PNM Billing Guide for Professional Claims

Click the 'Learning' page from the Provider Network Management (PNM) homepage or the PNM user dashboard to access, and download, full step-by-step guides of how to enter a professional claim in the PNM system.

Scroll down the 'Learning' page to the Professional Claims (Fee-for-Service) section and find:

- Guides for general professional claim submission using PNM.
- Guides for FQHC and RHC Wraparound and Cost Sharing claim submission using PNM.

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.

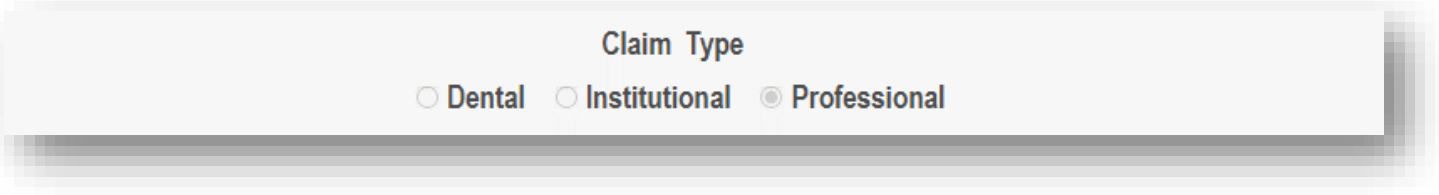
Certain fields have a "Search" hyperlink located next to this. This search function allows the user to look up information if they do not know it at the time of submission. Some examples of this include provider NPIs and diagnosis codes, among others.

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



NOTE: Federally Qualified Health Centers (FQHCs) submit claims for dental services on a professional submission form.

NOTE: For help with FQHC and RHC cost sharing claim submission, view the Submitting Professional Crossover Claims for FQHC and RHC Cost Sharing Payments in PNM - Quick Reference Guide found on the 'Learning' page.

NOTE: For help with FQHC and RHC wraparound claim submission, view the FQHC & RHC Professional Claim Submission for Wraparound Payments - Quick Reference Guide found on the 'Learning' page.

*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.

Pregnancy Indicator

<Blank> (default)
Yes

- Select the option to indicate whether the recipient is pregnant.

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

*Release of Information

<Blank> (default)
No
Yes

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

Place of Service *(populated from the Place of Service listed on the first service detail line)*

Special Program Indicator

<Blank> (default)
02 – Physically handicapped children's program
03 – Special federal funding
05 – Disability
09 – Second opinion or surgery

- Select a program code, if applicable.

EPSDT Condition Indicator *(Early and Periodic Screening, Diagnostic and Treatment)*

<Blank> (default)
No
Yes

- Completion of this field is required if the claim meets one of two criteria:
  1. If the service or supply was provided because of an EPSDT referral.
  2. If the service or supply is related to family planning.
- Hospice, Home Health Services, Private Duty Nursing, and ODM-Administered Waiver: This information is not applicable. Leave the field blank.

EPSDT Condition Code

<Blank> (default)
S2 – Under Treatment
ST – New Services Requested
NU – Patient Not Referred
AV – Patient Refused Referral

- If the EPSDT Condition Indicator was marked “Yes,” select an EPSDT Condition Code. These fields will be grayed out unless “Yes” is selected above.
- If an Early and Periodic Screening, Diagnostic and Treatment (EPSDT, known as Healthchek) service was provided, then indicate the circumstances or outcome: Select 'NU – PATIENT NOT REFERRED' if the service did not result in a referral. Select 'AV – PATIENT REFUSED REFERRAL' if a referral was offered but the individual declined it. Select 'ST – NEW SERVICES REQUESTED' if the screening provider has either scheduled the individual for another appointment or referred the individual to another provider for diagnostic or corrective treatment of at least one health problem identified during a Healthchek screening. Do not use this indicator for dental treatment referrals. Select 'S2 – UNDER TREATMENT' if the individual is currently being diagnosed or treated for a health problem by the provider as a result of a Healthchek referral.
- Up to three condition codes can be added. Previously selected values do not display in the remaining drop-down fields.

