USER MANUAL

Institutional Claims - Fee for Service

Department of Medicaid

Table of Contents

Introduction

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

Providers that can enter institutional claims include Hospitals, Nursing Facilities (NF), Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF-IID) and Psychiatric Residential Treatment Facilities (PRTF).

Submission of managed care claims will still be submitted through the managed care portals.

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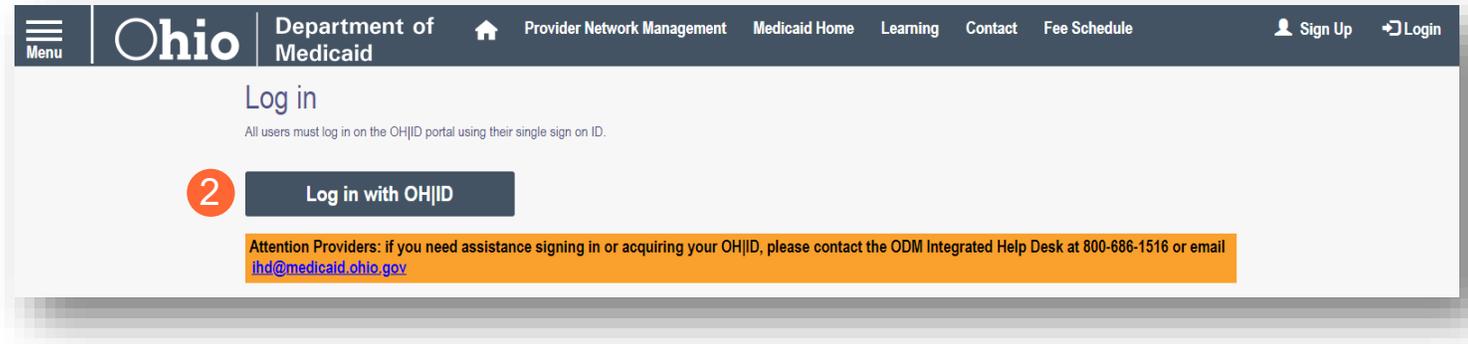
Step 3: The system will prompt you to enter your username and password on the IOP login screen. Once entered, click **Log in**.

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

🔒 **OHID**

Ohio's Digital Identity. One State. One Account.

Register once, use across many State of Ohio websites

Create account

Log In

3

OHID

Password 👁️

Log in

Forgot your OHID or password? | Get login help

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.

Terms

Whoever knowingly, or intentionally accesses a computer or computer system without authorization or exceeds the access to which that person is authorized, and by means of such access, obtains, alters, damages, destroys, or discloses information, or prevents authorized use of the information operated by the State of Ohio, shall be subject to such penalties allowed by law. All activities on this system may be recorded and/or monitored. Individuals using this system expressly consent to such monitoring and evidence of possible misconduct or abuse may be provided to appropriate officials. Users who access this system consent to the provisions of confidentiality of the information being accessed, but have no expectation of privacy while using this system.

In the event that an unauthorized user is able to access information to which they are not entitled, the user should immediately contact the site administrator.

4 ☐ Yes, I have read the agreement

Cancel

6

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.

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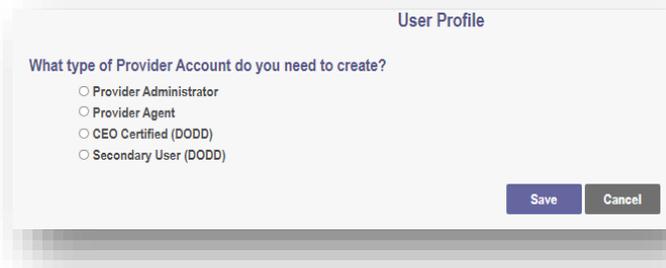
When you first login to the PNM system you will see a variety of buttons to help with administering providers. Some of the buttons, as indicated below, are only accessible to certain user roles.

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.'

