care Facility
50 – Hospice – Home
51 – Hospice - Medical Facility (Certified) Providing Hospice Level of Care
61 – Discharged/Transferred to a Hospital-Based Medicare Approved Swing Bed
62 – Discharged/Transferred to an Inpatient Rehabilitation Facility (IRF) Including Rehabilitation Distinct Part Units of a Hospital
63 – Discharged/Transferred to a Medicare Certified Long Term Care Hospital (LTCH)
64 – Discharged/Transferred to a Nursing Facility Certified under Medicaid But not Certified under Medicare
65 – Discharged/Transferred to a Psychiatric Hospital or Psychiatric Distinct Part Unit of a Hospital
66 – Discharged/Transferred to a Critical Access Hospital (CAH)
69 – Discharged/Transferred to a Designated Disaster Alternative Care Site
70 – Discharged/Transferred to Another Type of Health Care Institution not Defined Elsewhere in This Code List
81 – Discharged to Home or Self Care with a Planned Acute Care Hospital Inpatient Readmission
82 – Discharged/Transferred to a Short Term General Hospital for Inpatient Care with a Planned Acute Care Hospital Inpatient Readmission
83 – Discharged/Transferred to a Skilled Nursing Facility (SNF) with Medicare Certification with a Planned Acute Care Hospital Inpatient Readmission

84 – Discharged/Transferred to a Facility That Provides Custodial or Supportive Care with a Planned Acute Care Hospital Inpatient Readmission
85 – Discharged/Transferred to a Designated Cancer Center or Children's Hospital with a Planned Acute Care Hospital Inpatient Readmission
86 – Discharged/Transf to Home under Care of Organized HH Srvc Organization in Anticipation of Covrd Skilled Care w/ Planned Acute Care Hosp Inptnt Readmission
87 – Discharged/Transferred to Court/Law Enforcement with a Planned Acute Care Hospital Inpatient Readmission
88 – Discharged/Transferred to a Federal Health Care Facility with a Planned Acute Care Hospital Inpatient Readmission
89 – Discharged/Transferred to a Hospital Based Medicare Approved Swing Bed with a Planned Acute Care Hospital Inpatient Readmission
90 – Discharged/Transf to Inpatient Rehab Facility (IRF) Include Rehab Distinct Part Units of Hospital W/ Planned Acute Care Hospital Inpatient Readmission
91 – Discharged/Transferred to a Medicare Certified Long Term Care Hospital (LTCH) with a Planned Acute Care Hospital Inpatient Readmission
92 – Discharged/Transferred to Nursing Facility Certified under MCAID But not Certified under Medicare W/ Planned Acute Care Hospital Inpatient Readmission
93 – Discharged/Transferred to a Psychiatric Hospital or Psychiatric Distinct Part Unit of Hospital W/ A Planned Acute Care Hospital Inpatient Readmission
94 – Discharged/Transferred to a Critical Access Hospital (CAH) with a Planned Acute Care Hospital Inpatient Readmission
95 – Discharged/Transferred to Another Type of Health Care Instit not Defined Elsewhere in Code List W/ a Planned Acute Care Hospital Inpatient Readmission

- Select a code to indicate the disposition or discharge status of the patent at the end of the period covered by this claim. (The Patient Status code is defined by the NUBC).

Admission Date and Hour

- For inpatient services, enter the date of admission (in MM/DD/YYY format).
    - This is required when Type of Bill is 011X, 012X,018X, 021X, 022X, 028X, 041X, 065X, 066X, 086X.
- Enter the time/hour when the person was admitted for care. A 4-digit number (0925).

Discharge Hour

- Enter the time/hour when the person was discharged. Example: (0000 for midnight).

- This is required when Type of Bill is 0111, 0114, 0121, 0124, 0181, 0184, 0211, 0214, 0221, 0224, 0281, 0284, 0411, 0414, 0651, 0654, 0661, 0664, 0861 and 0864.

***Admission type**

<Blank> (default)
Emergency
Urgent
Elective
Newborn
Trauma
Information Not Available

- Select the option to indicate the priority of this admission or visit. (The Admission Type code set is defined by the NUBC.)
- NOTE: The use of 'Information Not Available' will cause the denial of hospital claims.

