# Table of Contents

**Chapter 1: General Information** ................................................................. 11

**Chapter 2: Contacts and Resources** ............................................................ 13

Provider Policies ............................................................................................. 13
  Payments ......................................................................................................... 13

Provider Contracts ........................................................................................... 13
  Provider Contract Maintenance .................................................................... 13

Provider Resources ........................................................................................ 15
  OHCA Call Tree ........................................................................................... 15
  Provider Inquiries ......................................................................................... 16
  Call Centers .................................................................................................. 17
  Claims ............................................................................................................ 17
  Eligibility Verification System (EVS) .......................................................... 18
  Member Inquiries .......................................................................................... 19
  SoonerCare Provider Portal ........................................................................ 19
  Provider Training and Field Representatives .............................................. 20
  OHCA Public Site ........................................................................................ 23
  OHCA Webpages .......................................................................................... 24

**Chapter 3: SoonerCare Provider Portal** ....................................................... 26

Introduction .................................................................................................... 26
  Important Website Notes ............................................................................. 26

Section A: Accessing the SoonerCare Provider Portal .................................... 26
  Getting to the SoonerCare Provider Portal .................................................. 27
  Registering for a Provider Portal Account ................................................... 27
  Types of Web Users ....................................................................................... 28
  Forgot Password ............................................................................................ 29

Section B: Web Features .................................................................................. 29
  Broadcast/Global Messages .......................................................................... 29
  Main Page ....................................................................................................... 29
  Eligibility Tab ................................................................................................. 33
  Claims Tab ...................................................................................................... 33
  Pricing Page .................................................................................................... 36
  Prior Authorizations Page ............................................................................. 37
  Referrals .......................................................................................................... 40
Table of Contents

Trade Files Page (Batch Submission) ................................................................. 40
Help Page ............................................................................................................... 42
Logout Link ............................................................................................................ 43

Chapter 4: Member Eligibility Verification ......................................................... 45
Introduction ........................................................................................................... 45
Member ID Card .................................................................................................... 45
Section B: Options to Verify Member Eligibility ................................................. 47
   EVS/AVR ............................................................................................................. 47
   Provider Portal ................................................................................................... 48
   Electronic Data Interchange (EDI) ..................................................................... 50
   Swipe Card ......................................................................................................... 50

Chapter 5: Claim Completion ............................................................................... 52
Introduction ........................................................................................................... 52
Section A: Paper Claim Recommendations ......................................................... 52
   Ordering Paper Claim Forms ........................................................................... 53
Section B: 1500, Professional, 837P ................................................................. 54
   1500 Claim Form Instructions .......................................................................... 54
   Direct Data Entry (DDE) Claim Submission – Professional ................................ 62
Section C: UB-04, Institutional, 837I ................................................................. 67
   UB-04 Claim Form Instructions ....................................................................... 67
   Direct Data Entry (DDE) Claim Submission – Institutional ............................. 74
Section D: ADA 2012, Dental, 837D ................................................................. 81
   ADA 2012 Claim Form Instructions .................................................................. 81
   Direct Data Entry (DDE) Claim Submission – Dental ..................................... 86
Section E: Drug/Compound Prescription Drug, Pharmacy, NCPDP ............... 90
   Drug/Compound Prescription Drug Claim Form Instructions ......................... 90
   Direct Data Entry (DDE) Claim Submission – Pharmacy, including compounds ... 96
Section F: Electronic Claim Attachments ............................................................ 100
   Helpful Tips ...................................................................................................... 100
Section G: Medicare-Medicaid Crossover Invoice ........................................... 102
   HCA-28: Medicare-Medicaid Crossover Invoice Form Instructions .................. 102
   HCA-28B: Medicare-Medicaid Crossover Invoice Form Instructions ............. 105

Chapter 6: Electronic Data Interchange ............................................................... 109
Introduction .......................................................................................................... 109
Table of Contents

EDI Resources ................................................................................................................. 110

Section A: Professional Claims (837 Professional) ......................................................... 110
  837 Professional Transaction ......................................................................................... 110

Section B: Institutional Claims (837 Institutional) .......................................................... 111
  837 Institutional Transaction .......................................................................................... 111

Section C: Dental Claims (837 Dental) .......................................................................... 112
  837 Dental Transaction .................................................................................................. 112

Section D: Pharmacy Claims ......................................................................................... 112
  Pharmacy Claims .......................................................................................................... 112

Section E: Claim Inquiries/Responses .......................................................................... 113
  276 Claim Inquiry Transaction (Batch) ........................................................................ 113
  277 Claim Inquiry Response Transaction (Batch) ......................................................... 114

Section F: Eligibility Inquiries/Responses .................................................................... 114
  270 Eligibility Inquiry Transaction (Batch) ................................................................. 114
  271 Eligibility Inquiry Transaction ............................................................................... 115

Section G: Remittance Advice (RA) ............................................................................. 115
  835 Remittance Advice ............................................................................................... 115

Section H: Electronic Claims/PAs with Paper Attachments ........................................... 115

Section I: Electronic Media Types .................................................................................. 116
  EDI Batched Electronic Transactions ......................................................................... 117

Section J: HIPAA Transaction and Code Set Requirements ......................................... 117

Chapter 7: Claims Resolution Process ......................................................................... 119

Introduction ...................................................................................................................... 119

Section A: Claim Creation .............................................................................................. 119

Section B: Data Entry ..................................................................................................... 121
  MMIS Edits .................................................................................................................... 121
  ClaimCheck Edits ......................................................................................................... 121

Section C: Resolutions .................................................................................................. 121
  Paid Claims ................................................................................................................... 122
  Denied Claims ............................................................................................................... 122
  Suspended Claims ........................................................................................................ 122
  Resubmit Status .......................................................................................................... 123
  Working Denied Claims .............................................................................................. 123

Chapter 8: Paid Claim Adjustment Procedures ............................................................... 126
# Table of Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction</td>
<td>126</td>
</tr>
<tr>
<td>Section A: Adjustment Categories</td>
<td>126</td>
</tr>
<tr>
<td>Non-Check Related Adjustments</td>
<td>126</td>
</tr>
<tr>
<td>Check-Related Adjustments</td>
<td>127</td>
</tr>
<tr>
<td>Negative Adjustment Amounts (Overpayments)</td>
<td>127</td>
</tr>
<tr>
<td>Positive Adjustments (Underpayments)</td>
<td>128</td>
</tr>
<tr>
<td>Section B: Adjustment Types and Workflow</td>
<td>129</td>
</tr>
<tr>
<td>Non-Check Related Adjustments (regions 50 and 56)</td>
<td>129</td>
</tr>
<tr>
<td>Check-Related Adjustments (regions 51 and 57)</td>
<td>129</td>
</tr>
</tbody>
</table>

## Chapter 9: Third Party Liability                                      131

| Introduction                                                           | 131  |
| OHCA Third Party Liability Program                                     | 132  |
| Section A: Services Exempt from Third Party                            | 133  |
| Liability/Cost Avoidance Requirements                                 | 133  |
| Cost Avoidance                                                         | 133  |
| Liability Insurance                                                    | 134  |
| Section B: TPL Claim Processing Requirements                           | 135  |
| Documentation Requirements                                             | 135  |
| Third Party Liability Identification                                   | 135  |
| Prior Authorization                                                    | 136  |
| Billing Procedures                                                      | 136  |
| Non-Covered Services or Lifetime Maximum Exceeded                       | 136  |
| Subsequent Third Party Liability Payment                               | 137  |
| Remittance Advice Information                                           | 137  |
| Insurance Carrier Reimburses OHCA Member                               | 137  |
| Section C: Coordination with Commercial Plans                          | 138  |
| HMO Billing OHCA                                                       | 138  |
| Section D: Medicare-OHCA Related Reimbursement                         | 139  |
| Medicare Enrolled Participating Provider Reimbursement Process         | 139  |
| Medicare Enrolled Non-participating Provider Reimbursement Process     | 140  |
| Crossover Claims                                                       | 140  |
| Prior Authorization                                                    | 141  |
| Medicare Non-Covered or Denied Services                                | 141  |
| Other TPL Resources                                                    | 141  |
Table of Contents

Section E: Member TPL Update Procedures .......................................................... 141
  Automated Recovery, Resource Data Request Letters and Questionnaires ........... 142
  General Update Procedures .............................................................................. 142
  Telephone Inquiry Procedures .......................................................................... 143
  Written Inquiry Procedures ................................................................................ 143
  Summary ............................................................................................................. 143

Chapter 10: Prior Authorization ........................................................................... 146
  Introduction ......................................................................................................... 146

  Section A: Prior Authorization Requests ................................................................. 146
    Medical and DME Requests ............................................................................. 146
    Dental Requests .................................................................................................. 147
    Pharmacy Requests ............................................................................................. 149
    Outpatient Rehabilitative Behavioral Health, Licensed Behavioral Health
      Professionals and Psychologist Services .............................................................. 149
    Inpatient Behavioral Health, Detoxification, Group Home and Therapeutic
      Foster Care Services ....................................................................................... 149
    Requests for Services to Illegal/Ineligible Aliens/Sooner To Be Sooners .......... 150

  Section B: Prior Authorization Process ............................................................... 150
    Retroactive Authorization ................................................................................... 151

  Section C: Reconsideration and Appeal Procedures ............................................ 151
    Level 1—Reconsideration ................................................................................. 151
    Level 2—Appeal ................................................................................................ 152

Chapter 11: Financial Services ............................................................................ 155

  Introduction ......................................................................................................... 155

