USER MANUAL

Professional Claims - Fee for Service

![Ohio Department of Medicaid logo]

Department of Medicaid

Table of Contents

Introduction

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

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

For additional FQHC & RHC claims resources, please refer to the specific Quick Reference Guides listed under the Professional Claims (Fee-for-Service) section on the PNM Learning page.

- FQHC & RHC Professional Claim Submission for FFS Members - Quick Reference Guide
- FQHC & RHC Professional Claim Submission for Wraparound Payments - Quick Reference Guide

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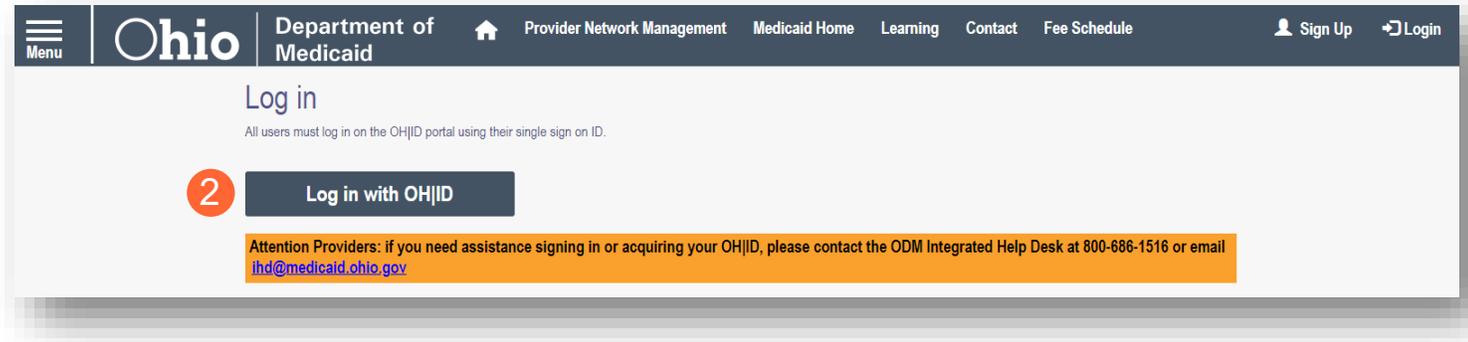
Step 3: The system will prompt you to enter your username and password on the IOP login screen. Once entered, click **Log in**.

- 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

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| 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

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Provider Home Page

There are two provider roles in PNM:

- **Provider Administrator:** *(Also known as CEO Certified for DODD)* A role assigned to a user in PNM that allows that user to create new enrollment applications, update provider records, and complete revalidations among other tasks. The Administrator role will also be able to grant accesses/actions to other users in PNM, known as Agents.

  - There is one Administrator role per NPI/Medicaid ID. However, a single user with the Administrator role can administer to multiple providers (NPIs/Medicaid IDs).

- **Provider Agent:** *(Also known as Secondary User for DODD)* A role assigned to a user in PNM that allows that user to complete specific actions such as updating a provider record, revalidation, claims submission, prior authorization, the viewing of reports, etc. These actions are assigned to each Agent by the Administrator for the Medicaid ID.

A user must select a role the first time they log into PNM.
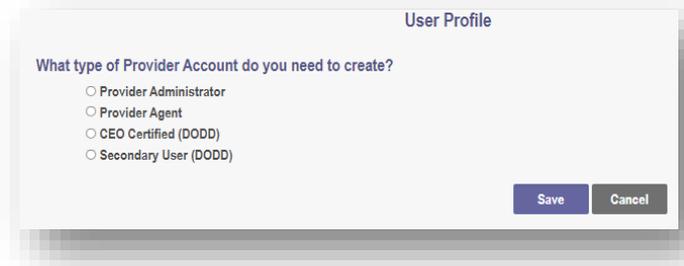
When you first login to the PNM system you will see a variety of buttons to help with administering providers. Some of the buttons, as indicated below, are only accessible to certain user roles.
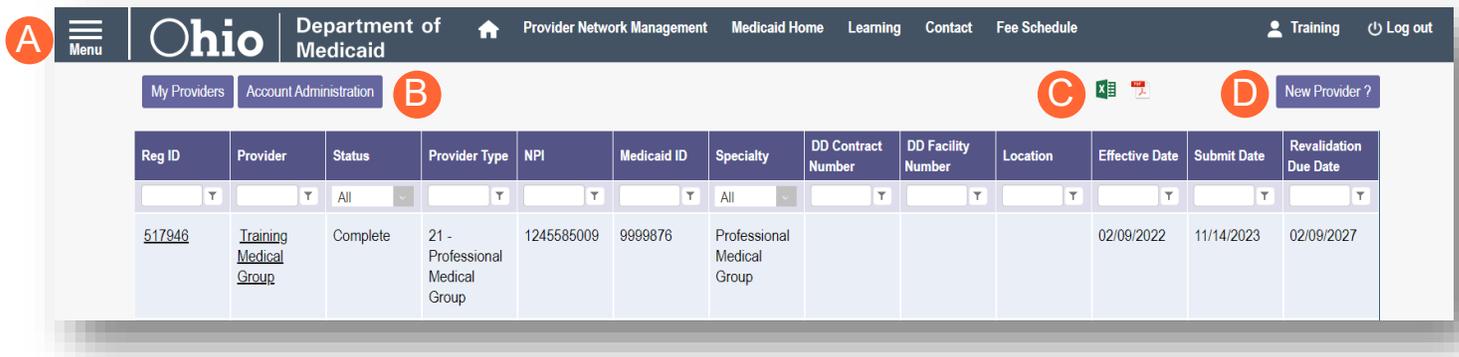
Menu: The menu can be accessed by clicking on the three bars in the top left corner of the screen. The Menu provides a variety of key topics to choose from such as the Provider Directory, Learning Resources, and Contact Us (A).