***Admit Source**

<Blank> (default)
1 – Non-Health Care Facility Point of Origin
2 – Clinic or Physician's Office
4 – Transfer from a Hospital *(Different Facility)*
5 – Transfer from a SNF *(Skilled Nursing Facility)*, ICF *(Intermediate Care Facility)*, ALF *(Assisted Living Facility)* or NF *(Other Nursing Facility)*
**5 – Born Inside Hospital*
6 – Transfer from Another Health Care Facility
**6 – Born Outside Hospital*
8 – Court/Law Enforcement
9 – Information not Available
D – Transfer from one Distinct Unit of the Hospital to Another Distinct Unit of the Same Hospital Resulting in a Separate Claim to the Payer
E – Transfer from Ambulatory Surgery Center
F – Transfer from a Hospice Facility

G – Transfer from a Designated Disaster Alternate Care Site

- Select the code to indicate the point of patient origin for the admission or visit. (The Admit Source code set is defined by the NUBC.)
- Admit Source is required when the Type of Bill is 011X or 013X.
- ***Options display only when "Newborn" is selected as the 'Admission Type.'***

Patient Paid Amount

- For hospitals, enter the amount of patient liability or share of cost, if applicable. (An amount less than $0.00 is not allowed.)
    - NOTE: Do NOT enter the Medicaid emergency room co-payment amount here.
- For Nursing Facilities (NFs) and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs-IID), enter the amount of patient liability or share of cost.

Submitted DRG

- Enter the Diagnosis Related Code (DRG) (max 4 digits) reported by the provider.

Final DRG *(populated automatically from payer after claim is processed)*

ACCIDENT INFORMATION

Accident State

<Blank> (default)
(50 states and District of Columbia, listed individually)

- If the service is related to an automobile accident, identify the state or territory in which the accident occurred.

PRIOR AUTHORIZATION & REFERRAL INFORMATION

Prior Authorization Number

- Complete this field only if prior authorization is required and has been approved by ODM for a service listed on the claim. Use the ODM prior authorization number assigned for the service.

Referral Number

- Complete this field only if there is a provider referral number related to this claim.

ATTENDING PHYSICIAN INFORMATION

***NPI**

- Enter (or use the [Search] function to select) the NPI of the attending physician. An NPI is the only acceptable identifier in this field.
- NOTE: This section is required when the Type of Bill is 011X or 013X.

Medicaid ID *(populated automatically)*

Last Name *(populated automatically)*

First Name *(populated automatically)*

REFERRING PROVIDER INFORMATION

***Referring Provider NPI**

- If a physician authorized a referral, enter (or use the [Search] function to select) the NPI of the referring provider. An NPI is the only acceptable identifier in this field.

Medicaid ID *(populated automatically)*

Last Name *(populated automatically)*

First Name *(populated automatically)*

***Primary Care Provider NPI**

- This field will be grayed out until a Referring Provider is entered. If a physician or dentist is the primary care provider, enter (or use the [Search] function to select) the NPI of the primary care provider. An NPI is the only acceptable identifier in this field.

Medicaid ID *(populated automatically)*

Last Name *(populated automatically)*

First Name *(populated automatically)*

RENDERING PROVIDER

***NPI**

- If a physician rendered care, enter (or use the [Search] function to select) the NPI of the rendering provider. An NPI is the only acceptable identifier in this field.

Medicaid ID *(populated automatically)*

Last Name *(populated automatically)*

First Name *(populated automatically)*

SERVICE FACILITY LOCATION INFORMATION

***NPI**

- If services were rendered at a facility, enter (or use the [Search] function to select) the NPI of the facility. An NPI is the only acceptable identifier in this field.

Medicaid ID *(populated automatically)*

Name *(populated automatically)*

Address1 *(populated automatically)*

Address2 *(populated automatically)*

City *(populated automatically)*

State *(populated automatically)*

Zip *(populated automatically)*

OTHER OPERATING PHYSICIAN INFORMATION

***NPI**

- If a physician other than the one listed under the 'Operating Physician Information' section/panel, assisted in the performance of a surgical procedure, enter (or use the [Search] function to select) the NPI of the physician. An NPI is the only acceptable identifier in this field.