Self Service   _   Self Service Selections:

View Provider File

Provider Correspondence

Remittance Advice

Recipient Eligibility

(3) Claims

Prior Authorization

Hospice
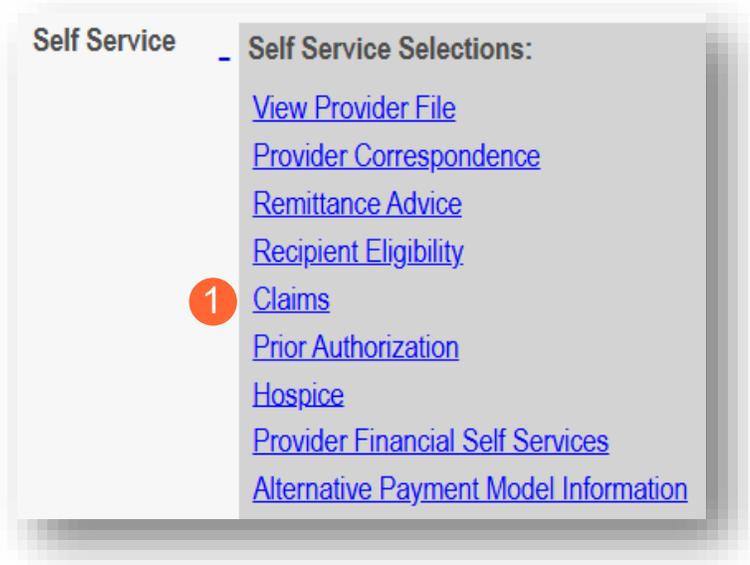
Provider Financial Self Services

Alternative Payment Model Information

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: Institutional
- 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 uploaded to a claim in Adjudicated, Deny, Open, Pay, or Pend status using the 'Upload' hyperlink. This process is explained on page 49 in the section, Attachments to a Previously Submitted Claim.

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

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: If action needs to be taken on a Paid Claim, use the buttons at the bottom of the screen

- **Copy**: Create a new claim copying the data of the paid claim.

- **Adjust:** Allows data to be changed to submit claim.

- **Void:** Lets provider void the previously paid claim.

- **Cancel:** Returns to the main menu.

Note: When clicking 'Copy' or 'Adjust' buttons all field values become editable and claim adjudication information is deleted

INSTITUTIONAL CLAIMS

If action needs to be taken on a <u>Denied Claim</u>, use the buttons at the bottom of the screen.

- **Resubmit**: Lets provider fix the data and resubmit the claim again

- **Cancel:** Returns to the main menu

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 Institutional 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 'Institutional' 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.

Diagnosis Code	ICD Version	Diagnosis Description
A081	ICD 10	ACUTE GASTROENTEROPATHY DUE TO NORWALK AGENT AND OTHER SMALL ROUND VIRUSES
A09	ICD 10	INFECTIOUS GASTROENTERITIS AND COLITIS, UNSPECIFIED
A213	ICD 10	GASTROINTESTINAL TULAREMIA
C49A4	ICD 10	GASTROINTESTINAL STROMAL TUMOR OF LARGE INTESTINE
C49A5	ICD 10	GASTROINTESTINAL STROMAL TUMOR OF RECTUM
C49A	ICD 10	GASTROINTESTINAL STROMAL TUMOR

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

- **Save**: Saves the Claim form and data entered.

  o 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.

  o 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.
  o 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 an Institutional 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.
- Medical Record Number *(situational)*.
    - The number assigned by the provider.

Service Information

Step 6: Enter or select the following information:

- Type of Bill (*required*)
    - If you do not know the Type of Bill Code, click 'Search' to lookup the code.
- Release of Information (*required*)
    - Yes
    - No
- From Date of Service (*required*)
- To Date of Service (*required*)
- Patient Status (*required*)
    - 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