  Section A: Payment Information .......................................................................... 155
    Payments ............................................................................................................ 155

  Section B: Remittance Advice (RA) ................................................................. 156
    Remittance Advice Section Descriptions ......................................................... 157
    Remittance Advice Sorting Sequence .............................................................. 159
    EOB Codes ........................................................................................................ 160
    Remittance Advice Examples .......................................................................... 161

  Section C: Electronic Remittance Advice .......................................................... 166

  Section D: 1099 & W-2s .................................................................................. 166

  Section E: Stop Payments, Voids, Re-issuance ................................................ 167
    Stop Payments ................................................................................................... 167
Check Void .......................................................................................................................... 167
Section F: Electronic Care Coordination Payments .............................................................. 168

**Chapter 12: SoonerCare Choice** .................................................................................. 176

Introduction .......................................................................................................................... 176
Quality Assurance ............................................................................................................... 176
Covered Members ................................................................................................................ 177
Native Americans ................................................................................................................. 177
SoonerCare Choice Exempt ................................................................................................ 177
Access to Care ..................................................................................................................... 178
Emergency Care .................................................................................................................. 178
Member Enrollment/Disenrollment ..................................................................................... 179
SoonerCare Choice Enrollment ......................................................................................... 179
Choosing a PCP/CM ............................................................................................................ 179
Capacity (Number of Members requested per PCP/CM) .................................................... 180
Changing PCP/CMs ............................................................................................................. 180
Disenrollment at the Request of the PCP/CM ................................................................... 180

Electronic Referrals ........................................................................................................... 181
Payment for Referred Services .......................................................................................... 182
Documenting the Medical File ............................................................................................ 182

Early and Periodic Screening Diagnosis and Treatment (EPSDT) ................................... 182
Schedule of EPSDT Services .............................................................................................. 183
Additional Requirements ................................................................................................... 183
EPSDT Bonus Payment ....................................................................................................... 183

Reporting Requirements ................................................................................................. 183
Reimbursement ................................................................................................................... 184
Care Coordination ............................................................................................................. 184
Claims .................................................................................................................................. 184
Immunization Incentive Payment ....................................................................................... 184
Care Management ............................................................................................................. 185

**Chapter 13: Insure Oklahoma** ..................................................................................... 188

Introduction .......................................................................................................................... 188
Section A: What is the Insure Oklahoma Individual Plan? .................................................. 188
Persons Ineligible for the Insure Oklahoma Individual Plan ............................................... 189
Coverage for Children ......................................................................................................... 189
Chapter 14: Pharmacy ................................................................. 193

Introduction ................................................................. 193

Pharmacy Policy (Rules) .................................................. 193

Prescription Drug Benefit ........................................... 194

Product Based Prior Authorization (PBPA) .................. 194

Pharmacy Lock-In Program ........................................ 195

Durable Medical Equipment (DME) ............................ 196

Chapter 15: LTC Nursing Facilities ............................... 198

Introduction ................................................................. 198

Section A: LTC Nursing Facility Provider Eligibility .... 198

Section B: PASRR .......................................................... 198

Section C: ICF/IID Process ........................................... 198

Section D: Member Level of Care Appeals Process .... 199

Section E: Billing Considerations .................................. 199

Chapter 16: Indian Health Services .............................. 201

Introduction ................................................................. 201

Section A: SoonerCare Eligibility ................................. 201

Section B: Contract Health Services ............................ 201

Chapter 17: Utilization Review ....................................... 203

Utilization Review Focus ............................................. 203

Federal Regulations ..................................................... 203

Utilization Review Monitoring .................................... 204

DXC Program Integrity System .................................... 204

Section A: Provider Utilization Review ....................... 204

Fraud Defined ........................................................... 204

Abuse Defined .......................................................... 205

Record Retention ......................................................... 205
<table>
<thead>
<tr>
<th>Section B: Member Utilization Review</th>
<th>206</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identification of Lock-In Members</td>
<td>206</td>
</tr>
<tr>
<td>Section C: Utilization Review Trends</td>
<td>207</td>
</tr>
<tr>
<td>Section D: Administration Review and Appeal Process</td>
<td>208</td>
</tr>
<tr>
<td>Appeals Procedures (excluding nursing homes and hospitals)</td>
<td>208</td>
</tr>
<tr>
<td>Appeals Procedures for Long-Term Care Nursing Facilities</td>
<td>208</td>
</tr>
</tbody>
</table>

**Chapter 18: Quality Assurance and Improvement** ............................................ 210

<table>
<thead>
<tr>
<th>Introduction</th>
<th>210</th>
</tr>
</thead>
<tbody>
<tr>
<td>Section A: Provider Utilization Review</td>
<td>210</td>
</tr>
<tr>
<td>Section B: On-Site Provider Audits</td>
<td>211</td>
</tr>
<tr>
<td>Section C: Member or Provider Complaints</td>
<td>212</td>
</tr>
<tr>
<td>Section D: Quality Improvement Studies/Projects</td>
<td>212</td>
</tr>
</tbody>
</table>

**Chapter 19: Forms** .............................................................................................. 214

**Revision History** ................................................................................................. 215
Chapter 1: General Information

The Oklahoma Health Care Authority (OHCA) is the state agency responsible for the administration of the Oklahoma Medicaid program. OHCA has a contractual agreement with DXC Technology (DXC), previously Hewlett Packard Enterprise (HPE), to be the fiscal agent for the Oklahoma Medicaid program. OHCA’s primary objective is to maintain a system that will accurately and effectively process and pay all valid Oklahoma Title XIX Medicaid program provider claims.

A provider’s participation in the Oklahoma Medicaid program is voluntary. However, providers who choose to participate in Medicaid must accept the Medicaid payment as payment in full for services covered by Medicaid. The provider is restricted from charging the Medicaid member the difference between the usual customary charge and Medicaid’s payment. Services not covered under the Medicaid program can be billed directly to the member.

This publication is the primary reference for submitting and processing claims, prior authorization requests, remittance advice and other related documents. This manual is not a legal description of all aspects of Medicaid law.

This manual is intended to provide basic program guidelines for providers that participate in the Oklahoma Medicaid program. Every effort has been made to ensure the accuracy of this manual; if there are any instances where the guidelines appear to contradict relevant provisions of the Oklahoma Medicaid policies and rules, the policies and rules will prevail. This manual does not take precedence over federal regulation, state statutes or administrative procedures. This manual was developed by OHCA and DXC for Oklahoma Medicaid providers.

The Provider Billing and Procedure Manual will receive periodic reviews, changes and updates. The online version of this manual is the most current version and is available on the OHCA website at www.okhca.org. Once there, select Providers, then select the Policies & Rules link, then select the Oklahoma Medicaid Provider Billing & Procedures Manual link listed under Guides & Manuals.
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Chapter 2: Contacts and Resources

Provider Policies

A provider is any individual or facility that qualifies and meets all state and federal requirements, and has a current contract with OHCA to provide health care services under SoonerCare or other OHCA-administered medical service programs.

Payments

Payments to providers under SoonerCare are made for services identified as personally-rendered services performed on behalf of a specific patient. There are no exceptions to personally-rendered services unless otherwise specified in coverage guidelines.

Payments are made on behalf of SoonerCare-eligible individuals for services within the scope of OHCA’s medical programs. Services cannot be paid under SoonerCare for ineligible individuals, services not covered under the scope of OHCA’s medical programs or services not meeting documentation requirements. These claims will be denied or payment will be recouped in some instances upon post-payment review.

For additional information on provider policies, go to www.okhca.org and select the Policy link under Providers. When the page appears, select the Oklahoma Health Care Authority Medical Rules link and select Chapter 30.

Provider Contracts

In order to be eligible to participate in Oklahoma SoonerCare programs, providers must have an approved provider contract on file with OHCA. Through this contract, the provider certifies all information submitted on claims is accurate and complies with all applicable state and federal regulations. This contract is effective once it is signed by the provider and has been reviewed and approved by OHCA.

Provider Contract Maintenance

Provider contracts must be renewed every four (4) years, excluding provider contracts for Nursing Homes and LBHP-under supervision. It is the responsibility of the provider to maintain records and contracts with OHCA.

All information changes including address, phone number, bank (including electronic funds transfer data) and group member changes
must be promptly reported. Failure to maintain current provider information can result in delay or denial of payments for services rendered. Changes for all provider record information should be made through the OHCA SoonerCare Provider Portal.