Medicaid ID *(populated automatically)*

Last Name *(populated automatically)*

First Name *(populated automatically)*

OPERATING PHYSICIAN INFORMATION

***NPI**

- If a physician performed a surgical procedure, enter (or use the [Search] function to select) the NPI of the physician. An NPI is the only acceptable identifier in this field.

Medicaid ID *(populated automatically)*

Last Name *(populated automatically)*

First Name *(populated automatically)*

OTHER PAYER INFORMATION

After entering data in this section/panel, press the 'Add' button to specify that another source, such as commercial insurance or Medicare, is the primary payer for the recipient.

NOTE: Information for each payer (other than Medicaid) must be entered separately. For example, if a recipient has both Medicare and commercial insurance, then create a different entry for each carrier.

***Other Payer Name**

- Enter the name of the payer that adjudicated the claim prior to submission.

***Health Plan ID**

- Enter the Health Plan ID of the other payer (Medicare plan or insurance company).
  - The Health Plan ID may be obtained from the individual's Medicare or private insurance card, an explanation of benefits (EOB) or electronic remittance advice (ERA) issued by the payer, or the payer itself. Each payer defines its own Health Plan ID. ODM does not maintain a list of Health Plan IDs.

***Claim Filing Indicator**

<Blank> (default)
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

- Never select “MEDICAID’. (It appears on this list because it is included in the 5010 version of the 837 transaction.)
- For Medicare Part A, select ‘MA – Medicare Part A.’
- For Medicare Part B, select ‘MB – Medicare Part B.’
- For a Medicare Advantage Plan, also known as Medicare Part C, select ‘16 – Health Maintenance Organization (HMO) Medicare Risk.’
- For third-party insurance other than Medicare, Select ‘CI – Commercial Insurance Co.’

***Payer Responsibility Sequence**

<Blank> (default)
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

- Select the payer's claim adjudication order. The value selected at the top of the claim submission page (Destination Payer Responsibility Sequence) will not display because it is already in use.

***Subscriber Number**

- Enter the cardholder's subscriber number assigned by the other payer.

Policy Number

- Enter the unique ID number the other payer uses to verify coverage and arrange payment for services.

- NOTE: If PNM requires information in this field, but you do not have a Policy Number for the other payer, enter the same number listed under Subscriber Number (the Medicaid Billing Number).

Group Name

- Enter the group name the other payer uses to identify the specific benefits associated to the cardholder's employer's plan.

- NOTE: If you do not have a group name for the other payer, this field can be left blank, if a number is listed in the Policy Number field.

Insurance Type Code

<Blank> (default)
Medicare Secondary Working Aged Beneficiary or Spouse with Employer Group Health Plan
Medicare Secondary End-Stage Renal Disease Beneficiary in the Mandated Coordination Period with an Employer s Group Health Plan
Medicare Secondary, No-fault Insurance including Auto is Primary
Medicare Secondary Worker's Compensation
Medicare Secondary Public Health Service (PHS)or Other Federal Agency
Medicare Secondary Black Lung
Medicare Secondary Veteran’s Administration
Medicare Secondary Disabled Beneficiary Under Age 65 with Large Group Health Plan (LGHP)
Medicare Secondary, Other Liability Insurance is Primary

- Select the proper code to identify the type of insurance.

*Patient Relationship To Subscriber

<Blank> (default)
Spouse
Self
Child
Employee
Unknown
Organ Donor
Cadaver Donor
Life Partner
Other Relationship

- If the policy holder or subscriber is the recipient, select ‘SELF’.

***Subscribers First Name**

- If the 'Patient Relationship to Subscriber' is specified as 'SELF", this field will be automatically populated. Otherwise, enter the information.

***Subscriber Last Name**

- If the 'Patient Relationship to Subscriber' is specified as 'SELF", this field will be automatically populated. Otherwise, enter the information.

Subscriber's Middle Name

- If the 'Patient Relationship to Subscriber' is specified as 'SELF", this field will be automatically populated. Otherwise, enter the information.