Patient Amount Paid

- Enter the amount of recipient spenddown or patient liability collected or applied.
- NOTE: Do NOT enter the Medicaid co-payment amount for any professional service subject to co-payment (explained in rule 5160-1-09 of the Ohio Administrative Code). So, a co-payment amount is automatically deducted from the Medicaid payment made to a provider. Entering a Medicaid co-payment amount in this field will result in a duplicate deduction.
- Hospice: For a recipient receiving hospice room and board in a long-term care facility (procedure code T2046), enter the amount of the recipient’s patient liability for the entire month that is to be applied toward the room and board. This patient liability amount is determined by the Ohio Department of Medicaid (ODM).

Hospital Discharge Date

- Home Health Services and Private Duty Nursing: Enter the date (format MM/DD/YYYY) of discharge when submitting a claim for increased post-hospital services provided after a qualifying hospital stay.

Last Menstrual Period

- Enter the beginning date (format MM/DD/YYYY) of the menstrual period if the service or supply is related to a pregnancy.
- Hospice, Home Health Services, Private Duty Nursing and ODM-Administered Waiver: This information is not necessary. Leave the field blank.

ACCIDENT INFORMATION

Accident Related To *(1st field)

<Blank> (default)
AA – Auto Accident
EM – Employment
OA – Other Accident

- If the service is related to an accident, choose the category most appropriate to the circumstances.

Accident Related To *(2nd field)*

<Blank> (default)
AA – Auto Accident
EM – Employment
OA – Other Accident

- If the Accident Related To *(1st field)* is selected, options, other than what was selected in the 1st field, will populate. Choose the subcategory most appropriate to the circumstances.

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.

Accident Date

- If the service is related to an automobile accident, enter the date (format MM/DD/YYYY) on which the accident occurred.

Accident Country

<Blank> (default)
(239 countries, listed individually)

- If the service is related to an automobile accident, enter the country 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.

REFERRING PROVIDER INFORMATION

*Referring Provider NPI

- If a physician authorized a referral or an order for the service or supply, enter (or use the [Search] function to select) the NPI of the referring provider. An NPI is the only acceptable identifier in this field.
- Hospice, Home Health Services, Private Duty Nursing and ODM-Administered Waiver: This information is not necessary. Leave the field blank.

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 INFORMATION

***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.
- A rendering provider NPI is required only when an entity such as a group practice, an ambulatory surgery center (ASC), or a hospice is submitting a claim for professional fees on behalf of an affiliated physician or individual practitioner. Member affiliations can be maintained by completing the 'Update' process for the group in PNM.
- A separate rendering provider NPI is not required for an ASC submitting a claim for a facility service, nor for a hospice submitting a claim for a hospice service, nor for other providers (fee-for-service clinics, cost-based clinics including independent laboratories, home health service providers, private duty nursing providers, ODM-administered waiver providers, etc.). These providers should leave this field blank.
- In order to comply with federal law and regulations codified in Section 1902(a)(27) of the Social Security Act and 42 CFR 431.107(b)(5), ODM added system functionality to its claims payment system that requires FQHC and RHC provider types to report individual practitioners' National Provider Identifiers (NPIs) in the rendering provider fields next to the procedure code in the detail lines of claims.
- Services rendered by mid-level health care workers (e.g., registered nurses) and unlicensed dependent practitioners (i.e., behavioral health trainees) at FQHCs and RHCs should continue to be reported under the overseeing practitioners' NPIs. Transportation, DME, laboratory, and radiology should continue to be reported under the organizational/billing NPI.

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)*

SUPERVISING PROVIDER

***NPI**

- If an individual provided oversight of the Rendering Provider, enter (or use the [Search] function to select) the NPI of the supervising provider. An NPI is the only acceptable identifier in this field.