- o 89 – Discharged/Transferred to a Hospital Based Medicare Approved Swing Bed with a Planned Acute Care Hospital Inpatient Readmission
  - o 90 – Discharged/Transf to Inpatient Rehab Facility (IRF) Include Rehab Distinct Part Units of Hospital W/ Planned Acute Care Hospital Inpatient Readmission
  - o 91 – Discharged/Transferred to a Medicare Certified Long Term Care Hospital (LTCH) with a Planned Acute Care Hospital Inpatient Readmission
  - o 92 – Discharged/Transferred to Nursing Facility Certified under MCAID But not Certified under Medicare W/ Planned Acute Care Hospital Inpatient Readmission
  - o 93 – Discharged/Transferred to a Psychiatric Hospital or Psychiatric Distinct Part Unit of Hospital W/A Planned Acute Care Hospital Inpatient Readmission
  - o 94 – Discharged/Transferred to a Critical Access Hospital (CAH) with a Planned Acute Care Hospital Inpatient Readmission
  - o 95 – Discharged/Transferred to Another Type of Health Care Instit not Defined Elsewhere in Code List W/ a Planned Acute Care Hospital Inpatient Readmission
- Admission Date and Hour *(situational)*
  - o Required when Type of Bill is 011X, 012X,018X, 021X, 022X, 028X, 041X, 065X, 066X, 086X.
  - o Data will be sent as one field. For example: 202404011100.
  - o Admission Hour 0000 is valid to represent 12:00 AM (midnight).
- Discharge Hour *(situational)*
- Admission Type *(required)*
  - o 1 – Emergency
  - o 2 – Urgent
  - o 3 – Elective
  - o 4 – Newborn
  - o 5 – Trauma
  - o 9 – Information Not Available
- Admit Source *(required)*
  - o 1 – Physician Referral
  - o 2 – Clinic Referral
  - o 3 – HMO Referral
  - o 4 – Transfer from Hospital
  - o 5 – Transfer from SNF
  - o 6 – Transfer from Another Health Care Facility
  - o 7 – Emergency Room
  - o 8 – Court/Law Enforcement
  - o 9 – Information Not Available

  *Displays if "Newborn" is selected as the 'Admission Type.'
  - o 5 – Born Inside Hospital
  - o 6 – Born Outside Hospital
- Patient Paid Amount *(situational)*
- Submitted DRG
  - o Diagnosis Related (DRG) code reported by the provider.

- *SERVICE INFORMATION

6 *Type of Bill	0110 Search	*Patient Status	30-Still Patient	Patient Paid Amount	
*Release of Information	Yes	Admission Date and Hour	04/01/2024 1100	Submitted DRG	
*From Date	04/01/2024	Discharge Hour		Final DRG	
*To Date	04/10/2024	*Admission type	Urgent		
		*Admit Source	7-Emergency Room		

'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.

+ ACCIDENT INFORMATION
+ PRIOR AUTHORIZATION & REFERRAL INFORMATION
+ ATTENDING PHYSICIAN INFORMATION
+ REFERRING PROVIDER INFORMATION
+ RENDERING PROVIDER
+ SERVICE FACILITY LOCATION INFORMATION
+ OTHER OPERATING PHYSICIAN INFORMATION
+ OPERATING PHYSICIAN INFORMATION
+ OTHER PAYER 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 State

- ACCIDENT INFORMATION

Accident State [⌄]

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 if there is an approved prior authorization for the service on the claim.

- PRIOR AUTHORIZATION & REFERRAL INFORMATION

Prior Authorization Number [   ]   Referral Number [   ]

Attending Physician Information

Enter the following information:

- Attending Physician 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 Last Name and First Name will auto-populate.
    - Note: Medicaid ID field will be populated only if NPI is not available.

- ATTENDING PHYSICIAN INFORMATION				
*NPI		Medicaid ID	Last Name	First Name
	Search			

Referring Provider Information

Enter the following information:

- Referring 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.

- REFERRING PROVIDER INFORMATION				
	*NPI	Medicaid ID	Last Name	First Name
Referring Provider	Search			

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.

- RENDERING PROVIDER				
* NPI		Medicaid ID	Last Name	First Name
	Search			

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.

- SERVICE FACILITY LOCATION INFORMATION							
*NPI	Medicaid ID	Name	Address1	Address2	City	State	Zip
Search							

Other Operating Physician Information

Enter the following information:

- Other Operating Physician 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 OPERATING PHYSICIAN INFORMATION			
*NPI	Medicaid ID	Last Name	First Name
Search			

Operating Physician Information

Enter the following information:

- Other Operating Physician 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.