Subscriber's Address Line 1

- Enter the subscriber's address.

Subscriber's Address Line 2

- Enter the subscriber's address line 2.

Subscriber's City

- Enter the subscriber's city.

Subscriber's State

- Enter the subscriber's state.

Subscriber's Zip

- Enter the subscriber's zip.

Claim Adjudication Level

<Blank> (default)
Header
Detail

- Select the indicator to identify the other paid claim level.
- PNM grays out this field if the other payer responsibility sequence is greater than the destination payer responsibility sequence.

Claim Number

- Enter the claim number assigned by the other payer.

Paid Date

- Enter the claim adjudication date by the other payer using the MM/DD/YYYY format.

Paid Amount

- Enter the paid amount by the other payer.

Non Covered Amount

- Enter the COB Total Non-Covered Amount.

*DIAGNOSIS CODES

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

After entering data in this section/panel, press the 'Add' button to add diagnosis codes. A maximum of 25 diagnosis codes can be entered.

*Sequence

<Blank> (default)
Principal
Admitting
Other
Patient Reason for Visit
External Cause of Injury

- Select the appropriate indication. (This diagnosis sequence code set is defined by the NUBC.)
- Of the maximum of 25 codes added, the following rules for each sequence apply:
  - Principal *(can use only once)*
  - Admitting *(can use only once)*
  - Other *(can use up to 25 times)*
  - Patient Reason for Visit *(can use up to 4 times)*
  - External Cause of Injury *(can use up to 13 times)*

*Diagnosis Code

- Enter (or use the [Search] function to select) the diagnosis code that corresponds to the selected sequence code. Omit the decimal point.

*ICD Version

<Blank> (default)
ICD 10
ICD 9

- Select the ICD version of the diagnosis code.

***Present on Admission**

<Blank> (default)
Yes
No
Unknown
Not Applicable

- Select the appropriate indication. (The Present on Admission code set is defined by the NUBC.)

Diagnosis Description *(populated automatically after a diagnosis code is entered)*

OUTPATIENT ADJUDICATION INFORMATION

Reimbursement Rate (Percentage as decimal)

- Enter the reimbursement rate as a decimal.

HCPCS Payable Amount

- Enter the HCPCS payable amount.

Claim Remark Code (MOA 03)

- Enter the claim remark code.

Claim Remark Code (MOA 04)

- Enter the claim remark code.

INPATIENT ADJUDICATION INFORMATION

Covered Days or Visits Count (MIA01)

- Enter the number of days of Medicaid eligibility, or coverage, for the dates of service.

Claim DRG Amount (MIA04)

- Enter the Diagnosis Related Code (DRG) amount.

Claim Remark Code (MOA05)

- Enter the claim remark code.

Claim Remark Code (MOA20)

- Enter the claim remark code.

HEADER OTHER PAYER ADJUSTMENT INFORMATION

If another payer has been entered in the 'Other Payer Information' panel, the claim adjudication level is 'Header', and the other payer responsibility sequence is prior to the destination payer, Health Plan ID will be available in the drop-down menu.

After entering data in this section/panel, press the 'Add' button to indicate adjustments at the header level. Each payer can have up to 30 adjustment lines.

*Health Plan ID

- Select the Health Plan ID of the other payer.

*Adjustment Group

<Blank> (default)
CO – Contractual Obligations
CR – Correction and Reversals
OA – Other Adjustments
PI – Payer Initiated Reductions
PR – Patient Responsibility

- Select the Claim Adjustment Segment (CAS) Group Code received from the carrier on the explanation of benefits, remittance advice, or 835 transaction.

*Reason Code

- If information is added to this section/panel, enter (or use the [Search] function to select) the claim-level Adjustment Reason Code (ARC) (for which there is a corresponding dollar amount) received from the carrier on the explanation of benefits, remittance advice, or 835 transaction.

*Amount

- Enter the amount, in dollars, corresponding to a particular claim-level ARC received from the carrier on the explanation of benefits, remittance advice or 835 transaction.

Quantity

- Enter the quantity adjusted by the other payer.