For additional information on provider enrollment criteria, call the OHCA toll-free at 1-800-522-0114 or at 405-522-6205 (Oklahoma City area), then select option 5. You can also go to www.okhca.org, select Enrollment listed under Providers, select the New Contracts link, and then select the appropriate option.
## Provider Resources

### OHCA Call Tree

Toll-free: 800-522-0114, or in Oklahoma City area: 405-522-6205

<table>
<thead>
<tr>
<th>Option</th>
<th>Unit</th>
<th>Call Types</th>
<th>Availability</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>OHCA Call Center</td>
<td>Policy and billing questions</td>
<td>8 a.m. to 5 p.m. M-F</td>
</tr>
<tr>
<td>2, 1</td>
<td>Internet Help Desk</td>
<td>Internet PIN resets or assistance with the SoonerCare Provider Portal</td>
<td>8 a.m. to noon &amp; 1-5 p.m. M-F</td>
</tr>
<tr>
<td>2, 2</td>
<td>EDI Help Desk</td>
<td>Batch transactions assistance</td>
<td>8 a.m. to noon &amp; 1-5 p.m. M-F</td>
</tr>
<tr>
<td>3, 1</td>
<td>Adjustments</td>
<td>Paid claim adjustments or outstanding A/R inquiries</td>
<td>7:30 a.m. to 4 p.m. M, W, Th, F Noon to 4 p.m. Tues</td>
</tr>
<tr>
<td>3, 2</td>
<td>Third Party Liability</td>
<td>Health insurance injury/accident questionnaires, third party insurance inquiries, estate recovery or subrogation issues</td>
<td>8 a.m. to 5 p.m. M-F</td>
</tr>
<tr>
<td>4</td>
<td>Pharmacy Help Desk (issues)</td>
<td>Pharmacy issues</td>
<td>8:30 a.m. to 7 p.m. M-F</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>9 a.m. to 5 p.m. Sat</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>11 a.m. to 5 p.m. Sun</td>
</tr>
<tr>
<td>5</td>
<td>Provider Contracts</td>
<td>Provider contracts</td>
<td>8 a.m. to 5 p.m. M-F</td>
</tr>
<tr>
<td>6, 1</td>
<td>Pharmacy Help Desk (authorizations)</td>
<td>Pharmacy authorizations</td>
<td>8:30 a.m. to 7 p.m. M-F</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>9 a.m. to 5 p.m. Sat</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>11 a.m. to 5 p.m. Sun</td>
</tr>
<tr>
<td>6, 2, 1</td>
<td>Behavioral Health Authorization (OP)</td>
<td>For Out-Patient Behavioral Health authorizations</td>
<td>8 a.m. to 5 p.m. M-F</td>
</tr>
<tr>
<td>6, 2, 2</td>
<td>Behavioral Health Authorization (IP)</td>
<td>For In-Patient Behavioral Health authorizations</td>
<td>8 a.m. to 5 p.m. M-F</td>
</tr>
<tr>
<td>6, 3</td>
<td>Medical Authorizations (status)</td>
<td>Medical authorization status</td>
<td>8 a.m. to 5 p.m. M-F</td>
</tr>
<tr>
<td>6, 4</td>
<td>Prior Authorizations</td>
<td>For prior authorizations for DME, medical services and emergency services for aliens</td>
<td>8 a.m. to 5 p.m. M-F</td>
</tr>
<tr>
<td>6, 5</td>
<td>Dental Authorizations</td>
<td>Dental authorizations (status only)</td>
<td>8 a.m. to 5 p.m. M-F</td>
</tr>
</tbody>
</table>
Provider Inquiries

Telephone inquiries are received between 8:00 a.m. and 5:00 p.m., Monday through Friday. (Pharmacy Help Desk is available extended hours seven days per week.)

Phone Numbers

Toll-free: 800-522-0114
Oklahoma City area: 405-522-6205

Reference the OHCA Call Tree provided above for additional information regarding option numbers, call tree units, call types, and availability for the following available services.

Available Services

Information available to providers through the call tree options include:

- Policy Questions
- Pharmacy Help Desk
- Provider Contracts
- Adjustments
- Third Party Liability (TPL)
- PIN resets
- Prior Authorization
- Medical
- Dental
- Behavioral Health

Before You Call

When calling the OHCA Call Center, have the following information available to expedite the research of the inquiry:

- The 10-character (nine numbers, alpha character) SoonerCare provider number
- The SoonerCare member's ID number
- The date(s) of service
- The billed amount
Call Centers

The OHCA is committed to providing customer service to the provider community, members and other interested parties. OHCA Call Center representatives answer inquiries regarding warrant information, proper billing procedures, prior authorizations and SoonerCare policy.

Claims

Mailing Paper Claims

Original, corrected and re-filed claims are submitted to the fiscal agent at the appropriate address listed in the General Information chapter of this manual. Claims mailed to addresses other than the assigned P.O. Box may result in payment delays. For a list of mailing addresses, refer to the General Information chapter of this manual.

Paper Claim Mailing Addresses

| Form UB-04 (Hospital or Home Health) | DXC Technology  
P.O. Box 18430  
Oklahoma City, OK 73154 |
|---|---|
| Dental (ADA) | DXC Technology  
P.O. Box 18110  
Oklahoma City, OK 73154 |
| Form 1500 | DXC Technology  
P.O. Box 54740  
Oklahoma City, OK 73154 |
| HMO Copay/Personal Care Services (Individual; not agency) | DXC Technology  
P.O. Box 18500  
Oklahoma City, OK 73154 |
| Long-Term Care Nursing Facilities | DXC Technology  
P.O. Box 54200  
Oklahoma City, OK 73154 |
| Pharmacy | DXC Technology  
P.O. Box 18650  
Oklahoma City, OK 73154 |
| Waiver Provider | DXC Technology  
P.O. Box 54016  
Oklahoma City, OK 73154 |
Written Inquiries

When inquiring in writing about the status of a SoonerCare claim, use the SoonerCare Claim Inquiry/Response form: HCA-17. Follow the instructions provided on the form. Attach a copy of the original claim and any supporting documentation, such as a copy of the remittance/denial, Medicare EOMB, consent forms or medical records required for review.

Mail Inquiry/Response forms, policy questions and any other written correspondence regarding hard-to-resolve SoonerCare claims to:

OHCA
Attention: Provider Services
P.O. Box 18506
Oklahoma City, OK 73154-0506

Eligibility Verification System (EVS)

The EVS system is available from 5:00 a.m. to 1:00 a.m. Information is accessible by entering the provider’s 9-digit SoonerCare ID number and alpha-character location code, as well as your 4-digit PIN. If you do not have a PIN, please call 1-800-522-0114 (option 2, option 1).

The automated voice response (AVR) system provides a nationwide toll-free telephone number to help providers obtain pertinent information. Providers are able to enter information on a touch-tone phone or by the AVR speech application.

EVS Phone Numbers

Nationwide toll-free: 1-800-767-3949
Oklahoma City area: 405-840-0650

Available Services

The following is a list of information that can be obtained through the AVR:

- Member eligibility with fax-back capabilities
- Provider warrant information
- Prior authorization with fax-back capabilities
- Claim status inquiry

More information regarding the EVS can be found in the Member Eligibility Verification chapter of this manual (chapter 4).
Member Inquiries

When inquiring by telephone, please call between 8:00 a.m. and 5:00 p.m., Monday through Friday.

Phone Numbers

Members toll-free: 800-522-0310
Oklahoma City area: 405-522-7171

Available Services

Information available for members through the call tree options include:

- Eligibility
- Claim status
- SoonerCare Member Services
- Pharmacy Help Desk
- Enrollment Agent
- Spanish assistance: 8:00 a.m. to 5:00 p.m. M-F

SoonerCare Provider Portal

The SoonerCare Provider Portal is OHCA’s secure website, offering providers a number of services from submitting claims on the web to fast verification of claim status. The SoonerCare Provider Portal is available 24 hours a day, 7 days a week, except during scheduled maintenance.

- New providers are assigned a PIN to access the website. To access the SoonerCare Provider Portal, go to www.okhca.org, select the Providers tab and select the Provider Portal link. For additional information regarding logging in for the first time and entering the SoonerCare Provider Portal, contact the Internet Help Desk or your SoonerCare Provider Representative. Contact information for the SoonerCare Provider Representatives is available in the next sub-section of this chapter.
Available Services

The following services are available to SoonerCare Provider Portal users:

- Global messaging
- Claims submission and resubmission
- Search/void claims
- Create/search provider referrals
- Create prior authorizations
- View authorization status/notice
- Search Fee Schedule/search provider
- View Payment History
- View/download Remittance Advice
- Eligibility verification
- Treatment History
- Managed Care/Capitation reports
- Update Provider File
- Provider letters

For additional information on the SoonerCare Provider Portal, please refer to the SoonerCare Provider Portal chapter of this manual (chapter 3).

Provider Training and Field Representatives

SoonerCare has a team of regional field representatives with in-depth knowledge of Oklahoma SoonerCare billing requirements and claim-processing procedures. Training is offered on billing, EVS and AVR, Electronic Data Interchange (EDI), and the SoonerCare Provider Portal. Field representatives provide training through on-site provider visits, webinars and workshops. They encourage providers to utilize electronic submission through the provider portal because it is fast, easy to use and saves money.
Training Objectives
The focus of the Provider Field Representative is to:

- Train newly enrolled providers and billers.
- Establish and maintain relationships with contracted providers to ensure correct claim adjudication and resolution.
- Conduct targeted outreach for provider types and specialties.
- Create and present policy, portal and program updates to existing providers through training workshops.
- Conduct policy and portal training through webinars and bi-monthly SoonerCare 101 training.

Providers may contact their field representative to request a visit for training at the provider's location. Field representatives are responsible for arranging their own schedules. They are available Monday through Friday for on-site provider visits. On-site provider visits are normally scheduled two weeks in advance. Since field representatives are often out of the office, please allow a minimum of 48 hours for telephone calls and emails to be returned.

Provider Workshops
Field representatives are responsible for the development and presentation of educational workshops about all procedural aspects of the Oklahoma Medicaid Management Information System (OKMMIS).

OHCA and DXC present scheduled workshops throughout the year to educate providers on Oklahoma SoonerCare claim processing procedures. Workshops are announced in bulletins, global messages, newsletters and on the OHCA website at www.okhca.org. Group training can also be arranged at the request of individual provider groups or associations.
Chapter 2: Contacts and Resources

Be Prepared
The following information should be provided to assist your field representative in planning the visit or workshop:

- Individual or Group SoonerCare Provider ID
- Number of attendees
- Time and location of the event
- Issues to be addressed
- Point of contact, in case additional information is needed prior to the event

Contact Information
A complete list of field representatives with contact information can be accessed on the public website, www.okhca.org. Select Training under the Providers heading, then select SoonerCare Provider Representatives under Contact Us located on the right side of the webpage.