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

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

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

Accessing the Provider Self Service Panel

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

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

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

Step 3: Click the 'Claims' hyperlink.

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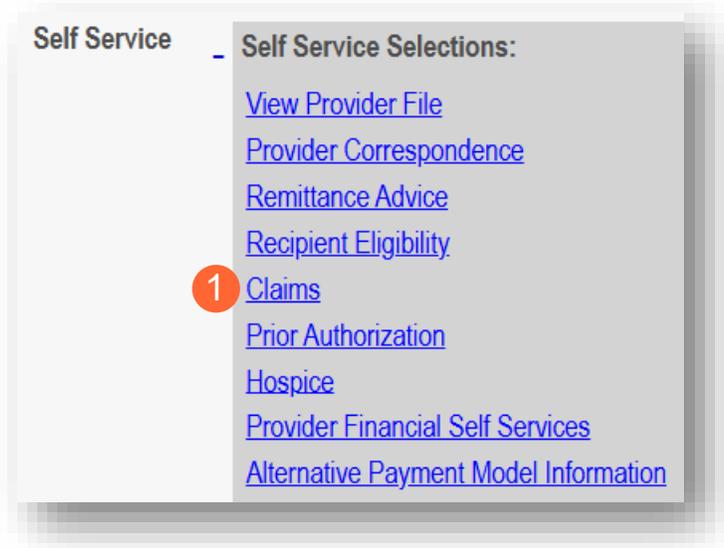
Step 2: The Claims search panel will appear. Enter any or all the following information:

- 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: Professional
- 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 column and Attachments '**Upload**' hyperlink appears to 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 46 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 are displayed in a collapsed section. To view them, 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**: Allows provider to create a new claim by 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 'Copy' or 'Adjust' buttons are clicked, all field values become editable and claim adjudication information is deleted.

PROFESSIONAL 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.
- **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 Professional Claims can be submitted through PNM.

Step 1: Click the 'Claims' hyperlink.
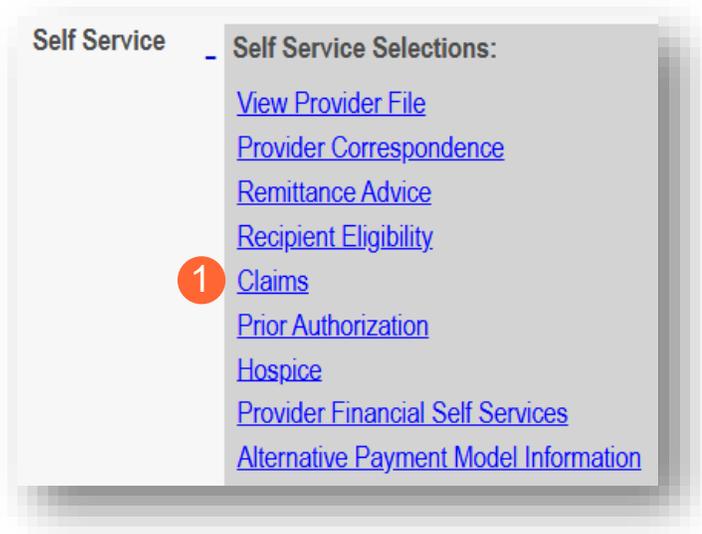
Step 2: To submit a Claim, click the 'Submit Claim' icon at the top of the page or select 'Submit Claim' from the drop-down menu next to 'Jump To'.

Step 3: Under Claim Type, select the 'Professional' 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 insert the information into the claim field.