ICD PROCEDURE CODES

After entering data in this section/panel, press the 'Add' button to add diagnosis codes. A maximum of 25 International Classification of Diseases (ICD) procedure codes can be entered.

***Sequence**

<Blank> (default)
Other
Principal

- Select the appropriate sequence for the procedure code.
- Of the maximum of 25 codes added, the following rules for each sequence apply:
    - Other *(can use up to 25 times)*
    - Principal *(can use only once)*

***ICD Procedure Code**

- Enter (or use the [Search] function to select) the ICD procedure code.

***ICD Version**

ICD 10 (default)
ICD 9

- Select the ICD version of the diagnosis code.

***Date**

- Enter the date of service (as MM/DD/YYYY).

ICD Procedure Code Description *(populated automatically after a procedure code is entered)*

OCCURENCE INFORMATION

After entering data in this section/panel, press the 'Add' button to add occurrences. A maximum of 24 occurrence lines can be entered.

***Occurrence Code**

- Enter (or use the [Search] function to select) the occurrence code. (The Occurrence code set is defined by the NUBC.)

***Occurrence Date**

- Enter the date of the occurrence (as MM/DD/YYYY).

Occurrence Description *(populated automatically after an occurrence code is entered)*

OCCURENCE SPAN INFORMATION

After entering data in this section/panel, press the 'Add' button to add occurrence spans. A maximum of 24 occurrence span lines can be entered.

***Occurrence Span Code**

- Enter (or use the [Search] function to select) the occurrence span code. (The Occurrence Span code set is defined by the NUBC.)

***From Date**

- Enter the beginning date of the occurrence span (as MM/DD/YYYY).

***To Date**

- Enter the end date of the occurrence span (as MM/DD/YYYY), if applicable.

Occurrence Description *(populated automatically after an occurrence span code is entered)*

CONDITION CODE INFORMATION

After entering data in this section/panel, press the 'Add' button to add condition information. A maximum of 24 condition lines can be entered.

***Condition Code**

- Enter (or use the [Search] function to select) the condition code. (The Condition code set is defined by the NUBC.)

Condition Description *(populated automatically after a condition code is entered)*

VALUE CODE INFORMATION

After entering data in this section/panel, press the 'Add' button to add value information. A maximum of 24 value lines can be entered.

***Value Code**

- Enter (or use the [Search] function to select) the value code. (The Value code set is defined by the NUBC.)
- All NF and ICF-IID claims must include the number of Covered Days reported with value code 80 and the number of non-covered days with value code 81.
- On NF and ICF-IID claims, enter the lump sum amount, when applicable, with value code 31; the words 'Patient Liability Amount' will display for the 'Value Code Description.' Enter additional value codes as applicable for NF crossover claims.

***Amount**

- Enter the dollar amount associated with the value code.

Value Code Description *(populated automatically after a value code is entered)*

*SERVICE DETAILS

In the ‘Service Details’ section/panel, each service is represented as a line item. Each line is numbered in the order in which it is entered. Display rows are arranged in ascending order; meaning later line items are displayed below earlier line items.

After entering data in this section/panel, press the ‘Add’ button to add the service line. A maximum of 999 service lines can be added.

*Revenue code

- Enter (or use the [Search] function to select) a 4-digit revenue center code on inpatient and outpatient claims. (The Revenue Center code set is defined by the NUBC.)
- NOTE: Revenue codes must be submitted in the ascending order of the date of service.

Procedure Type *(populated automatically as “HCPCS”)*

Procedure Code

- In this field, enter (or use the [Search] function to select) the five-character Healthcare Common Procedure Coding System (HCPCS) code which corresponds to the service.

Procedure Modifier

- When applicable, enter each two-character procedure code modifier associated with the supply or service; up to four modifiers may be specified.
- NOTE: Modifiers are not shown in the display rows for the service lines at the top of the section/panel. Select ‘Edit’ for a service line to see the modifiers that have been entered in the data fields.

Line Control Number

- Enter a reference number for the service detail.

*From DOS *(Date of Service)*

- Enter the beginning date for the span of the service.

To DOS *(Date of Service)*

- Enter the end date for the span of the service when the ‘From DOS’ and ‘To DOS’ do not match.
- NOTE: The date cannot be smaller than the ‘From DOS’ date and cannot be a future date.