Medicaid ID *(populated automatically)*

Last Name *(populated automatically)*

First Name *(populated automatically)*

AMBULANCE INFORMATION

If ambulance transportation was involved in this claim, enter the details regarding the ambulance transportation.

PNM will validate the ambulance drop-off location address, city, state, and ZIP against the United States Postal Service (USPS) data.

*Pick-up Address Line 1

- Enter the first line of the address where the ambulance pick-up occurred.

Pick-up Address Line 2

- Enter the second line of the address where the ambulance pick-up occurred, if applicable.

*Pick-up City

- Enter the city where the ambulance pick-up occurred.

*Pick-up State

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

- Select the state where the ambulance pick-up occurred.

*Pick-up Zip

- Enter the ZIP code where the ambulance pick-up occurred.

Drop Off Location Name

- Enter the name of the ambulance drop off location.

*Drop Off Address Line 1

- Enter the first line of the address where the ambulance drop off occurred.

Drop Off Address Line 2

- Enter the second line of the address where the ambulance drop off occurred, if applicable.

*Drop Off City

- Enter the city where the ambulance drop off occurred.

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

***Drop Off State**

- Select the state where the ambulance drop off occurred.

***Drop Off Zip**

- Enter the ZIP code where the ambulance drop off occurred.

Transport Information

- Enter the details pertaining to the ambulance transport.

Patient Weight (LB)

- Enter the weight of the patient in pounds.

Transport Distance (Miles)

- Enter the number of miles traveled by the ambulance for the transport.

***Condition Indicator**

<Blank> (default)
Yes
No

- Select the appropriate option to indicate whether condition codes apply to this claim.

*Condition Code

<Blank> (default)
01 – Patient was admitted to a hospital
04 – Patient was moved by stretcher
05 – Patient was unconscious or in shock
06 – Patient was transported in an emergency situation
07 – Patient had to be physically restrained
08 – Patient has visible hemorrhaging
09 – Ambulance service was medically necessary
12 – Patient is confined to a bed or chair

- If the Condition Indicator was marked “Yes,” select a Condition Code.
- Up to five condition codes can be added. Previously selected values do not display in the remaining drop-down fields.

*Transportation Reason Code

<Blank> (default)
A – Patient was transported to nearest facility for care of symptoms, complaints, or both
B – Patient was transported for the benefit of a preferred physician
C – Patient was transported for the nearness of family members
D – Patient was transported for the care of a specialist or for availability of specialized equipment
E – Patient Transferred to Rehabilitation Facility

- Select the appropriate transportation reason code relating to the ambulance transport.

Round Trip Purpose

- If a round trip occurred, enter the round-trip purpose.
- A maximum of 80 characters can be entered.

Stretcher Purpose

- If a stretcher was used, enter the stretcher purpose.
- A maximum of 80 characters can be entered.

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.

For FQHCs and RHCS, use the 'Other Payer' panels to report MCO payments when submitting a claim for FQHC/RHC wraparound payments.

NOTE: For help with FQHC and RHC wraparound claim submission, view the FQHC & RHC Professional Claim Submission for Wraparound Payments - Quick Reference Guide found on the 'Learning' page.

NOTE: For help with FQHC and RHC cost sharing claim submission, view the Submitting Professional Crossover Claims for FQHC and RHC Cost Sharing Payments in PNM - Quick Reference Guide found on the 'Learning' page.

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.)
- Transportation: Wheelchair van services (procedure codes A0130, S0209, and T2001) are never covered by Medicare, regardless of trip origin or destination or any other factor. On claims exclusively for wheelchair van services, omit all Medicare-related information. On claims for ambulance services, include Medicare-related information for dually eligible individuals.

*FQHC and RHC Claim Filing Indicators Used with Claims Submitted to ODM for Wraparound Payments and Cost Sharing

- FQHCs and RHCs should select 'HM – Health Maintenance Organization' for Medicaid wraparound payments.