<table>
<thead>
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<th>Phone Number</th>
<th>Counties within the Region</th>
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<td>405-416-6715</td>
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<td>Carter, Cleveland, Garvin, Love, McClain</td>
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<td>Atoka, Bryan, Choctaw, Coal, Johnston, Marshall, Murray, Pontotoc, Pushmataha</td>
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<td>5</td>
<td>405-522-7497</td>
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<tr>
<td>6</td>
<td>405-522-7034</td>
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<td>8</td>
<td>405-522-7132</td>
<td>Rogers, Tulsa County north of I-44</td>
</tr>
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<td>9</td>
<td>405-416-6716</td>
<td>Creek, Okmulgee, Tulsa County south of I-44</td>
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<td>Oklahoma County north of 23rd St.</td>
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<td>11</td>
<td>405-522-7154</td>
<td>Oklahoma County south of 23rd St.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Out-of-State Consultant: 405-416-6721</td>
</tr>
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</table>
OHCA Public Site

The OHCA administers the state of Oklahoma’s Medicaid agency program known as SoonerCare. Primary programs under SoonerCare include: SoonerCare Traditional, SoonerCare Choice and SoonerPlan. The OHCA public site, www.okhca.org, (see screen sample below) provides information for Medicaid members and providers, including data on programs, and health and medical policies.
OHCA Webpages

**Calendar:** The Calendar page can be used to find dates and details on meetings and other upcoming events.

**Contact Us:** Use the Contact Us page to find everything from OHCA addresses and telephone numbers to driving directions to the OHCA office.

**Provider:** The Provider page provides information on becoming a Medicaid provider, provider-type details, claim management tools, program reference resources, rule and policy data, free training opportunities and SoonerCare updates.

**Publications:** The Publications page includes links to most OHCA publications, forms and OHCA information on statistical reports and data.
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Chapter 3: SoonerCare Provider Portal

Introduction

Any SoonerCare provider can access the Provider Portal with a Provider ID and an OHCA-generated personal identification number (PIN). Once the provider has established a Provider Portal account, the account administrator can create new clerks and grant each clerk role-specific access. The Provider Portal is free of charge and is available to any SoonerCare provider with internet access.

Important Website Notes

- Passwords and challenge question answers are case sensitive.
- All dates should be entered in MMDDYYYY format.
- Dollars and cents should be separated by a decimal.
- Line totals will not be calculated automatically; the user must multiply the units by the unit rate to ensure the correct total billed amount.
- Do not populate the TPL amount unless another payer has paid a specific amount toward the claim.
- Decimals should not be used when entering diagnosis codes

Section A: Accessing the SoonerCare Provider Portal

The SoonerCare Provider Portal can be accessed on most computer systems, with the following recommendations:

- Microsoft Internet Explorer browser version 7.0 and higher or Mozilla Firefox browser version 2.0 and higher, although other browsers may work
- 128-bit key encryption
- Customized security settings to access information across domains
- Disable pop-up ad blocker (or set settings to allow all for this website)
Getting to the SoonerCare Provider Portal

1. Navigate to www.okhca.org
2. Select the Provider Portal link located under the Providers section of the home page, or select Secure Sites from the Providers menu after selecting the Providers link.

Registering for a Provider Portal Account

Each new Provider Portal account (users who have never registered with OHCA) will require registration (creating a permanent username, password and challenge questions/answers).

Register Now

1. Select Register Now from the Provider Portal home page. Instructions for Registration Step 1 of 2 will vary by role:
   
   • **Providers**—Enter SoonerCare Provider Number, Service Location and PIN in the corresponding fields.
   
   • **Billing Agents**—Enter Trading Partner ID and PIN in the corresponding fields.
   
   • **Clerks**—Enter First Name, Last Name, Birth Date, Last 4 of DLN, and Clerk Code in the corresponding fields (clerk codes are generated by the provider).

Instructions for Registration Step 2 of 2–Security Information will be the same for all types:

1. Enter a user ID. Select Check Availability to verify whether or not the user ID is available for use in the SoonerCare Provider Portal. Enter a password in the Password and Confirm Password fields. Passwords must be 8-20 characters in length, contain a minimum of one numeric digit, one uppercase letter and one lowercase letter.

2. Enter a name in the Display Name field. This will be the name that appears on the Provider main menu. Enter a phone number and extension, if applicable. Enter an email in the Email and Confirm Email fields.

3. Select a site key and enter a passphrase.

4. Select three questions from the Challenge Question #1-3 drop-down lists. Enter an answer in the respective Answer to #1-3 fields. For providers only: after reading
Chapter 3: SoonerCare Provider Portal

Provider Billing and Procedures Manual

the User Agreement, enter your name in the Please sign by typing your full name here field.

5. Once all fields have been entered, click Submit. A confirmation message will be sent to the email address on file, as entered in the Email field.

Types of Web Users

Providers

Providers will receive a letter by email containing the provider’s access PIN. This PIN, used in conjunction with the Provider ID, will grant the provider initial access to the SoonerCare Provider Portal. Only providers with an active SoonerCare contract will receive a PIN letter. Separate PIN letters will be mailed to each location. It is recommended that providers initialize their account and immediately create users (clerks) that will be used to operate the Internet application on a daily basis. Operating daily under the master user (Provider) poses certain security risks and should only be used when managing the account.

Billing Agents

Billing agents are given logon credentials directly from DXC. When users initialize their accounts, they will be prompted to establish a password, challenge questions and answers, site key token and contact information upon initializing their accounts. *Billing Agents do not have the ability to create, grant access to, or revoke permissions of other users.*

Clerks

The provider or billing agent who created the clerk will give clerks logon credentials. Users will be required to establish a password, challenge questions and answers, site key token and contact information upon initializing their accounts. *Clerks do not have the ability to create, grant access to, or revoke permissions of other users.*

Enrollment Agents

Each provider can assign one (1) active clerk to be their enrollment agent. In addition to their other functions, this enrollment agent will have access to renew or make changes to the provider’s contract with OHCA; including licensing information, banking details, and ownership information where applicable.
Forgot Password

Users who forget their passwords may still gain access to the SoonerCare Provider Portal through the self-authentication process. The self-authentication process requires the user to change his or her password by selecting the Forgot Password? link from the Site Token Password page.

In the Forgot Password window, the user should answer the designated challenge question. Once the answer has been validated, a message will be sent to the email on record with a temporary password. Though not required, it is recommended that the user create a new password instead of using the temporary password.

Section B: Web Features

The OHCA SoonerCare Provider Portal has many features to help providers with anything related to Medicaid billing. This section will cover several SoonerCare Provider Portal features.

Broadcast/Global Messages

There are two (2) types of broadcast/global messages—unsecure and secure. Unsecure messages will only display on the login splash page; all providers will see these messages. Secure messages can be directed to an individual provider, a specific provider type, or to the entire provider community. These messages will display to the end-user once they have logged in to the provider portal.

Broadcast Messages will always display any active messages not checked as read. Next to each message is the following check box: “Please acknowledge receipt of message by checking this box.” Once this is selected, the message will no longer appear on the provider Home Page once the page has been refreshed.

Main Page

The Main page is also the user’s home page. The Main page shows the display name, taxonomy number and contains shortcut links to areas of the website.

My Home

The My Home tab at the top of the page will always bring the user back to their main page.
My Profile

The My Profile page allows the user to edit options specific to their logon including their display name, phone number and email address. This page also allows the user to change their password, token, site key, and challenge questions and answers.

Manage Accounts

The Manage Accounts page is designed to establish the security credentials for users and clerks, as well as allow users to update and maintain user account data. Only a provider-level sign on with give a user access to the Manage Accounts page.

Provider

After users access the website for the first time and initialize their account, they may access the Manage Accounts page. The provider can delegate assignments by using the Add New Clerk, Add Registered Clerk, Add Registered Billing Agent, Designate Billing Agent and Enrollment Agent tabs.

Once the Provider has submitted the billing agent or clerk information, the billing agent or clerk can establish his or her username, password, contact name, email and phone number by selecting the Register Now link on the portal logon page.

The status and authorized functions for billing agents and clerks are maintained by the provider using the Manage Accounts page.

Adding a New Clerk

Adding a clerk is done by selecting the Add New Clerk tab.

1. In the First and Last Name fields, enter the clerk’s name.
2. In the Birth Date field, enter the clerk’s birth date.

3. Enter the last four DLN of the clerk.

4. Select the check boxes of the functions the clerk will have authorization to access.

5. Click Submit once the information has been added.

6. Click Confirm to confirm the additions made to the new clerk.

7. Once the confirmation is complete, an informational message will appear with a clerk code. The clerk code is used for the new clerk to register for the SoonerCare Provider Portal with the Register Now link. The clerk code can also be used if the existing clerk is registering under another provider.

**Granting Access to Other Providers of Existing Billing Agent/Clerk**

After a clerk or agent is created, he or she will automatically have access to the provider account under which he or she was created. For the clerk or agent to access other providers’ accounts, access must be granted.

**Add Registered Clerk**

1. Select the Add Registered Clerk tab.

2. Enter the last name of the clerk.

3. Enter the existing clerk code generated by the previous provider.

4. Select the check boxes of the functions the clerk will have authorization to access.

5. Click Submit after adding the information.

6. Click Confirm to complete adding the registered clerk.

**Add Registered Billing Agent**

1. Select the Add Registered Billing Agent tab.

2. Enter the display name of the billing agent.

3. Enter the existing agent code. If the agent code is unknown, the agent code is located in My Profile-Role Qualifiers from the billing agent user account.