Final EAPG *(Enhanced Ambulatory Patient Group)* *(populated automatically from FI after claim is processed)*

Payment Action *(populated automatically from FI after claim is processed)*

Status *(populated automatically from FI after claim is processed. Prior to submitting the claim, the status will display as 'Pending Submission.')*

***Unit**

- Enter the number of units appropriate to the service or supply being reported.

***Unit of Measurement**

<Blank> (default)
UN – Unit
DA – Days

- Select the appropriate value for 'Unit' (days or units).

***Total Charges**

- On hospital claims, enter the total charges (covered and non-covered), in dollars, associated with the service being reported for this line item and date of service.
- On Nursing Facility (NF) or Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs-IID) claims, enter the total charges, in dollars, associated with the service being reported for this line item and date of service. For non-covered services on a NF claim, enter $0 in total charges.

Paid Amount *(populated automatically from FI after claim is processed)*

NDC DETAILS

Line level provider information should only be entered if it is different than in the header level. After entering data in this section/panel, for National Drug Code (NDC), press the 'Add' button to add additional provider information. A maximum of 1 NDC can be entered per detail line. If multiple NDCs need to be added for a service line, start a new detail line, and select the same service line number from the drop-down.

A National Drug Code (NDC) is an 11-digit number that specifically identifies the manufacturer, product, and package size. It is made up of three segments of five digits, four digits, and two digits respectively. Omit separators when entering an NDC. If the NDC printed on a drug package consists of only 10 digits, then add a leading zero to the appropriate segment.

The Service Line selections in the drop-down menu are dependent upon the number of service lines entered under the 'Service Details' panel. For example, if 3 service lines are added, the options of "1, 2, 3" will be available in the Service Line drop-down menu.

A National Drug Code (NDC) is required on any service detail that has RCC's 25X or 636.

*Service Line

- Select the appropriate service line relating to the provider.

*NDC

- Enter (or use the [Search] function to select) the 11-digit National Drug Code (NDC) for the service line. (The NDC doe set is defined by the U.S. Food and Drug Administration (FDA).

*Unit of Measure

Unit (default)
Gram
Milligram
Milliliter
International Unit

- Select the appropriate unit of measure.

Prescription Number

- Enter the prescription number for the drug.

*Total Unit

- Enter the total unit of the drug.

ADDITIONAL PROVIDER INFORMATION – SERVICE DETAIL

Line level provider information should only be entered if it is different than in the header level. After entering data in this section/panel, press the 'Add' button to add additional provider information. A maximum of 50 records can be added.

The Service Line selections in the drop-down menu are dependent upon the number of service lines entered under the 'Service Details' panel. For example, if 3 service lines are added, the options of "1, 2, 3" will be available in the Service Line drop-down menu.

***Service Line**

- Select the appropriate service line relating to the provider.

***Provider Type**

<Blank> (default)
Rendering Provider
Referring Provider
Operating Physician
Other Operating Physician

- Select the appropriate provider type.

***Provider NPI**

- Enter (or use the [Search] function to select) the NPI of the provider. An NPI is the only acceptable identifier in this field.

Last Name *(populated automatically)*

First Name *(populated automatically)*

Middle Name *(populated automatically)*

OTHER PAYER PAID AMOUNT – SERVICE DETAIL SCREEN

Enter information in this section when there is an Other Payer, and the other payer adjudication level is 'Detail.' After entering data in this section/panel, press the 'Add' button.

If another payer has been entered in the 'Other Payer Information' panel, the claim adjudication level is 'Detail', and the other payer responsibility sequence is prior to the destination payer, Health Plan ID will be available in the drop-down menu.

***Service Line**

- Select the appropriate service line relating to the payer paid amount.

Revenue Code *(populated automatically based on the service line selected)*

Procedure Code *(populated automatically based on the service line selected)*

***Health Plan ID**

- Select the Health Plan ID of the other payer.

***Amount Paid**

- Enter the amount paid by the other payer.

Paid Date *(populated automatically from the 'Other Payer Information' panel)*

***Paid Service Unit Count**

- Enter the number of the units paid by the other payer.