FQHC and RHCs Submitting cost sharing claims to ODM: Other Payer Potential Insurance Combinations	Required Claim Filing Indicator(s) to use
Medicare part B (MB)	MB
Commercial (CI) and Medicare part B (MB)	CI and MB
Medicare part C (16)	16
Commercial (CI) and Medicare part C (16)	CI and 16
Medicare part C (16) and Medicare wrap around payment (MB)	16 and MB
Commercial (CI), Medicare part C (16) and Medicare wrap around payment (MB)	CI, 16, and MB

- 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.'
- FQHCs and RHCs should select 'MB' to report Medicare wraparound payments from the Medicare Administrative Contractor (MAC).

*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's 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’.
- For FQHC and RHC claim submissions for wraparound payments, 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.
- For FQHC and RHC claim submissions for wraparound payments, leave this line item blank.

Subscriber’s Address Line 2

- Enter the subscriber’s address line 2.
- For FQHC and RHC claim submissions for wraparound payments, leave this line item blank.

Subscriber’s City

- Enter the subscriber’s city.
- For FQHC and RHC claim submissions for wraparound payments, leave this line item blank.

Subscriber’s State

- Enter the subscriber’s state.
- For FQHC and RHC claim submissions for wraparound payments, leave this line item blank.

Subscriber’s Zip

- Enter the subscriber’s zip.
- For FQHC and RHC claim submissions for wraparound payments, leave this line item blank.

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.
- For FQHC and RHC claim submissions for wraparound payments, select ‘Header.’

Claim Number

- Enter the claim number assigned by the other payer.
- For FQHC and RHC claim submissions for wraparound payments, enter the ICN of the Managed Care Plan.

Paid Date

- Enter the claim adjudication date by the other payer using the MM/DD/YYYY format.
- For FQHC and RHC claim submissions for wraparound payments, enter the date that the Managed Care claim was paid.

Paid Amount

- Enter the paid amount by the other payer.
- For FQHC and RHC claim submissions for wraparound payments, enter the amount paid by the Managed Care Organization (MCO).

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 12 diagnosis codes can be entered.

*Diagnosis Code

- Enter (or use the [Search] function to select) the diagnosis code that corresponds to the selected sequence code. Omit the decimal point.
- Hospice: At least one terminal diagnosis is required.
- Transportation: For ground or air ambulance service, a diagnosis is optional. For wheelchair van service, do not specify a diagnosis, and omit diagnosis code pointers in the 'Service Detail' panel.

*ICD Version

<Blank>
ICD 10 (default)
ICD 9

- Select the ICD version of the diagnosis code.

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.

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.

NOTE: For help with FQHC and RHC cost sharing claim submission, view the Submitting Professional Crossover Claims for FQHC and RHC Cost Sharing Payments in PNM - Quick Reference Guide found on the 'Learning' page.

NOTE: For help with FQHC and RHC wraparound claim submission, view the FQHC & RHC Professional Claim Submission for Wraparound Payments - Quick Reference Guide found on the 'Learning' page.

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.
- A Health Plan ID will be available in the drop-down menu only if the claim adjudication level is 'Header' and the other payer responsibility Before precedes the destination payer responsibility.

*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.
- For FQHC and RHC claim submissions for wraparound payments, select 'CO – Contractual Obligations.'

*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.

- For FQHC and RHC claim submissions for wraparound payments, enter code ’45’ (Charge exceed fee schedule/maximum allowable or contracted/legislated fee arrangement).
- The Claim Adjustment Reason Code (CARC) should match the information provided on the Other Payer's Explanation of Benefits (EOB). If there was no EOB because the other insurance was not billed (for a non-covered service), select a CARC that most closely reflects the reason for non-payment by the other payer (e.g., 96). A current list of CARCs can be found at: Claim Adjustment Reason Codes | X12.

***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.
- For FQHC and RHC claim submissions for wraparound payments, enter the difference between the PPS amount and the MCO (and, if applicable, another payer) amount.

Quantity

- Enter the quantity adjusted by the other payer.
- For FQHC and RHC claim submissions for wraparound payments, leave this line item blank.