- OPERATING PHYSICIAN INFORMATION			
* NPI	Medicaid ID	Last Name	First Name
Search			

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 situational and available to report when claim adjudication level is 'Header.'

- OTHER PAYER INFORMATION

* Other Payer Name :	* Patient Relationship To Subscriber :	Claim Adjudication Level :
* Health Plan ID :	* Subscribers First Name :	Claim Number :
* Claim Filing Indicator :	* Subscriber Last Name :	Paid Date :
* Payer Responsibility Sequence :	Subscriber's Middle Name :	Paid Amount :
* Subscriber Number:	Subcriber's Address Line 1:	Non Covered Amount:
Policy Number:	Subcriber's Address Line 2:	
Group Name:	Subcriber's City:	ADD
Insurance Type Code :	Subcriber's State : Subcriber's Zip :	

- 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:
- Sequence *(required)*
    - Principle (does not repeat)
    - Admitting (does not repeat)
    - Other (can repeat a maximum of 24 times)
    - Patient Reason for Visit (can repeat a maximum of 3 times)
    - External Cause of Injury (can repeat a maximum of 12 times)
- Diagnosis Code *(required)*
    - 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.
- Present on Admission *(required)*
    - Yes
    - No
    - Unknown
    - Not Applicable
- Click **Add** to add the diagnosis code to the claim submission.
    - A maximum of 24 diagnosis codes can be added.

- * DIAGNOSIS CODES

No records found.

*Sequence	*Diagnosis Code		*ICD Version	*Present on Admission	Diagnosis Description	
Admitting	A048	Search	ICD 10	U - Unknown	OTHER SPECIFIED BACTERIAL INTESTINAL INFECTIONS	ADD

- The added diagnosis appears on a list.
- Repeat the process to add other diagnoses.

- * DIAGNOSIS CODES

* Sequence	* Diagnosis Code	* ICD Version	* Present On Admission	Diagnosis Code Description		
Admitting	A048	ICD 10	U	OTHER SPECIFIED BACTERIAL INTESTINAL INFECTIONS	Edit	Delete

*Sequence	*Diagnosis Code		*ICD Version	*Present on Admission	Diagnosis Description	
		Search	ICD 10			ADD

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.

+ OUTPATIENT ADJUDICATION INFORMATION
+ INPATIENT ADJUDICATION INFORMATION
+ HEADER OTHER PAYER ADJUSTMENT INFORMATION
+ ICD PROCEDURE CODES
+ OCCURRENCE INFORMATION
+ OCCURRENCE SPAN INFORMATION
+ CONDITION CODE INFORMATION
+ VALUE CODE INFORMATION

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)

- OUTPATIENT ADJUDICATION INFORMATION

| Reimbursement Rate(Percentage as decimal): | | Claim Remark Code(MOA 03): | |
| HCPCS Payable Amount: | | Claim Remark Code(MOA 04): | |

Inpatient Adjudication Information

Enter the following information:
- Covered Days or Visits Count (MIA01)
- Claim DRG Amount (MIA04)
- Claim Remark Code (MOA05)
- Claim Remark Code (MOA20)

- INPATIENT ADJUDICATION INFORMATION

| Covered Days or Visits Count (MIA01): | | Claim Remark Code (MOA05): | |
| Claim DRG Amount (MIA04): | | Claim Remark Code (MOA20): | |

Header Other Payer Adjustment Information

Enter the following information:

- Heath Plan ID
  - o 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
  - o Required when an adjustment amount is reported.
  - o 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
  - o If you do not know the Reason Code, click 'Search' to lookup the code.
- Amount
- Quantity
  - o The quantity adjusted by the other payer.

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

- HEADER OTHER PAYER ADJUSTMENT INFORMATION				
* Health Plan ID	* Adjustment Group	* Reason Code Search	* Amount	Quantity Add

ICD Procedure Codes

Enter the following information:

- Sequence
  - o Principle (does not repeat)
  - o Other (repeats maximum of 24 times)
- ICD Procedure Code
  - o If you do not know the ICD Procedure Code, click 'Search' to lookup the code.
- ICD Version
  - o Defaults to ICD 10 but can be changed.
- Date [of the procedure]

- Click **Add** to add the information. A maximum of 24 values can be added.