OTHER PAYER ADJUSTMENT INFORMATION – SERVICE DETAIL

Enter information in this section when there is an adjustment to the Other Payer amount. After entering data in this section/panel, press the 'Add' button.

If another payer has been entered in the 'Other Payer Information' panel, the claim adjudication level is 'Detail', and the other payer responsibility sequence is prior to the destination payer, Health Plan ID will be available in the drop-down menu.

***Service Line**

- Select the appropriate service line relating to the other payer adjustment.

Revenue Code *(populated automatically based on the service line selected)*

Procedure Code *(populated automatically based on the service line selected)*

***Health Plan ID**

- Select the Health Plan ID of the other payer.

***Adjustment Group**

<Blank> (default)
CO – Contractual Obligations
CR – Correction and Reversals
OA – Other Adjustments
PI – Payer Initiated Reductions
PR – Patient Responsibility

- Select the Claim Adjustment Segment (CAS) Group Code received from the carrier on the explanation of benefits, remittance advice, or 835 transaction.

***Reason Code**

- Enter (or use the [Search] function to select) the claim-level Adjustment Reason Code (ARC) (for which there is a corresponding dollar amount) received from the carrier on the explanation of benefits, remittance advice, or 835 transaction.

***Amount**

- Enter the amount, in dollars, corresponding to a particular claim-level ARC received from the carrier on the explanation of benefits, remittance advice or 835 transaction.

Quantity

- Enter the quantity adjusted by the other payer.

ATTACHMENT

Press the ‘Choose File’ button to prepare an attachment for submission. Clicking ‘Choose File’ will access the folders on your computer where you can locate the document(s) to be uploaded to the claim submission. After adding a document and choosing a document type in this section/panel, press the ‘Add’ button.

A maximum of 10 documents can be uploaded per claim with a maximum file size of 1.25 GB per file.

*Upload attachment

- Click ‘Choose File’ to attach a document to the claim submission.

*Document Type

Admission Summary (default)
Certification
Completed Referral Form Dental Models
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

- An attachment is required for the adjudication of certain claims. When a required attachment is submitted with a claim, the claim will be suspended for review. An attachment that is not required will not be reviewed; the accompanying claim will be processed as though there were no attachment listed. The mere presence of an attachment will not cause a claim to be suspended for review. Therefore, submit an attachment only when an attachment is required.

- The following file types are acceptable to upload:
    - 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

This selection allows for the addition of notes to be added to the claim submission. A note can be a maximum of 80 characters. After adding a note in this section/panel, press the 'Add' button. A maximum of 10 notes can be added.

***Note Reference Code**

<Blank> (default)
ALG - Allergies
DCP – Goals, Rehabilitation Potential, or Discharge Plans
DGN – Diagnosis Description
DME – Durable Medical Equipment (DME) and Supplies
MED - Medications
NTR – Nutritional Requirements
ODT – Orders for Disciplines and Treatments
RHB – Functional Limitations, Reason Homebound, or Both
RLH – Reason Patient Leaves Home
RNH - Times and Reasons Patient Not at Home
SET – Unusual Home, Social Environment, or Both
SFM – Safety Measures
SPT – Supplementary Plan of Treatment
UPI – Updated Information

***Note**

- Type in the note to be added to the claim submission.

PROVIDER BILLING NOTES

This selection allows for the addition of billing notes to be added to the claim submission. A note can be a maximum of 80 characters. After adding a note in this section/panel, press the ‘Add’ button. One note can be added.

***Note Reference Code**

<Blank> (default)
ADD – Additional Information

- Select 'ADD' if you are submitting a claim more than 365 days after the date of service because of either a hearing decision or a delay in a recipient's eligibility determination.
- Select 'ADD' if you are entering a Medicaid co-payment exclusion code in the 'Note' field.