4. Select the check boxes of the functions the clerk or billing agent will have authorization to access.

5. Click Submit once the information has been added.
Chapter 3: SoonerCare Provider Portal

Provider Billing and Procedures Manual

6. Click Confirm to confirm the additions made to the new clerk/billing agent.

**Revising Billing Agent or Clerk Access**

When a billing agent or clerk no longer needs access to your provider account, or if functions need to be added/removed, you may edit account privileges.

1. From the Add New Clerk, Add Registered Clerk, or Add Registered Billing Agent tabs, a list of available users will appear at the bottom of each webpage.
2. For clerks, select the name of the clerk to update access. For billing agents, select the billing agent code.
3. Edit the Status and/or the Functions of the clerk or billing agent.
4. Click Submit after adjustments have been made.
5. Click Confirm to confirm the changes.

**Designate Billing Agent**

The Designate Billing Agent function is used to allow billing agents to receive Capitation Summaries, Remittance Advice, and Roster transactions.

1. Select the Designate Billing Agent tab.
2. Select the transaction from the Transaction Type drop-down list.
3. Select the billing agent from the Billing Agent drop-down list.
4. Click Designate to Receive.

If all Transaction Types are designated to the billing agent, the Transaction Type drop-down list will be disabled.

To remove a Transaction Type from a billing agent, select the Remove link associated with the transaction to be removed. Any transactions removed will then appear in the Transaction Type drop-down list and can be added again at a later time.

**Enrollment Agent**

The Add Enrollment Agent function is used to allow an agent to initiate, update or renew the provider contract.

1. First, the agent will need to be set up as a clerk and given at least one (1) role. This will allow them to become an option in the drop-down list.
2. The agent will then need to register and log in to the portal so their status changes from “Active Pending” to “Active”. This will allow them to become an option in the drop-down list.
3. Select the specific Enrollment Agent from the drop-down list.
4. Click the Add Enrollment Agent button. The Enrollment Agent will then be added.
5. An Enrollment Agent can be removed by clicking the Remove button.

Switch Provider
The Switch Provider page is only available to clerks and billing agents. This feature allows the user to select the provider he or she wishes to access. The provider must add access to the billing agent or other user by using Add Registered Clerk or Add Registered Billing Agent through Manage Accounts before this functionality is available. To switch to a different provider:
1. Select the Switch Provider tab from the main page.
2. Select the Switch Provider option from the menu.
3. Enter at least one criterion.
4. Click Search.
5. Select the radio button next to the provider from the Available Providers results list.
6. Click Submit.
7. Click Close.

Eligibility Tab
The purpose of the Eligibility tab is to verify eligibility of SoonerCare members. To run a query, a valid Member ID, Social Security Number, Birth Date, Name or Case Number is required. These are combined with the From Date of Service and To Date of Service fields. The resulting data appears below the search criteria. Calendar buttons next to the dates of service fields will activate a calendar pop-up feature to aid date selection.

Claims Tab
The Claims tab facilitates the communication of claim data between the OHCA and the provider community.
Providers without access to HIPAA-compliant Practice Management software, a clearinghouse or a virtual access network
(VAN) still have the ability to submit claims electronically. Direct Data Entry (DDE) enables the provider to submit individual claim information electronically to OHCA/DXC without the constraint of having to submit the data in HIPAA-compliant format. DDE claim pages are available on the OHCA SoonerCare Provider Portal for claim types (i.e., professional, institutional, dental and pharmacy).

These pages contain separate boxes/fields where claim data must be populated. As with paper claim forms, box/field population requirements depend on the billing situation. However, if a provider attempts to submit a claim via the DDE page and has not populated all required fields, the system will prompt a pop-up box stating which required fields are unpopulated.

DDE processes can only be performed for one claim at a time.

**Search Claims**

Users may inquire about claims already submitted to the OHCA/DXC using member ID, claim ID, status, dates of service and paid dates. A results box from the search will appear below the search criteria in the form of a summary list. Results will appear with navigation links below the box to view the next or previous list of results from the query. Each summary result item is linked to the claim detail page in the Claim ID field.

**Steps:**

1. Select Claims from the main menu to navigate to the Search Claims screen or move the mouse pointer over the Claims tab, highlight and select Search Claims.

2. If known, the claim ID number can be entered in the Claim ID field. All other fields may be left blank.

3. If known, the member ID number can be entered in the Member ID field.

4. Enter a date in the Service From and To fields.

5. If known, the claim type can be selected from the Claim Type drop-down list.

6. The Claim Status field can be set to Denied, Paid, Suspended or Resubmit.

7. If known, the claim paid date can be entered in the paid Date field.

8. Click Search.
From the search results, click [+] to expand the claim being viewed. Click the Claim ID to view detailed claim information. Select the Export results link to export claim results to an Excel spreadsheet.

**Claim Submission**

Providers need to confirm they are logged in under the correct provider number location prior to beginning claim submission process, then select the claim type.

**Resubmit Claim – Denied Claims Only**

1. Pull up Denied claims (from the Claim Status field), along with any other search criteria.
2. Select Claim ID link of claim for correction.
3. Click Edit.
4. Change information in field containing incorrect data, select Resubmit, and then click Confirm.

**Void Claim – Paid Claims Only**

1. Pull up Paid claims (from the Claim Status field), along with any other search criteria.
2. Select Claim ID link of claim to be voided.
3. Click Void. This will create an account receivable for the amount previously paid, which will be deducted from a future warrant. When available, the name of the person voiding the claim will appear when searching for a claim status.

**Copy Claim – Paid Claims Only**

1. Pull up Paid claims (from the Claim Status field), along with any other search criteria.
2. Select Claim ID link of claim to be copied.
3. Click Copy.
4. Select the radio button that best fits the claim being submitted. Each radio button will display the fields that will be copied over to a new claim.
5. Click Copy.
6. After the new claim appears, make any additions to the new claim and submit.
Pricing Page

The Search Fee Schedule page allows users to inquire on pricing information for procedures, drugs and DRG through the Internet. Selecting the tabs for Procedure, NDC or DRG will change the available options for searching. A drop-down list is available for the user to select the associated benefit package and the resulting data will be based on that selection. The search results summary will appear in list form below the criteria. This summary will be linked to a detail page.

Procedure Pricing

The detail page for procedure pricing will display the vital procedural components. The results link will only appear if data is located for the entered procedure code and other criteria. Displayed data may include:

- Allowed Amount
- Prior Authorization Required
- Age Restriction
- Maximum Units
- Gender
- Lifetime Limitation
- Diagnosis Restrictions
- Specialty Restrictions
- Attachment Required
- Ambulatory Surgical Facility Fee
- Ambulatory Payment Classification Fee
- Discounted

NDC (Drug) Pricing

The detail page for drug pricing will display vital data regarding the drug. The results link will only appear if data is located for the NDC code entered. Displayed data may include:

- State Maximum Allowable Cost (SMAC)
- Maximum Allowable Cost (MAC)
- Est. Acquisition Cost Wholesale (EACW)
- Est. Acquisition Cost Wholesale Percentage (EACW%)
- Est. Acquisition Cost Percentage (EAC%)
- Est. Acquisition Cost (EAC)
- Prior Authorization Required
- Maximum Units
- Maximum Days’ Supply
- Age Restrictions
- Gender Requirement
- Unit of Measure (Pharmacy Claims)
- Unit of Measure (Claims other than Pharmacy)

**DRG Pricing**

The detail results for DRG pricing is based on the DRG entered and the discharge date. Results will only appear if data is located for the DRG criteria entered. Displayed data may include:

- Peer Group
- Diagnosis Related Group (DRG)
- Rate

**Prior Authorizations Page**

The Prior Authorizations page allows the user to submit new PA requests, inquire about pending PA requests and inquire/copy notices.

**Prior Authorization Submission (Create Authorization)**

The Create Authorization link allows users to request a prior authorization.

The header section requests information about the patient and provider. Enter appropriate information in these fields. Below the header section is a diagnosis summary box the user can utilize to add a primary diagnosis (the first diagnosis entered) and additional diagnosis codes. The Service Detail section is used to enter service type codes and related details. The Medical Justification box is used as a free-form text box for additional information from the provider to OHCA PA analysts.

The next section is used to add attachments. The user selects the method of transmission and uploads the file (if applicable), enters a description of the attachment and selects Add. The user is instructed to add the attachment first and then add the service by
selecting Add Service to associate the attachment with the service. When complete, users will select Submit.

If required information is missing, the user will be prompted to enter that information and then the user will select Submit again.

An Attachment Form Cover Sheet will be generated for each attachment when the Transmission Method is marked as By Mail or By Fax. The user will click Attachment Coversheet(s) on the Authorization Receipt screen to select and print the cover sheets.

Prior Authorization Inquiry (View Authorization Status)

1. Select the Prior Authorizations link on the main menu.
2. Select the View Authorization Status link.
3. To view authorizations beginning with today’s date or greater, select the Prospective Authorizations tab.
4. To search for authorizations using different criteria, select the Search Authorizations tab. If you have the PA number, enter it in the Authorization Tracking Number field.
5. If you do not have the PA number, you may search for it by entering the Member ID, Assignment Code, Code Type/Code, Day Range or Service Date.
6. Click Search.

Search results are displayed in a list box. If additional results exist, they may be viewed by using the pagination numbers below the list box. Selecting the Authorization Tracking Number will open the PA detail window.