DIAGNOSIS CODE	ICD VERSION	DIAGNOSIS DESCRIPTION		
	ICD 10			Search

DIAGNOSIS CODE	ICD VERSION	DIAGNOSIS DESCRIPTION		
	ICD 10	gastro		Search

SEARCH RESULTS

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

- ADDITIONAL PROVIDER INFORMATION-SERVICE DETAIL

* Service Line	* Provider Type	* Provider NPI	Last Name	First Name	Middle Name

Search   **ADD**

NPI	MEDICAID ID	BUSINESS/LAST NAME	FIRST NAME	
		smith		**Search**

SEARCH RESULTS

NPI	Medicaid ID	Business/Last Name	First Name	Address Line 1	Address Line 2	City	State	Zip
1003005455	10000046	SMITH	NANCI	2400 CORPORATE EXCHANGE DR		COLUMBUS	OH	43231
1003144130	9999915	SMITH THERAPY SERVICES		141 WASHINGTON AVE		COLUMBUS	OH	43231

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 for a period of 72 hours or until the claim is modified or submitted, whichever occurs first.
    - o A saved claim can be retrieved through a search of the Claim Search panel for the status '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 the 'Professional' claim type, select the following information from the drop-down menu in each field:

- Destination Payer Name
  - o Ohio Department of Medicaid

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

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

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

Destination Payer: Submitting Claims for FQHC and RHC Wraparound Payments

*See **Appendix 1** on page 54 for specific information on how to submit a claim for FQHC and RHC wraparound payments.*

When submitting claims for wraparound payment, the following selections should be made:

Destination Payer Name: Ohio Department of Medicaid

Destination Payer ID: MMISODJFS – Ohio Department of Medicaid

Destination Payer Responsibility Sequence: ODM's responsibility to pay the claim (NOT 'Primary')

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 *(in MM/DD/YYYY format).* (Omitting the separating slashes causes an error.)
    - o Once these are entered, the recipient's information (Last Name, First Name, Gender, Address) will be filled in automatically.
- Enter the [Provider's] Patient Control Number *(Patient Account Number).*
    - o This string of characters is the internal tracking number for the patient/recipient in the provider's recordkeeping system. This number can be used as a data point when completing a claim search in PNM.
- Medical Record Number *(optional)*
    - o This number is assigned by the provider.
- Pregnancy Indicator *(optional)*
    - o Yes
    - o (Blank)

Service Information

Step 6: Enter or select the following information:

- Release of Information *(required)*
    - Yes
    - No
- Special Program Indicator *(optional)*
    - 02 – Physically handicapped children's program
    - 03 – Special federal funding
    - 05 – Disability
    - 09 – Second opinion or surgery
- Early Periodic Screening, Diagnosis and Treatment (EPSDT) Condition Indicator *(optional)*
    - Yes
    - No
- EPSDT Condition Code *(available only when 'Yes' is selected for EPSDT Condition Indicator)*
    - Up to three entries can be made:
        - S2 – Under Treatment
        - ST – New Services Requested
        - NU – Patient Not Referred
        - AV – Patient Refused Referral
- Patient Amount Paid *(optional)*
- Hospital Discharge Date *(optional)*
- Last Menstrual Period *(optional)*

'Situational' Sections

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

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

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

```
+ ACCIDENT INFORMATION
+ PRIOR AUTHORIZATION & REFERRAL INFORMATION
+ REFERRING PROVIDER INFORMATION
+ RENDERING PROVIDER
+ SERVICE FACILITY LOCATION INFORMATION
+ SUPERVISING PROVIDER
+ AMBULANCE INFORMATION
+ OTHER PAYER INFORMATION
```

Accident Information

Enter or select the following information:

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

- ACCIDENT INFORMATION

| * Accident Related To | AA - Auto Accident | Accident State | OH | Accident Country | US |
| Accident Related To | OA - Other Accident | Accident Date | 05/05/2022 | | |

Prior Authorization & Referral Information

Enter the following information:

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

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

- PRIOR AUTHORIZATION & REFERRAL INFORMATION	
Prior Authorization Number	Referral Number

Referring Provider Information

A Referring Provider should only be reported by Medicaid School Program providers when a skilled therapist refers a service for a student.

Enter the following information:

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

Rendering Provider

Note: Only one Rendering Provider (NPI) can be entered in this section/panel. A professional claim submitted via PNM with multiple rendering providers will either be returned to PNM with an error or denied and reported on the 835/RA.

Enter the following information:

- Rendering Provider NPI
  - If you do not know the provider's NPI, click 'Search' to look up 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 look up 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							

Supervising Provider

If the claim requires a supervising provider, enter the following information:

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

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

Ambulance Information

Enter the following information:

Note: PNM will validate the ambulance drop-off location; address, city, state, and ZIP Code against the United States Postal Service (USPS) address database. If the address is not valid, an error message will be displayed.