***Note**

- Type in the note to be added to the claim submission.
- When a claim is submitted more than 365 days after the date of service because of either a hearing decision or a delay in a recipient's eligibility determination by the Ohio Department of Medicaid (ODM), the claim must be submitted within 180 days after the hearing decision or eligibility determination date.
    - Hearing decision note format: *APPEALS XXXXXXX CCYYMMDD* (XXXXXXX is the hearing number and CCYYMMDD is the date on the hearing decision letter.)
    - Eligibility determination note format: *DECISION CCYYMMDD* (CCYYMMDD is the date on the eligibility determination notice from ODM.)
- When a Medicaid co-payment exclusion applies, as described in rule 5160-35-04 of the Ohio Administrative Code, enter a 10-character exclusion note in this field. (There must be a space after the word 'COPAY' so that the note characters plus the space equal 10 characters.)
    - Format for emergency exclusion: *COPAY EMER*
    - Format for hospice exclusion: *COPAY HSPC*
    - Format for pregnancy exclusion: *COPAY PREG*

REVIEWER NOTES

This section/panel remains blank until the claim is adjudicated. If the reviewer of the claim has notes to provide, those will be listed here.

DELAYED SUBMISSION/RESUBMISSION INFORMATION

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

NOTE: A document needs to be uploaded under ‘Attachments’ to justify the use of this section/panel and data entered must be retained for future audit purposes.

Previously Denied ICN

- Enter the Internal Control Number (ICN) of the previously denied claim.

Reason for Delay

<Blank> (default)
Proof of Eligibility Unknown or Unavailable
Litigation
Authorization Delays
Delay in Certifying Provider
Third Party Processing Delay
Delay in Eligibility Determination
Administration Delay in the Prior Approval Process
Other
Natural Disaster
Delay In Supplying Billing Forms
Delay in Delivery of Custom-made Appliances
Original Claim Rejected or Denied Due To a Reason Unrelated To The Billing Limitation Rules

CLAIM ADJUDICATION

Data in this section/panel appears only after the adjudication of the claim by the payer. This section/panel is view only and shows the status of the claim in the claim level.

Claim Status *(populated automatically by FI)*

Total Paid Amount *(populated automatically by FI)*

Claim Submission Date *(populated automatically by FI)*

Claim Paid Date *(populated automatically by FI)*

ICN *(populated automatically by FI)*

Adjudication Date *(populated automatically by FI)*

Total Charges *(populated automatically by FI)*

CoPay Amount *(populated automatically by FI)*

CLAIMSXTEN INFORMATION

Data in this section/panel appears only after the adjudication of the claim by the payer. This section/panel is view only and shows any ClaimsXten history number or audit result related to the current claim.

RELATED ICN SCREEN

Data in this section/panel appears only after the adjudication of the claim by the payer. This section/panel is view only and shows any ICN that is related to the current claim and the reason why the claims are related.

CARC & RARC INFORMATION

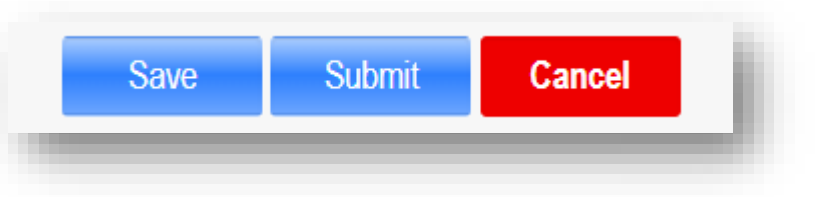
Data in this section/panel appears only after the adjudication of the claim by the payer. This section/panel is view only and shows CARC and RARC information. CARC and RARC information will be organized to be 10 lines per page.

ADJUDICATION ERRORS

Data in this section/panel appears only if there are errors in the claim adjudication process with FI.

MALICIOUS ATTACHMENTS

After the claim submission is reviewed, if an attached document is found to contain damaging macros, it will be flagged as a 'malicious attachment.' Malicious attachments for the claim submission will be listed in this section. To replace the malicious attachment documents, follow the steps outlined in the Institutional Claims User Guide.



Note:
If you're submitting EDI claims, make sure you populate the **PWK segment with value B4** when using the Form 6653 process.

If you're submitting Portal claims, simply attach the completed Form 6653 to your claim and select "Form 6653" from the document type dropdown.

Following these steps will help avoid delays and keep your claims moving.