Search results may also be exported to a Microsoft Excel spreadsheet by selecting the Export results link.

Prior Authorization Summary

The Prior Authorization Summary page appears when a user searches for a PA using the View Authorization Status page. The header section outlines information about the patient and provider. Below the header section is the Service Provider/Service Details Information section that displays the line items and notes.

To view additional authorization-specific information, select [+] for each header listed.

Line item boxes are used to review procedure code-related details and status. The Reason comments section relates to each line item highlighted in the Line Item summary box.
The Remarks column is used to review notes entered by an OHCA PA analyst. Select the View link to view comments:

- To view the original request sent, click View Original Request.
- To print a copy of the Summary, click Print Preview. A copy will appear in a new window and can be printed by selecting Print.
- To return to the Search Authorization tab, select Back to View Authorization Status.

Prior Authorization Notices

Go to the Prior Authorizations menu, select the View Authorization Status link, then select the Authorization Notices tab and search using one of the following:

- Member ID or member name to access recent PA notices submitted under your provider number for that member.
- The Authorization tracking number of a specific PA. This brings up only the notices related to that number.
- Enter either a Day Range or From and To dates of service.
- Select Search to view the PA notices under your provider number.
- Select the date listed under the Date Sent column. This will bring up the PA notice letter, which can be printed.

On each column, providers can select the column links that allow them to sort in ascending or descending order.

Additional Tidbits for Successful Use

- When searching by either a specific PA number, member ID or member name the Date Span fields are auto populated with a 6-month span. The From date field counts back six months from the To date field. The To date field is the current day the search is being conducted.
- The Web program holds a 60-day rolling submission history. For example, if the PA request was entered into the system on 01/01/06, it will be available for online viewing until 03/02/06.
• When logged on to a Group Provider number, the system will bring up PA information for every provider in that group.

• On the Authorization Notices menu, a message counter (Unread Notices) has been added that counts the number of unread PA notices under the provider logon.

Referrals

Create Referrals
The Create Referral tab under Referrals will allow the user to create a new referral. The Member Information will allow the user to enter the Recipient ID, which will populate the member’s name and date of birth. The Remaining Referral Information will allow entry of the Referred To Provider by NPI. The user will choose between Initial Visit Only and Ongoing Referral, then enter the Referral Start Date and Referral End Date, and the Reason for Referral.

Search Referral
The Search Referral allows providers to search for a referral using the following:

• Referral Tracking Number
• Recipient ID
• Referring or Servicing Provider

Trade Files Page (Batch Submission)
The Trade Files option is available to providers to facilitate file transfers between the provider community, billing agents, clearinghouses, other involved agencies and the OHCA.

File Upload
The File Upload page allows users to select a file from a local hard drive and upload it to the OHCA. Users of this feature include providers who wish to upload batch claim submissions and managed care providers who wish to upload PCP information. Batch upload is an Internet submission option that is available to providers who wish to submit large claim batches or inquiries. To use the Batch Upload option providers must use HIPAA-compliant software or clearinghouse/VANs that are capable of submitting required data in HIPAA-compliant ANSI X12 Addenda format. Once the provider has ensured the batch claim data have been converted into the
corresponding HIPAA-compliant format and has successfully completed authorization testing with the DXC team, they then have the ability to upload an entire batch file/transaction into the Oklahoma Medicaid Management Information System (OKMMIS).

If users wish to upload a batch, they must navigate to the Files Exchange menu. Select the Upload Files link from the Files Exchange Option to access the file upload page (see screen sample below).

![File Upload Screen](image)

From this page, the user will select the Transaction Type from the drop-down list. Select Browse to locate the file to upload. At this point, the user will have the ability to change the file name in the Save as Filename box. Once the information is complete, the user will select Upload.

The user will receive an Upload File Confirmation pop-up window upon successful completion of the file upload. This window will verify the name the file was saved under (see screen sample below).

![Upload File Confirmation](image)

The Upload process is now complete for the user. This process must be repeated for all files uploaded via the web upload tool.

Select the Search tab to search for uploaded files. Use the drop-down list to select the Transaction Type. Enter a partial filename in
the Filename field. The search results will display the Transaction ID and date the file was uploaded.

**File Download**

The File Download page allows users to select a file from the Provider Portal and download it to their system. Available files will be listed as filename links. The download process will begin when the filename is selected. Users of this feature include providers who wish to download batch claims or response files and managed care providers who wish to download managed care roster information.

To download a file (i.e., an 835 Remittance Advice), select the Download Files link; the Download page will open. Files created for the specific user/provider will be found on this page (see screen sample below).

To download a file, select the appropriate option from the File Status drop-down list. Select a category type from the Category drop-down list. Enter a date range and click **Search**. A list of available files will appear. Select a file to start the download. (The file download will vary based on browser settings.)

**NOTE:** If you are downloading multiple files, you will want to extract the file and rename it before downloading another file to avoid replacing the original file with your new file.

**Help Page**

Help pages for the SoonerCare Provider Portal site are dynamic, meaning that the help text that displays is unique to the particular page the user is viewing. Select the question mark (?) located at the right corner of each grey webpage header. This will open a separate window providing details of the webpage the user is currently navigating to.
Logout Link

Selecting the Logout link ends the current session on the SoonerCare Provider Portal and redirects the user to the non-secure menu options. Clicking Login will take the user to the Log On page.
This page intentionally left blank.
Chapter 4: Member Eligibility Verification

Introduction

SoonerCare (Oklahoma Medicaid) is a health coverage program jointly funded by the federal and state governments that assists in payment of some or all medical bills for many people who can't afford them. OHCA is the state agency that administers the program and determines financial eligibility using federal poverty income guidelines. Members should apply for SoonerCare and renew their benefits online at www.mysoonercare.org.

Member ID Card

SoonerCare members receive a permanent plastic identification card. The newest version of the Medicaid Medical ID card is a white card with blue graphics. The ID card can be used for accessing the Provider Portal, EVS system or a commercial swipe machine system to verify a member’s eligibility prior to providing a SoonerCare service. Shown below is an example of the previous and current versions of the medical ID card.
Members are encouraged to keep their card with them at all times; however, this card is not required for the member to receive services. The purpose of the ID card is to provide sufficient
information to verify eligibility of the member. The card by itself is not a guarantee of eligibility. Eligibility can be verified by using the member’s ID number from their card, Social Security number with date of birth, first and last name along with date of birth, or the member’s Case Number.

It is the provider’s responsibility to verify the member’s eligibility on a per visit basis to ensure the member’s continued eligibility for Medicaid SoonerCare coverage. Failure to verify eligibility prior to rendering services could result in delay or denial of payment.

Section B: Options to Verify Member Eligibility

As an Oklahoma SoonerCare provider, it is imperative to verify a member’s eligibility prior to providing services each time a service is provided.

Providers can check member eligibility using one of four sources:

- Eligibility Verification System (EVS)
- SoonerCare Provider Portal
- Electronic Data Interchange (EDI)
- Swipe Machine

Providers need a Personal Identification Number (PIN) to access the Provider Portal and EVS. If a provider forgets their PIN, they can obtain it by calling the Internet Help Desk at 405-522-6205 or toll-free at 800-522-0114 and selecting options 2, then 1.

EVS/AVR

The EVS is a national toll-free telephone number to help providers obtain member eligibility, provider warrant, prior authorization and claim inquiry information. Providers can also request prior authorization and eligibility fax backs. There are two ways to use the EVS system: A caller may use the touch-tone system or the automated voice response (AVR)/speech recognition system. A PIN is required to access member eligibility information. The 4-digit PIN expires every six months. Providers may reset their PIN by remaining on the phone and following the prompts.

Touch-Tone System

The touch-tone system allows a caller to go through the call using the telephone’s number pad. The caller’s telephone must have touch-tone capability; rotary style phones will not work on the touch-tone system.
Alpha Conversion

Entering the provider’s SoonerCare ID number can access eligibility information. This will be a 9-digit number and one alpha character location code that was assigned by the OHCA. A location conversion code has been established for the alphabet to be used in conjunction with the EVS. The codes are patterned to coincide with the location of numbers and letters on a telephone keypad. For example, the letter A converts to *21. The number 21 represents the second button and the first letter on that button of the telephone keypad. The letter R converts to *72, representing the seventh button, third letter. See the alpha conversion chart below.

**Alpha Conversion Chart for EVS**

```
A=*21  F=*33  K=*52  P=*71  U=*82  Z=*12
B=*22  G=*41  L=*53  Q=*11  V=*83
C=*23  H=*42  M=*61  R=*72  W=*91
D=*31  I=*43  N=*62  S=*73  X=*93
E=*32  J=*51  O=*63  T=*81  Y=*93
```

AVR/Speech Recognition

Providers without a touch-tone phone can access information using the AVR. The AVR system allows a caller to use a speech application. By speaking into the phone, a caller is able to use the system to get access information. The system is available seven days a week, from 5 a.m. to 1 a.m.

Toll-free: 800-767-3949
OKC Metro Area: 405-840-0650

Provider Portal

Providers have the ability to verify member eligibility on the SoonerCare Provider Portal.

Follow these steps to verify a member’s eligibility:

1. Select the Eligibility tab.
2. Select the Eligibility Verification link.
3. Enter search criteria to verify eligibility. The field options are Member ID, Case Number, SSN, First and Last Name, Date of Birth, and Dates of Service.

Each option requires that a date-of-service (DOS) range of up to 13 months also be entered. The Calendar option
4. Click Submit.