- Pick-up Address Line 1
- Pick-up Address Line 2
- Pick-up City
- Pick-up State
- Pick-up Zip
- Drop Off Location Name
- Drop Off Address Line 1
- Drop Off Address Line 2
- Drop Off City
- Drop Off State
- Drop Off Zip
- Patient Weight (LB)
- Transport Distance (Miles)
- Condition Indicator
    - Indicate whether condition codes apply to this claim.
        - Yes
        - No
- Condition Code
    - Up to five (5) values can be added.
        - 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 had visible hemorrhaging
        - 09 – Ambulance service was medically necessary
        - 12 – Patient is confined to a bed or chair
- Transport Reason Code
    - 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
- Round Trip Purpose
- Stretcher Purpose

Other Payer Information

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

This section explains how to submit FQHC and RHC claims to ODM for wraparound payments. See Appendix 1 for specific information on how to submit a claim for FQHC and RHC wraparound payments.

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 (and FQHC/RHC wraparound payments received from the Medicare Administrative Contractor)
  - 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

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- o S – Secondary
  - o T – Tertiary
  - o A – Payer Responsibility Four
  - o B – Payer Responsibility Five
  - o C – Payer Responsibility Six
  - o D – Payer Responsibility Seven
  - o E – Payer Responsibility Eight
  - o F – Payer Responsibility Nine
  - o G – Payer Responsibility Ten
  - o H – Payer Responsibility Eleven
  - o U – Unknown
- Subscriber's Number
- Policy Number
- Group Name
- Insurance Type Code
  - o 12 – Medicare Secondary Working Aged Beneficiary or Spouse with Employer Group Health Plan
  - o 13 – Medicare Secondary End-Stage Renal Disease Beneficiary in the Mandated Coordination Period with an Employer s Group Health Plan
  - o 14 – Medicare Secondary, No-fault Insurance including Auto is Primary
  - o 15 – Medicare Secondary Worker's Compensation
  - o 16 – Medicare Secondary Public Health Service (PHS)or Other Federal Agency
  - o 41 – Medicare Secondary Black Lung
  - o 42 – Medicare Secondary Veteran's Administration
  - o 43 – Medicare Secondary Disabled Beneficiary Under Age 65 with Large Group Health Plan (LGHP)
  - o 47 – Medicare Secondary, Other Liability Insurance is Primary
- Patient's Relationship to Subscriber
  - o 01 – Spouse
  - o 18 – Self
  - o 19 – Child
  - o 20 – Employee
  - o 21 – Unknown
  - o 39 – Organ Donor
  - o 40 – Cadaver Donor
  - o 53 – Life Partner
  - o 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
  - o 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
  - o PNM grays out this field if other payer responsibility sequence is greater than the destination payer responsibility sequence or the claim adjudication level is 'Detail'.
  - o If destination or other payer responsibility sequence is unknown, this field will be optional and available to report when the claim adjudication level is 'Header'.

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

FQHC and RHC Claims for Wraparound Payments

See Appendix 1 for specific information on how to submit a claim for FQHC and RHC wraparound payments.

When submitting a claim for wraparound payment, the coordination-of-benefits (COB) information needs to be listed. Enter the information for the other payer. In some fields, specific information is needed.

- Health Plan ID: The Medicaid Provider ID number for the payer

Managed Care Entity	ABD Medicaid Provider ID	CFC Medicaid Provider ID	MyCare Provider ID	OhioRISE Medicaid Provider ID
Aetna Better Health of Ohio			0082400	
Aetna Better Health OhioRISE				0445886
AmeriHealth Caritas (eff. 12/1/2022)	0461036	0462293		
Buckeye Community Health Plan	0077145	0077148	0082408	
CareSource	0077191	0077193	0082409	
Comm. Ins. Co. (eff. 12/1/2022) DBA Anthem Blue Cross and Blue Shield	0464227	0464229		
Humana Health Plan of Ohio, Inc. (eff. 12/1/2022)	0461038	0462285		
Molina HealthCare of Ohio Inc	0077182	0077186	0082414	
Paramount Advantage	0077188	0077190		
United Healthcare Community Plan	0077110	0077115	0082405	

- Claim Filing Indicator: Health Maintenance Organization (HMO)
- Paid Amount: The approved/allow amount specified by the Managed Care Organization (MCO)

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Diagnosis Codes

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

Enter or select the following information:

- Diagnosis Code *(required)*
  - o If you do not know the Diagnosis Code, click 'Search' to look up the code.
    - ▪ Diagnosis codes with decimal points are not accepted. Enter Diagnosis Codes that do not contain a decimal point.
    - ▪ PNM defaults to the ICD 10 code, but this selection can be changed if needed.
  - o The Diagnosis Description auto-populates after the Diagnosis Code is selected.
- Click **Add** to add the diagnosis code to the claim submission.
  - o A maximum of 12 diagnosis codes can be added.

- The added diagnosis appears on a list.

- Repeat the process to add other diagnoses.

Additional 'Situational' Sections

To expand collapsed sections, click the '+' icon. 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.