Occurrence Information

Enter the following information:
- Occurrence Code
  - o If you do not know the Occurrence Code, click 'Search' to lookup the code.
- Occurrence Date
- The Occurrence Description will auto-fill after the code is entered.

- Click **Add** to add the information.
- A maximum of 24 lines can be added.

Occurrence Span Information

Enter the following information:
- Occurrence Span Code
  - o If you do not know the Occurrence Span Code, click 'Search' to lookup the code.
- From Date
- To Date

- Click **Add** to add the information.
- A maximum of 24 lines can be added.

Condition Code Information

Enter the following information:
- Condition Code
  - If you do not know the Condition Code, click 'Search' to lookup the code.
- The Condition Description will auto-fill after the code is entered.

- Click **Add** to add the information.
- A maximum of 24 lines can be added.

- CONDITION CODE INFORMATION

*Condition Code		Condition Description	
	Search		Add

Value Code Information

A value code of 80 or 81 is required with the Type of Bill is 011X or 086X or 02XX or 06XX.

Enter the following information:
- Value Code
  - If you do not know the Value Code, click 'Search' to lookup the code.
- The Value Code Description will auto-fill after the code is entered.
- Amount

- Click **Add** to add the information.
- A maximum of 24 lines can be added.

- VALUE CODE INFORMATION

*Value Code		*Amount	Value Code Description	
	Search			ADD

Service Details

Step 7: Enter or select the following information:

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

- Revenue Code *(required – 4 digits)*
    - If you do not know the Revenue Code, click 'Search' to lookup the code.
- Procedure Code *(situational)*
    - If you do not know the Procedure Code, click 'Search' to lookup the code.
- Procedure Modifier *(situational)*
    - Up to 4 values can be added.
- Line Control Number *(situational)*
- From Date of Service *(required)*
    - For inpatient claims, each From Date of Service should be the header date of service.
    - For outpatient claims, the From Date of Service should only be 1 day.
- To Date of Service *(situational)*
    - For inpatient claims, each To Date of Service should be the header date of service.
    - For outpatient claims, the To Date of Service should only be 1 day.
- Unit *(required)*
- Unit of Measurement *(required)*
    - DA – Days
    - UN – Unit
- Total Charges *(required)*

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 999 service lines can be added.

Service Line	*Revenue Code	Procedure Type	Procedure Code	*Unit	Unit Of Measurement	*From DOS	To DOS	*Total Charges	Paid Amount	Status			
1	0201	HCPCS		2.000	UN	05/01/2024	05/08/2024	503.19		Pending Submission	Edit	Copy	Delete

Total Amount Billed: 503.19
Total Amount Paid: 0

ADD

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.

+ NDC DETAILS
+ ADDITIONAL PROVIDER INFORMATION-SERVICE DETAIL
+ OTHER PAYER PAID AMOUNT-SERVICE DETAIL SCREEN
+ OTHER PAYER ADJUSTMENT INFORMATION-SERVICE DETAIL
+ ATTACHMENT
+ PROVIDER NOTES
+ REVIEWER NOTES
+ DELAYED SUBMISSION/RESUBMISSION INFORMATION
+ CLAIM ADJUDICATION
+ CLAIMSXTEN INFORMATION
+ RELATED ICN SCREEN
+CARC AND RARC INFORMATION

34

NDC (National Drug Code) Details

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.
- NDC *(required to complete, only if information is added to this section)*
    - If you do not know the NDC Code, click 'Search' to lookup the code.
    - If you have a compound drug to indicate, enter each of the ingredients and their respective NDC code separately. (Ex: If a compound drug has 6 ingredients, enter the Service Line, NDC, Unit of Measure, Prescription Number (if necessary) and Total Unit for each of the ingredients. The same Service Line (number) can be used for each ingredient if the compound drug is related to a specific service line entry.
- Units of Measure *(required to complete, only if information is added to this section)*
    - International Unit
    - Gram
    - Milligram
    - Milliliter
    - Unit
- Prescription Number *(situational)*
- Total Unit
    - Total Unit of the drug

<u>Note:</u> If multiple drugs need to be entered for a service line, repeat the service line (only one drug can be added per service line).