   Status A indicates the electronic request for eligibility was accepted by Oklahoma SoonerCare and does not reflect the eligibility of the member. The eligibility and benefit programs for the member will appear below the status.

5. Select a member ID from the search results to view eligibility details.

6. To print the eligibility results, click Print Preview. A new window displays, from which you can print the eligibility details.

Follow these steps to add third-party liability (TPL) to a member’s eligibility:

1. Follow steps 1-5 in the section above for eligibility verification.

2. Click [+] to expand the TPL header.

3. Enter the name of the carrier in the Carrier Name field.

4. Enter the carrier ID in the Carrier ID field.

5. Enter the policy number in the Policy Number field.

6. Enter the group ID in the Group ID field.

7. Select the Person or Organization radio button from the Policy Holder field.

8. If you selected the Person radio button, enter the policy holder’s first name, last name, and middle initial in the Policy Holder Last Name First Name and MI fields.

   If you selected the Organization radio button, enter the policy holder’s organization in the Policy Holder Organization field.

9. Select the policy type from the Policy Type drop-down list.

10. Select the coverage type from the Coverage Type drop-down list.

11. Select the relationship from the Relationship drop-down list.

12. Enter the employer ID in the Employer ID field.

13. Enter the effective and end dates in the Effective and End Date fields.

14. Click Add.
Electronic Data Interchange (EDI)

EDI is a way for providers to check eligibility on a larger scale than the previously listed options. Providers purchase third-party, HIPAA compliant software used to send a 270 transaction with their search criteria and receive a 271 response, which provides eligibility information. A 271 will provide information on the different programs the member is eligible for, as well as any TPL or Medicare information.

Swipe Card

This device, similar to a credit card machine, plugs into a phone jack. The provider swipes the SoonerCare ID card through the reader, which reads the magnetic strip. The eligibility information is displayed on the screen or printed on a paper slip. To implement a swipe card system, providers must contact a third-party swipe card vendor directly.
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Chapter 5: Claim Completion

Introduction

The following information is intended to provide procedures for submitting claims to the OHCA. For information on what services are covered by the Oklahoma SoonerCare program, please access the agency rules. Rules can be found at www.okhca.org.

There are three methods for submitting claims to the OHCA: paper, direct data entry (DDE) via the SoonerCare Provider Portal and through 837 batch transactions. Below is a paper-to-electronic conversion table for the different claim submission types. Please refer to the EDI chapter of this manual for instructions on completing the HIPAA transaction types.

<table>
<thead>
<tr>
<th>Paper Claim Form</th>
<th>DDE</th>
<th>HIPAA Transactions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1500</td>
<td>Professional</td>
<td>837P</td>
</tr>
<tr>
<td>UB-04</td>
<td>Institutional</td>
<td>837I</td>
</tr>
<tr>
<td>ADA 2012</td>
<td>Dental</td>
<td>837D</td>
</tr>
<tr>
<td>Pharmacy Drug Claim Form</td>
<td>Pharmacy</td>
<td>NCPDP, version 5.1</td>
</tr>
<tr>
<td>Compound Prescription Drug Claim Form</td>
<td>Pharmacy</td>
<td>NCPDP, version 5.1</td>
</tr>
</tbody>
</table>

Section A: Paper Claim Recommendations

Claim forms are prepared as follows:

1. Enter complete information with a typewriter, personal computer or ballpoint pen (blue or black ink). Do not use red ink.
2. Keep names, numbers, codes, etc., within the designated boxes and lines.
3. Provide the required information for every claim line. Do not use ditto marks or the words “same as above.”
4. Verify accuracy of the information before submitting the claim.
5. Follow the instructions for preparing paper claim forms provided in this chapter.
6. 1500, UB-04, Drug/Compound and ADA 2012 claim forms are scanned into the OKMMIS. Paper claim forms should be submitted on the original forms to facilitate the
scanning process. Use only 1500 and UB-04 claim forms with red drop-out ink.

7. Mail paper claims to the appropriate mailbox address listed in each claim section.

8. Send any necessary attachments with your claim. The attachments for a claim should be placed under the identified claim for processing; place claim form on top. Do not place the attachment on top of the claim form or it will be associated to previously processed claim. Do not apply any staples to the claim or attachments.

Ordering Paper Claim Forms

UB-04, 1500 and ADA 2012 (dental) claim forms can be ordered from a standard form supply company. DXC does not distribute supplies of these forms. Drug and Compound prescription claim forms can be downloaded from the OHCA website, ordered by contacting the OHCA Call Center or through a written request to:

DXC Form Request
P.O. Box 18650
Oklahoma City, OK 73154-0650
Section B: 1500, Professional, 837P

1500 Claim Form Instructions

The 1500 Health Insurance Claim Form (formerly known as the HCFA-1500 and CMS-1500), is the required claim form used by medical providers for professional services, unless otherwise
specified. The provider must purchase these forms. This section explains how to complete the paper 1500 Health Insurance Claim Form.

The form locator chart below indicates which fields are required, not required, required, if applicable or not captured. Where necessary, directions applicable to specific provider types are noted.

**1500 Claims Mailing Address**

Please mail paper claims to the appropriate mailing addresses below:

**1500**
DXC Technology
P.O. Box 54740
Oklahoma City, OK 73154

**Waiver Services**
DXC Technology
P.O. Box 54016
Oklahoma City, OK 73154

**HMO Copay/Personal Care Service (individual, not agency)**
DXC Technology
P.O. Box 18500
Oklahoma City, OK 73154

**Lab or DME**
DXC Technology
P.O. Box 18430
Oklahoma City, OK 73154
### 1500 Claims Field Descriptions

<table>
<thead>
<tr>
<th>Field</th>
<th>Requirement</th>
<th>1500 Field Description/Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Required</td>
<td>Insurance selection: Select the box for Medicaid.</td>
</tr>
<tr>
<td>1A</td>
<td>Required</td>
<td>Insured’s ID Number: Enter the member’s 9-digit SoonerCare ID number.</td>
</tr>
<tr>
<td>2</td>
<td>Required</td>
<td>Patient’s Name: Enter the member’s full last name, first name and middle initial. (Last, First, Middle Initial)</td>
</tr>
<tr>
<td>3</td>
<td>Not Required</td>
<td>Patient’s Birth Date: Enter the member’s birth date. (MM/DD/YY) Sex: Select the appropriate box.</td>
</tr>
<tr>
<td>4</td>
<td>Not Required</td>
<td>Insured’s Name: Insured’s last name, first name, middle initial. (Last, First, Middle Initial)</td>
</tr>
<tr>
<td>5</td>
<td>Not Required</td>
<td>Patient’s Address: (No., Street), City, State, ZIP Code, Telephone (including area code).</td>
</tr>
<tr>
<td>6</td>
<td>Not Required</td>
<td>Patient relationship to insured</td>
</tr>
<tr>
<td>7</td>
<td>Not Required</td>
<td>Insured’s Address: (No., Street), City, State, ZIP Code, Telephone (including area code).</td>
</tr>
<tr>
<td>8</td>
<td>Not Required</td>
<td>Reserved for NUCC Use</td>
</tr>
<tr>
<td>9</td>
<td>Not Required</td>
<td>Other Insured’s Name: Other Insured’s last name, first name, middle initial. (Last, First, Middle Initial)</td>
</tr>
<tr>
<td>9A</td>
<td>Not Required</td>
<td>Other Insured’s Policy or Group Number</td>
</tr>
<tr>
<td>9B</td>
<td>Not Required</td>
<td>Reserved for NUCC Use</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Other Insured’s Date of Birth: (MMDDYY) Sex: Select the appropriate box.</td>
</tr>
<tr>
<td>9C</td>
<td>Not Required</td>
<td>Reserved for NUCC Use</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Employer’s Name or School Name</td>
</tr>
<tr>
<td>9D</td>
<td>Situational</td>
<td>Insurance Plan Name or Program Name: If other insurance is available, enter the commercial or private insurance plan name.</td>
</tr>
<tr>
<td>10</td>
<td>Situational</td>
<td>Is Patient’s Condition Related to: Select the appropriate box for each of the three categories.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>10A: Employment? – (current or previous) Check Yes or No to indicate if the services being billed are employment related.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>10B: Auto Accident? – Check Yes or No to indicate if the services being billed are related to an auto accident. Plate (State) – Enter the 2-character state code, if applicable.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>10C: Other Accident? – Check Yes or No to indicate if the services being billed are related to an accident of another type.</td>
</tr>
<tr>
<td>10D</td>
<td>Not Captured</td>
<td>Claim Codes (Designated by NUCC)</td>
</tr>
<tr>
<td>11</td>
<td>Situational</td>
<td>Insured’s Policy Group or FECA Number: If member has more than one form of TPL (private or commercial insurance), enter policy number of second carrier.</td>
</tr>
<tr>
<td>Section</td>
<td>Required/Not Required</td>
<td>Description</td>
</tr>
<tr>
<td>---------</td>
<td>-----------------------</td>
<td>-------------</td>
</tr>
<tr>
<td>11A</td>
<td>Not Required</td>
<td>Insured’s Date of Birth: Enter the insured’s birth date (MMDDYY). Sex: Select the appropriate box.</td>
</tr>
<tr>
<td>11B</td>
<td>Not Required</td>
<td>Other Claim ID (Designated by NUCC) Employer’s Name or School Name</td>
</tr>
<tr>
<td>11C</td>
<td>Situational</td>
<td>Insurance Plan Name or Program Name: If other insurance is available, enter the commercial or private insurance plan name.</td>
</tr>
<tr>
<td>11D</td>
<td>Situational</td>
<td>Is There Another Health Benefit Plan?: Check the appropriate box. Provide third or additional private or commercial insurance information on a separate piece of paper using directions provided for field 9.</td>
</tr>
<tr>
<td>12</td>
<td>Not Required</td>
<td>Patient’s or Authorized Person’s Signature</td>
</tr>
<tr>
<td>13</td>
<td>Not Required</td>
<td>Insured’s or Authorized Person’s Signature</td>
</tr>
<tr>
<td>14</td>
<td>Situational</td>
<td>Date of Current Injury, Illness, or Pregnancy (LMP): Enter the date (MMDDYY) for any of the following, if applicable: <em>Illness</em> – date of first symptom/onset of illness <em>Injury</em> (Accident) – date of accident <em>Pregnancy</em> – OB claims must indicate date member was first seen for the pregnancy <strong>Qualifier</strong>—Enter applicable qualifier: 431 – Onset of Current Symptoms or Illness 481 – Last Menstrual Period</td>
</tr>
<tr>
<td>15</td>
<td>Not Required</td>
<td>Other Date: If patient has had same or similar illness, enter first date (MMDDYY). <strong>Qualifier</strong>—Enter applicable qualifier: 454 – Initial Treatment 304 – Latest Visit or Consultation 453 – Acute Manifestation of Chronic Condition 439 – Accident 455 – Last X-ray 471 – Prescription 090 – Report Start 091 – Report End 444 – Report EndrtstaConsultation</td>
</tr>
<tr>
<td>16</td>
<td>Not Required</td>
<td>Dates Patient Unable to Work in Current Occupation</td>
</tr>
<tr>
<td>17</td>
<td>Situational</td>
<td>Name of Referring Provider or Other Source: Enter the qualifier “DN” for the Referring Provider or “DK” for the Ordering Provider in the first small box.</td>
</tr>
<tr>
<td>17A</td>
<td>Situational</td>
<td><strong>Shaded</strong>—ID Number of Referring Provider: (small box) Enter the 2-character qualifier “1D” to indicate the referring provider’s ID number is a SoonerCare ID number. <em>(Optional)</em> (large box) Enter the 10-character Oklahoma SoonerCare provider ID number of the referring provider if the member is enrolled in the SoonerCare Choice or Insure Oklahoma Individual Plan programs. <em>(Required, if applicable)</em></td>
</tr>
</tbody>
</table>
### Chapter 5: Claim Completion