> \+ OUTPATIENT ADJUDICATION INFORMATION
> \+ HEADER OTHER PAYER ADJUSTMENT INFORMATION

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

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):	

Header Other Payer Adjustment Information

Enter the following information:

- Heath Plan ID
  - o 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
  - o This information is required when an adjustment amount is reported.
  - o Each Adjustment Group can be repeated up to six times for each 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 look up the code.
- Amount
- Quantity
  - o The quantity adjusted by the other payer.

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

- HEADER OTHER PAYER ADJUSTMENT INFORMATION

* Health Plan ID	* Adjustment Group	* Reason Code	* Amount	Quantity	
		Search			Add

Wraparound Claims

See Appendix 1 for specific information on how to submit a claim for FQHC and RHC wraparound payments.

When submitting a claim for wraparound payment, fill out the following information in this section if the provider's total submitted charge is greater than the payment made by the MCO. The difference in amount is reported in the claim header.

- Adjustment Group: CO (Contractual Obligation)
- Reason Code: 45 (Charge exceed fee schedule/maximum allowable or contracted/legislated fee arrangement)
  - o For example, if submitted charges are $100 and the MCO paid a total of $25, then the different of $75 is reported with CO 45.

Service Details

Step 7: Enter or select the following information:

- Procedure Code *(required)*
    - If you do not know the Procedure Code, click 'Search' to look up the code.
- Date of Service *(required)*
- Line Control Number *(optional)*
- Prior Authorization Number *(optional)*
- Referral Number *(optional)*
- Durable Medical Equipment (DME) Certification Type *(optional)*
    - I – Initial
    - R – Renewal
    - S – Revised
- DME Duration (month) *(needs to be filled out only if DME Certification Type is selected)*
- Certification Revision or Recertification Date *(required when DME certification type is 'R' or 'S')*
- Place of Service *(required)*
    - If you do not know the Place Code, click 'Search' to look up the code.
- Modifier *(optional)*
    - Up to four values are allowed.
- Diagnosis Pointer *(required)*
    - A maximum of 4 values per procedure.
- Referred EPSDT Service *(optional)*
    - Yes
- Family Planning *(optional)*
    - Yes
- Emergency *(optional)*
    - Yes
- Charges *(required)*
    - The submitted amount for the procedure.
- Billed Units *(required)*
- Unit of Measurement *(required)*
    - UN – Units
    - MJ – Anesthesia Minutes

Note: At least one service detail needs to be entered:

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

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

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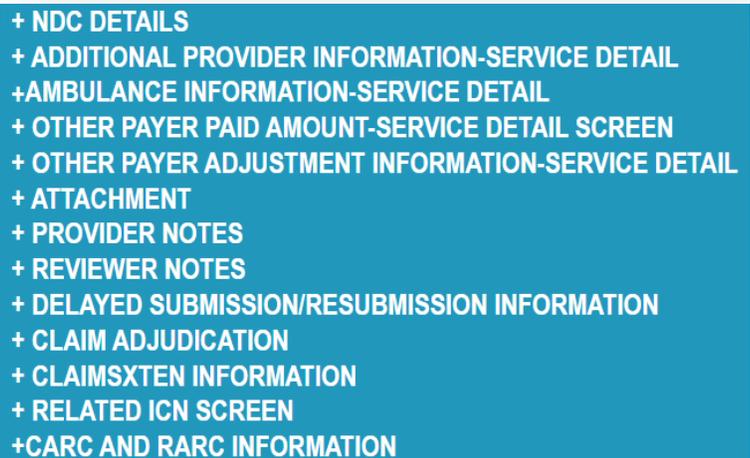
To expand any of the collapsed sections, click the '+' icon. When the section is expanded, enter any necessary information.

- 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
+AMBULANCE 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

NDC (National Drug Code) Details

Enter or select the following information:

- Service Line *(required only if information is added to this section)*
  - Enter the number of the service detail to which the NDC applies.
- NDC *(required only if information is added to this section)*
  - If you do not know the NDC Code, click 'Search' to look up the code.
- Units of Measure *(required only if information is added to this section)*
  - International Unit
  - Gram
  - Milligram
  - Milliliter
  - Unit
- Prescription Number *(optional)*
- Total Unit
  - Enter the aggregate number of units of the drug.

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

Note: Only one drug can be entered on a service line. If more than one drug is to be reported on the claim, add service lines.
    A maximum of 30 service details can be added.

- NDC DETAILS

*Service Line	*NDC	*Unit Of Measure	Prescription Number	*Total Unit	
[dropdown]	[____] Search	Unit [dropdown]	[____]	[____]	Add

Additional Provider Information – Service Detail

If there is more than one rendering provider for this claim, list them in this section.

Enter or select the following information:

- Service Line *(required only if information is added to this section)*
    - Enter the number of the service detail to which the information applies.
- Provider Type *(required 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 only if information is added to this section)*
    - If you do not know the provider's NPI, click 'Search' to look up the provider.
    - Once the NPI is entered, the Medicaid ID, Last Name, and First Name will auto-populate.