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

- NDC DETAILS					
*Service Line	*NDC	*Unit Of Measure	Prescription Number	*Total Unit	
⌄	Search	Unit ⌄			Add

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)*
    - Referring Provider
    - Primary Care Provider (Referral)
    - Rendering Provider
    - Supervising Provider
    - Service Facility Location
    - Ordering Provider
- 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.

- ADDITIONAL PROVIDER INFORMATION-SERVICE DETAIL

* Service Line	* Provider Type	* Provider NPI		Medicaid ID	Last Name	First Name	Middle Name	
⌄	⌄		Search					ADD

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)*
    - Health Plan ID will only display in the drop-down list if the adjudication level is selected 'Detail' and other payer responsibility sequence is prior to destination payer.
- 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 PAID AMOUNT-SERVICE DETAIL SCREEN							
*Service Line	Revenue Code	Procedure Code	*Health Plan ID	*Amount Paid	Paid Date	*Paid Service Unit Count	
⌄			⌄				Add

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.
- Revenue Code
- 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.

- OTHER PAYER ADJUSTMENT INFORMATION-SERVICE DETAIL

*Service Line	Revenue Code	Procedure Code	*Health Plan ID	*Adjustment Group	*Reason Code	*Amount	Quantity
⌄			⌄	⌄	Search		⌄ Add

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.

- ATTACHMENT

	Line Item	Document ID	Document Type	
📄	1	10232838841666352618	Referral Form (Ohio 6653)	Delete

* Upload attachment:

Choose File   No file chosen

* Document Type:

Admission Summary ⌄   Add

Acceptable File Types:

- o   Word: doc, docx
- o   Excel: xls, xlsx, xlsm, xlsx
- o   Image: mdi, jpe, jpeg, jpg, png, gif, bmp, tif, tiff
- o   PDF: pdf
- o   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:

- Select a Note Reference Code
    - 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 – Reasons 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
- A maximum of 80 characters can be typed for the note.
- A maximum of 10 notes can be added.

Click **Add** to add a note.
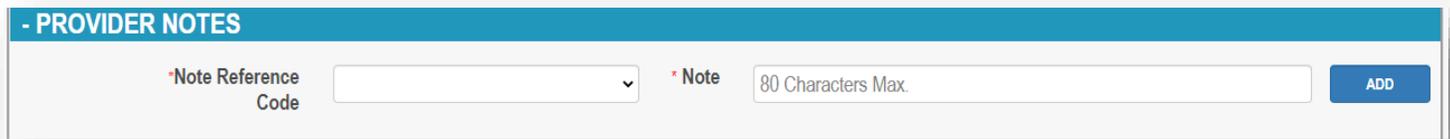
The added note appears on a line. You can edit or delete the note by clicking the corresponding button.

Provider Billing Notes

Prior to submitting the claim, PNM does provide a space to add a note to bypass timely filing requirements.

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

- Select 'ADD – Additional Information' as the Note Reference Code.
- A maximum of 80 characters can be typed for the note.

Click **Add** to add a note.

Click **Edit** to make a change to added note or **Delete** to remove the added note.

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, select 'ADD' for the Note Reference Code and enter "APPEALS XXXXXXX CCYYMMDD" for the Note. *(XXXXXXX is the hearing number and CCYYMMDD is the date on the hearing decision letter.)*

- PROVIDER BILLING NOTES	
*Note Reference Code	*Note
ADD - Additional Information ▾	APPEALS XXXXXXX CCYYMMDD **ADD**

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

To denote a delay in an eligibility decision, select 'ADD' for the Note Reference Code and enter "DECISION CCYYMMDD" for the Note. *(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".

- PROVIDER BILLING NOTES	
*Note Reference Code	*Note
ADD - Additional Information ▾	DECISION CCYYMMDD **ADD**

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, select 'ADD' for the Note Reference Code and enter "COPAY EMER" for the Note. (There must be a space after the word 'COPAY'.)

Hospice Exclusion

To denote a Medicaid co-payment hospice exclusion, select 'ADD' for the Note Reference Code and enter "COPAY HSPC" for the Note. (There must be a space after the word 'COPAY'.)