*SERVICE DETAILS

In the 'Service Detail' 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.

NOTE: For help with FQHC and RHC cost sharing claim submission, view the Submitting Professional Crossover Claims for FQHC and RHC Cost Sharing Payments in PNM - Quick Reference Guide found on the 'Learning' page.

NOTE: For help with FQHC and RHC wraparound claim submission, view the FQHC & RHC Professional Claim Submission for Wraparound Payments - Quick Reference Guide found on the 'Learning' page.

After entering data in this section/panel, press the 'Add' button to add the service line. A maximum of 50 service lines can be added.

*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.
- Hospice, Home Health Services, Private Duty Nursing, and ODM-Administered Waiver: Procedure codes for home health nursing services (G0299, G0300), home health aide service (G0156), or therapy service (G0151, G0152, G0153) that are provided on the same day, may be reported on the same claim.
- FQHCs and RHCs should enter the procedure code (T1015) for Service Line 01.

*Date of Service

- Enter the date (format MM/DD/YYYY) on which the service was provided.
- A separate service line is required for each date of service.

Line Control Number

- Enter a reference number for the service detail.

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.

DME Certification Type *(Durable Medical Equipment)*

<Blank> (default)
I – Initial
R – Renewal
S – Revised

- Select the appropriate code to indicate the Durable Medical Equipment certification type.

DME Duration (month)

- Enter (in months) the length of time DME equipment is needed.
- This field is grayed out if DME Certification Type is not selected.

Certification Revision or Recertification Date

- Enter the date (format DD/MM/YYYY) for the certification, revision, or recertification.
- This field is grayed out if DME Certification Type is not selected or is selected as 'I - Initial.'

*Place of Service

- Hospice, Home Health Services, Private Duty Nursing, and ODM-Administered Waiver: Enter (or use the [Search] function to select) the two character/digit place code that best describes the place of service. Do NOT use old code '09,' which now means "prison" and will cause denial of the claim.
- Independent Laboratory: Use '81.'
- Transportation: For ground ambulance, use '41.' For air ambulance, use '42.' For wheelchair van, use '99.'

Modifier

- When applicable, enter each two character/digit procedure code modifier associated with the supply or service. Up to 4 values can be entered.
- 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.
- On a claim submission for an FQHC, the following modifiers can be entered:

Modifier	**Encounter**
U1	Medical services (offered by every FQHC)
U2	Dental services
U3	Behavioral health services
U4	Physical or occupational therapy
U5	Speech pathology or audiology services

U6	Podiatric services
U7	Optometrist or optician services
U8	Chiropractic services
U9	Transportation (with procedure code T2003 as Service Line 02)

- On a claim submission for an RHC, the following modifiers can be entered:

Modifier	**Encounter**
U1	Medical and behavioral health services
U9	Transportation *(*As of 1/1/2022 RHC's may submit claims under the PPS for RHC transportation service with procedure code T2003 as Service Line 02)*

*Diagnosis Pointer

<Blank> (default)
1 through 8

- Enter the diagnosis pointer for the procedure code.
- At least one diagnosis code pointer is required for most services and supplies.
- Up to 4 values can be added per procedure.

Referred EPSDT Service

<Blank> (default)
Yes

- Indicate whether the service or supply was provided because of an EPSDT referral.

Family Planning

<Blank> (default)
Yes

- Indicate whether the service or supply is related to family planning.

Emergency

<Blank> (default)
Yes

- Completion of this field is optional, but you may select 'Yes' to indicate that the service or supply provided was emergency-rated.

- Hospice, Home Health Services, Private Duty Nursing, and ODM-Administered Waiver: This information is not applicable. Leave the field blank.

Final EAPG *(populated automatically from FI after claim is processed)*

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

Status *(populated automatically from FI. If the claim has not been submitted, 'Pending Submission' displays)*

***Charges**

- Enter (in dollars) the usual and customary charge for the service or supply.