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

Ambulance Information – Service Detail

Enter or select the following information:

- Service Line *(required only if information is added to this section)*
  - Enter the number of the service detail to which the information applies.
- Pick Up Address Line 1 *(required only if information is added to this section)*
- Pick Up Address Line 2 *(required only if information is added to this section)*
- Pick Up City *(required only if information is added to this section)*
- Pick Up State *(required only if information is added to this section)*
- Pick Up Zip *(required only if information is added to this section)*
- Drop-off Location Name *(optional)*
- Drop Off Address Line 1 *(required only if information is added to this section)*
- Drop Off Address Line 2 *(required only if information is added to this section)*
- Drop Off City *(required only if information is added to this section)*
- Drop Off State *(required only if information is added to this section)*
- Drop Off Zip *(required only if information is added to this section)*

Note: PNM will validate the ambulance drop-off location; address, city, state, and ZIP Code against the United States Postal Service (USPS) address database. If the address is not valid, an error message will be displayed.

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

Other Payer Paid Amount – Service Detail Screen

Enter or select the following information:

- Service Line *(required only if information is added to this section)*
  - Enter the number of the service detail to which the information applies.
- Health Plan ID *(required only if information is added to this section)*
  - Health Plan ID will be displayed in the drop-down menu only if the adjudication level is 'Detail' and the other payer responsibility Before precedes the destination payer responsibility.
- Amount Paid *(required only if information is added to this section)*
- Paid Service Unit Count *(required only if information is added to this section)*
  - The number of units paid by the other payer.

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

Other Payer Adjustment Information – Service Detail

Enter or select the following information:

- Service Line *(required only if information is added to this section)*
  - Enter the number of the service detail to which the information applies.
- Health Plan ID *(required only if information is added to this section)*
- Adjustment Group *(required only if information is added to this section)*
  - Each Adjustment Group can be repeated up to six times for each other payer.
    - CO – Contractual Obligations
    - CR – Correction and Reversals
    - OA – Other adjustments
    - PI – Payor Initiated Reductions
    - PR – Patient Responsibility
- Reason Code *(required only if information is added to this section)*
  - If you do not know the Reason Code, click 'Search' to look up the code.
- Amount *(required 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 service details can be added.

Attachment

Step 9: Before 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:

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

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

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

Acceptable File Types:

- 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

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

- Select a Note Reference Code:
    - ADD – Additional Information
    - CER – Certification Narrative
    - DCP – Goals, Rehabilitation Potential, or Discharge Plans
    - DNG – Diagnosis Description
    - TPO – Third Party Organization Notes

- A note can be a maximum of 80 characters in length.

- PROVIDER NOTES	
*Note Reference Code	*Note
⌄	80 characters max

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 NOTES	
*Note Reference Code	*Note
ADD - Additional Information ⌄	APPEALS XXXXXXX CCYYMMDD

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 NOTES

*Note Reference Code	*Note
ADD - Additional Information	DECISION CCYYMMDD

Medicaid School Program Claims (MSP)

Below are instructions for notes to list when submitting a Medicaid School Program (MSP) claim.

When a Medicaid School Program (MSP) claim is submitted, a Note Reference Code of 'CER' must be selected for the 'Note Reference Code' field, and 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 5101:3-35-04 of the Ohio Administrative Code. Format: ATTEST YES or ATTEST NAY (There must be a space after the word 'ATTEST'.)

- PROVIDER NOTES

*Note Reference Code	*Note
CER - Certification Narrative	ATTEST YES

- PROVIDER NOTES

*Note Reference Code	*Note
CER - Certification Narrative	ATTEST NAY

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'.)

- PROVIDER NOTES

*Note Reference Code	*Note
ADD - Additional Information	COPAY EMER

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'.)

- PROVIDER NOTES

*Note Reference Code	*Note
ADD - Additional Information	COPAY HSPC

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'.)

- PROVIDER NOTES	
*Note Reference Code	*Note
ADD - Additional Information	COPAY PREG

Delayed Submission/Resubmission Information

Indicate a reason for a delayed submission or resubmission of the claim:

- Enter a previously denied Internal Control Number (ICN)

- DELAYED SUBMISSION/RESUBMISSION INFORMATION

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

Previously Denied ICN: [ ]   Reason for Delay: [ ]

The list of reasons corresponds to Electronic Data Interchange (EDI) information and may apply to delays in managed care claim submissions. Delays in submission of fee-for-service claims are usually indicated in the provider notes.

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 information is entered in the following sections. When a claim is reviewed and returned, however, 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
+ AMBULANCE 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
+ADJUDICATION ERRORS
+MALICIOUS ATTACHMENTS

Submit the Claim

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

Note: If there are any errors preventing submission, error messages will be displayed 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.

13 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.