Pregnancy Exclusion

To denote a Medicaid co-payment pregnancy exclusion, select 'ADD' for the Note Reference Code and enter "COPAY PREG" for the Note. (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.

- Enter a previously denied Internal Control Number (ICN).
- 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.

- DELAYED SUBMISSION/RESUBMISSION INFORMATION

Disclaimer: Documentation to justify the use of this panel and data entered must be retained for future audit purpose.

Reason for Delay:

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

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

```
+ NDC DETAILS
+ ADDITIONAL PROVIDER INFORMATION-SERVICE DETAIL
+ OTHER PAYER PAID AMOUNT-SERVICE DETAIL SCREEN
+ OTHER PAYER ADJUSTMENT INFORMATION-SERVICE DETAIL
+ ATTACHMENT
+ PROVIDER NOTES
+ PROVIDER BILLING NOTES
+ REVIEWER NOTES
+ DELAYED SUBMISSION/RESUBMISSION INFORMATION
+ CLAIM ADJUDICATION
+ CLAIMSXTEN INFORMATION
+ RELATED ICN SCREEN
+CARC AND RARC INFORMATION
+ADJUDICATION ERRORS
+MALICIOUS ATTACHMENTS
```

Submit the Claim

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

Note: If there are any errors 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.

Below errors are created. Please click on the error text to navigate to the panel or field where errors are encountered

*Medicaid billing number is required
*Missing Recipient date of birth
*Patient Control Number is required
*Release of Information is required
*At least one service detail is required.
*Diagnosis code is required.

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.

Transaction failed transformation
Response code is
Error Message:
Error

ErrorCode	ErrorDescp
ERR106006	Provider does not have Direct affiliation.

Please contact FI support. support@OMES.com

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 Status PAY
ICN 2022256029317
Paid Amount $47.19
Adjudication Date 04/15/2024

- 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.

Claim Status DENY
ICN 230375000002
Paid Amount $0.00
Adjudication Date 04/15/2024

-ADJUDICATION ERRORS

Service Line Number	ErrorCode	ErrorDescp
01	150	NO CONTRACT TERM FOUND FOR SERVICE

47

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:

24056W256347

Year — Days this Year — Source of Claim — Number of the claim depending on the number of claims received today

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)*
    - o Ohio Department of Medicaid
- Claim Type: Professional
- **Claims Status**
    - o **Adjudicated**
    - o **Pay**
    - o **Open**
    - o **Deny**
    - o **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 the red **Clear** button.

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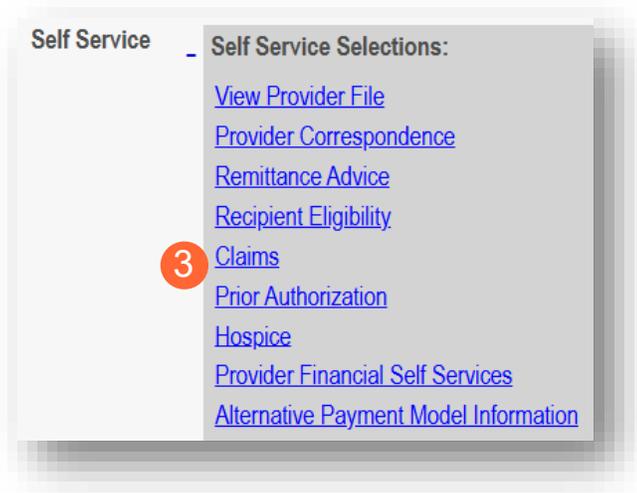
Step 1: Review the malicious attachments list on the claim submission page in the 'Malicious Attachment' section.

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

+MALICIOUS ATTACHMENTS

MemberId	Attachment	Uploaded Date
125555555555	483953productionticket_1.docx	8/7/2024 7:05:56 PM
121204321212	483953productionticket.docx	8/7/2024 3:31:03 PM

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.

Self Service

Self Service Selections:

View Provider File
Provider Correspondence
Remittance Advice
Recipient Eligibility
Claims
Prior Authorization
Hospice
Provider Financial Self Services
Alternative Payment Model Information

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