***Billed Units**

- Enter the number of units appropriate to the service or supply.
- Transportation: For each line item other than mileage, enter 1.

***Unit of Measurement**

<Blank> (default)
UN – Units
MJ – Anesthesia Minutes

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

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

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. On a drug package, the printed NDC often includes separators such as hyphens or dashes (Ex: 55555-4444-22). 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. For compound drugs, enter the NDC for each ingredient (the same Service Line can be selected).

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.

***NDC**

- Enter (or use the [Search] function to select) the 11-digit National Drug Code (NDC) for the service line. (The NDC code 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
Supervising Provider
Service Facility
Referring Provider
Primary Care Provider
Ordering Provider

- 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.

Medicaid ID *(populated automatically)*

Last Name *(populated automatically)*

First Name *(populated automatically)*

Middle Name *(populated automatically)*

AMBULANCE 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 ambulance information.

Enter information if it is different than what is listed in the 'Ambulance Information' section/panel.

***Service Line**

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

***Pick-up Address Line 1**

- Enter the first line of the address where the ambulance pick-up occurred.

Pick-up Address Line 2

- Enter the second line of the address where the ambulance pick-up occurred, if applicable.

***Pick-up City**

- Enter the city where the ambulance pick-up occurred.

***Pick-up State**

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

- Select the state where the ambulance pick-up occurred.

***Pick-up Zip**

- Enter the ZIP code where the ambulance pick-up occurred.

Drop Off Location Name

- Enter the name of the ambulance drop off location.

***Drop Off Address Line 1**

- Enter the first line of the address where the ambulance drop off occurred.

Drop Off Address Line 2

- Enter the second line of the address where the ambulance drop off occurred, if applicable.

***Drop Off City**

- Enter the city where the ambulance drop off occurred.

***Drop Off State**

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

- Select the state where the ambulance drop off occurred.

***Drop Off Zip**

- Enter the ZIP code where the ambulance drop off occurred.

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.

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.

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 (EOB), 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 (EOB), 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.
- For FQHC and RHC claim submissions for wraparound payments, enter the amount paid by the other payer.

Quantity

- Enter the quantity adjusted by the other payer.
- For FQHC and RHC claim submissions for wraparound payments, enter the number of units of service.

VALUE CODE INFORMATION

- For FQHC and RHCs enter value code information, if needed.
- Enter amount.

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.

NOTE: If a note needs to be added, that is greater than 80 characters, it can be added in the form of a Word document as an attachment.

***Note Reference Code**

<Blank> (default)
ADD – Additional Information
CER – Certification Narrative
DCP – Goals, Rehabilitation Potential, or Discharge Plans
DNG – Diagnosis Description
TPO – Third Party Organization Notes

- Select 'CER' if you are submitting a Medicaid School Program (MSP) claim.
- 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 Medicaid School Program (MSP) claim is submitted, a 10- character attestation code must be entered in this field to show whether or not the claim is certified by the executive officer of the MSP provider or his/her designee in accordance with rule 5160-35-04 of the Ohio Administrative Code. (There must be a space after the word 'ATTEST' so that the note characters plus the space equal 10 characters.)
    - Format: *ATTEST YES* or *ATTEST NAY*
- 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), enter the appropriate reason code. 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

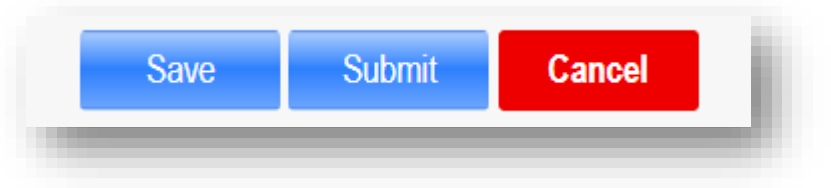
Data in this section/panel appears only after the adjudication of the claim by the payer. This section/panel is view only and shows CARC and RARC information. CARC and RARC information will be organized to be 10 lines per page.

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 Professional 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.