13 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

Fiscal Intermediary (FI) ICN Logic

After the claim is submitted, an Internal Control Number (ICN) will be created for the claim. The source of the claim is shown in the first six characters of the ICN. ('YY' stands for the last two digits of the year. 'JJJ' stands for the Julian date, 000 to 366, within the year.)

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 **Clear**.

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

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

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

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

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

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

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

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

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

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

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

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

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

Malicious Attachments

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

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.

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

Step 3: Upload a 'clean' version of the document by clicking the 'Claims' hyperlink.
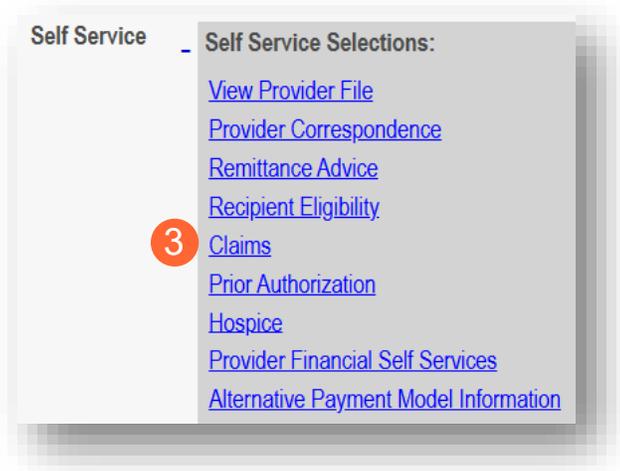
Step 4: The Claims search panel will appear. Enter any or all the following information:

- Internal Control Number—ICN *(tracking number assigned to the claim)*
- Medicaid Billing Number
- Patient Account Number
- Rendering Provider ID
- Amount Billed
- Payor Name *(required field)*
  - o Ohio Department of Medicaid
- Claim Type: Professional
- Claims Status
  - o Adjudicated
  - o Pay
  - o Open
  - o Deny
  - o Pend

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- 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 the red Clear button.

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.

Appendix 1: Submitting Claims for FQHC and RHC Wraparound Payments

Step 1:

A red asterisk (*) listed next to any field, indicates that field is required to be completed within that section of the Claims Submission page.

On the Claims Submission page, select the 'Professional' Claim Type (including FQHC dental claims).

Select the following information from the drop-down lists:

- Destination Payer Name: Ohio Department of Medicaid
- Destination Payer ID: MMISODJFS – Ohio Department of Medicaid
- Destination Payer Responsibility Sequence: The role of ODM as payer of the claim.

  o ODM is the last payer in the sequence.
  o Examples: For an individual who has Medicaid coverage both under managed care and under fee-for-service, the MCO is the Primary payer, and ODM is Secondary. For an individual who has Medicaid coverage both under managed care and under FFS and commercial coverage with one insurance carrier, the commercial carrier is the Primary payer, the MCO is Secondary, and ODM is Tertiary. For an individual who has Medicaid coverage both under managed care and under FFS and coverage with two other insurance carriers, the main carrier is the Primary payer, the next carrier is Secondary, the MCO is Tertiary, and ODM is 4th-level (Quaternary).

Step 2: Scroll down and locate the Other Payer Information section.

Click '+' to expand that section and enter information for the Medicaid Managed Care Organization (MCO).
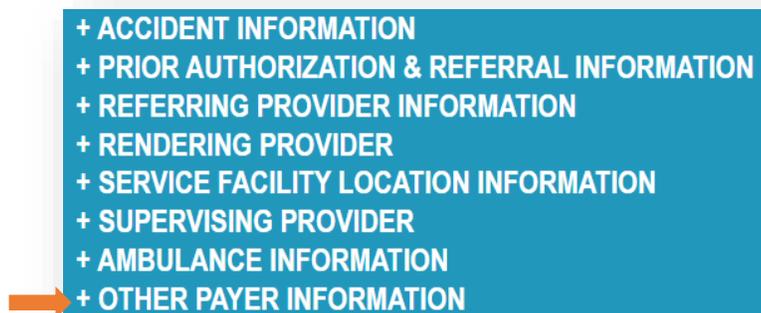
Step 3: Scroll down and locate the Other Payer Information section.

Enter the information for the other payer. In some fields, specific information is needed. Enter all other applicable coordination-of-benefits (COB) information. ('Subscriber' is the Medicaid Recipient.)

Other Payer Name: The full name of the organization involved with the payment of the claim.

Health Plan ID: The Medicaid Provider ID number for the payer.

> Aetna Better Health OhioRISE, 0445886
>
> AmeriHealth Caritas ABD, 0461036
>
> AmeriHealth Caritas CFC, 0462293
>
> Anthem Blue Cross and Blue Shield ABD, 0464227
>
> Anthem Blue Cross and Blue Shield CFC, 0464229
>
> Buckeye Health Plan ABD, 0077145
>
> Buckeye Health Plan CFC, 0077148
>
> CareSource ABD, 0077191
>
> CareSource CFC, 0077193
>
> Humana Healthy Horizons ABD, 0461038
>
> Humana Healthy Horizons CFC, 0462285
>
> Molina HealthCare ABD, 0077182
>
> Molina HealthCare CFC, 0077186
>
> Paramount Advantage ABD, 0077188
>
> Paramount Advantage CFC, 0077190
>
> UnitedHealthcare Community Plan ABD, 0077110
>
> UnitedHealthcare Community Plan CFC, 0077115

Claim Filing Indicator:

> Select "HM - Health Maintenance Organization (HMO)" for Medicaid wraparound payments.

Payer Responsibility Sequence: Select the MCO's (or other third-party insurance's) level of responsibility for the payment of the claim.

Subscriber Number: Enter the Medicaid Billing Number (the same Medicaid Billing Number entered under the Recipient Information section of the Claims Submission page).

Policy Number: Enter the same number listed under Subscriber Number (the Medicaid Billing Number).

Group Name: Leave this line item blank.

Insurance Type Code: Leave this line item blank.

Patient Relationship to Subscriber: Select "Self."

Subscriber First Name: Enter the first name of the subscriber to the coverage.

Subscriber Last Name: Enter the last name of the subscriber to the coverage.

Subscriber's Middle Name: Enter the middle name of the subscriber to the coverage.

Subscriber's Address Line 1: Leave this line item blank.

Subscriber's Address Line 2: Leave this line item blank.

Subscriber City: Leave this line item blank.

Subscriber State: Leave this line item blank.

Subscriber Zip: Leave this line item blank.

Claim Adjudication Level: Select **"Header."**

Claim Number: Enter the ICN of the Managed Care Plan.

Paid Date: Enter the date that the Managed Care claim was paid.

Paid Amount: Enter the amount paid by the MCO.

Non Covered Amount: Leave this line item blank.

After all information has been entered, click **Add**.

Repeat the process if additional payers need to be entered.

Step 4: Click '+' to expand the Header Other Payer Adjustment Information section.

Health Plan ID: Select the appropriate Health Plan ID from the drop-down menu *(drop-down options will be based on Health Plans listed in the Other Payer Information section).*

Adjustment Group: Select "CO." (Contractual Obligations)

Reason Code: Enter code "45." (Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement).

For example, if submitted charges are $100 and the MCO paid a total of $25, then the difference of $75 is reported with CO 45.

Amount: Enter the difference between the PPS amount and the MCO (and, if applicable, another payer) amount.

Quantity: Leave this line item blank.

After all information has been entered, click **Add.**

Repeat the process if additional payers need to be entered.

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Step 5: It is necessary to report COB payment information at the detail level only if the MCO is the secondary payer and another payer is primary.

Click '+' to expand the Other Payer Paid Amount-Service Detail Screen and the Other Payer Adjustment Information–Service Detail sections.

+ OTHER PAYER PAID AMOUNT-SERVICE DETAIL SCREEN
+ OTHER PAYER ADJUSTMENT INFORMATION-SERVICE DETAIL

Other Payer Paid Amount – Service Detail Screen

Service Line: Select the appropriate service line for service information entered in the Service Detail section as it relates to the other payer paid amount.

Health Plan ID: Select the appropriate Health Plan ID from the drop-down menu *(drop-down options will be based on Health Plans listed under Other Payer Information section).*

Amount Paid: Enter the amount paid by the other payer.

Paid Service Unit Count: Enter the number of units paid by the other payer *(cannot be greater than billed unit).*

Information is reported about every payer and each payer is entered on a separate line.

After information has been entered, click **Add**.

Repeat the process if additional payers need to be entered.

- OTHER PAYER PAID AMOUNT-SERVICE DETAIL SCREEN

*Service Line	Procedure Code	*Health Plan ID	*Amount Paid	Paid Date	*Paid Service Unit Count

ADD

Other Payer Adjustment Information – Service Detail

Service Line: Select the number of the service line in the Service Detail section for which other payer information is being entered.

Health Plan ID: Select the appropriate Health Plan ID from the drop-down menu *(drop-down options will be based on Health Plans listed under Other Payer Information section).*

Adjustment Group: Select the option listed on the Explanation of Benefits (EOB) from the other payer.

> CO - Contractual Obligations
> CR - Correction and Reversals
> OA - Other adjustments
> PI - Payor Initiated Reductions
> PR - Patient Responsibility

Reason Code: Enter the Reason Code listed on the Explanation of Benefits (EOB) from the other payer.

> If you do not know the Reason Code, click 'Search' to look up the appropriate code.

Amount: Enter the amount paid by the other payer.

Quantity: Enter the number of units of service.

Information is reported about every payer and each payer is entered on a separate line.

After information has been entered, click **Add**.

Repeat the process if additional payers need to be entered.

Step 6: Make sure that all necessary sections/panels are completed on the Claims Submission page.

Click **Submit** to submit the claim for review.