#### Provider Billing and Procedures Manual

<table>
<thead>
<tr>
<th>Code</th>
<th>Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>17B</strong></td>
<td>Situational</td>
<td><strong>Unshaded</strong>—NPI Number of Ordering or Referring Provider: Enter the 10-digit National Provider Identifier (NPI) number of the ordering physician or the 10-digit NPI from the referral form if the member is enrolled in the SoonerCare Choice or Insure Oklahoma Individual Plan programs. Referral form submission with the claim is not required.</td>
</tr>
<tr>
<td><strong>18</strong></td>
<td>Situational</td>
<td>Hospitalization Dates Related to Current Service: Enter the requested FROM and TO dates. <em>(MM/DD/YY)</em></td>
</tr>
<tr>
<td><strong>19</strong></td>
<td>Situational</td>
<td>Additional Claim Information <em>(Designated by NUCC)</em>: If the primary insurance carrier did not issue payment, write the words “Carrier Denied” in this box. A copy of the insurance payment detail or insurance denial must be attached to paper claims.</td>
</tr>
<tr>
<td><strong>20</strong></td>
<td>Not Required</td>
<td>Outside Lab?: Select the appropriate box. $ Charges: 8-digit numeric field</td>
</tr>
<tr>
<td><strong>21A-L</strong></td>
<td>Situational</td>
<td>Diagnosis or Nature of Illness or Injury: Enter up to 12 ICD diagnosis codes, with up to seven (7) characters per code, in order of importance. These indicators will correspond to the appropriate procedures and be listed in box 24E.</td>
</tr>
<tr>
<td><strong>22</strong></td>
<td>Not Required</td>
<td><strong>SoonerCare Resubmission Code; Original Ref No.</strong></td>
</tr>
<tr>
<td><strong>23</strong></td>
<td>Situational</td>
<td>Prior Authorization Number: The prior authorization (PA) number is not required as the information is systematically verified. The CLIA certification number is required to be put in this block when billing for laboratory services.</td>
</tr>
<tr>
<td><strong>24</strong></td>
<td></td>
<td>Detail service lines should be listed in the unshaded areas of 24 A-J. A maximum of six (6) service lines are allowed per claim.</td>
</tr>
</tbody>
</table>
| **24A** | Required | **Date(s) of Service:**  
*Unshaded* (bottom): Enter FROM and TO dates (MM/DD/YY) for the billing period for each service rendered.  
*Shaded* (top): Enter NDC qualifier “N4” followed by the 11-digit NDC number (e.g., N49999999999); NDC should go directly over dates, do not enter any spaces or dashes. |
| 24B | Required | **Place of Service:**  
*Unshaded (bottom)*: Enter the place of service code for the place services were rendered.  

**Place of Service Codes:**  
**CODE** | **DESCRIPTION**  
--- | ---  
11 | Office  
12 | Home  
20 | Urgent care facility  
21 | Inpatient hospital  
22 | Outpatient hospital  
23 | Emergency room  
24 | Ambulatory surgical center (ASC)  
25 | Birthing center  
26 | Military treatment facility  
31 | Skilled nursing facility (SNF)  
32 | Nursing facility (NF)  
33 | Custodial care facility  
34 | Hospice  
41 | Ambulance – land  
42 | Ambulance – air or water  
51 | Inpatient psychiatric facility  
52 | Psychiatric facility – partial hospitalization  
53 | Community mental health center  
54 | Intermediate care facility/developmentally disabled (ICF/MR)  
55 | Residential substance abuse treatment facility  
56 | Psychiatric residential treatment center  
61 | Comprehensive inpatient rehabilitation facility  
62 | Comprehensive outpatient rehabilitation facility  
65 | End-stage renal disease treatment facility  
71 | State or local public health clinic  
72 | Rural health clinic (RHC)  
81 | Independent laboratory  
99 | Other unlisted facility  

*Shaded (top)*: Do not enter anything in this field.

| 24C | Not Required | **Emergency Indicator (EMG):**  
*Unshaded (bottom)*: If services are related to an emergency, enter Y; if not, enter N.  

*Shaded (top)*: Do not enter anything in this field.
<table>
<thead>
<tr>
<th>Section</th>
<th>Type</th>
<th>Description</th>
</tr>
</thead>
</table>
| 24D     | Situational | Procedures, Services or Supplies (Explain unusual circumstances): CPT/HCPCS; Modifier  
*Unshaded* (bottom): Enter one (1) CPT or one (1) HCPCS code and up to four (4) modifiers for the service rendered.  
*Shaded* (top): If your procedure code requires an NDC, enter the unit of measure as "UN" for unit, "F2" for international unit, "ML" for milliliter, or "GR" for gram, followed by the metric decimal quantity. (e.g., UN103.50). Do not use spaces or dashes; do not include a description or any information beyond what is indicated above. The NDC should be placed above the corresponding HCPCS code. |
| 24E     | Situational | Diagnosis Pointer:  
*Unshaded* (bottom): Enter the alpha codes (A-L), in order of importance, which correspond to the ICD diagnosis code listed in field 21. A minimum of one (1) and maximum of four (4) diagnosis code pointers can be entered per line; do not enter the full diagnosis code.  
*Shaded* (top): Do not enter anything in this field. |
| 24F     | Required | $ Charges:  
*Unshaded* (bottom): Enter the charges for each line item on the claim form.  
*Shaded* (top): Do not enter anything in this field. |
| 24G     | Required | Days or Units:  
*Unshaded* (bottom): Enter the appropriate number of units of services provided for the procedure code. Whole and decimal numbers are acceptable.  
*Shaded* (top): Do not enter anything in this field. |
| 24H     | Situational | EPSDT Family Plan:  
*Unshaded* (bottom): If the services provided were related to an EPSDT/Family Planning visit, enter Y; if not, enter N or leave blank.  
*Shaded* (top): If Y is entered in the unshaded box as described above, the 2-digit referral type must be entered in the shaded area above the box. Appropriate codes are:  
NU: Not Available  
AV: Available, Not Used  
ST: New Services Requested  
S2: Under Treatment |
| 24I-J   | When entering the rendering provider's ID number, only use the shaded areas of 24I-J.  
When entering the provider's NPI number, use the unshaded area of 24J. |
<table>
<thead>
<tr>
<th>Field</th>
<th>Required/Not Required</th>
<th>Description</th>
</tr>
</thead>
</table>
| **24I** | Not Required | **ID Qualifier:**  
*Unshaded* (bottom): This field is already populated with NPI, indicating that the provider number listed for the rendering provider is the NPI.  
*Shaded* (top): Enter the 2-character qualifier indicating the type of provider number being used for the rendering provider; enter 1D to indicate the type of provider number used is for Oklahoma SoonerCare. |
| **24J** | Situational | **Rendering Provider ID Number:**  
*Unshaded* (bottom): Enter the rendering provider’s 10-digit NPI.  
*Shaded* (top): Enter the 10-character Oklahoma SoonerCare provider number of the rendering provider. This field can be left blank if billing and rendering numbers, including location code, are identical. |
| **25** | Not Required | Federal Tax ID Number |
| **26** | Not Required | Patient’s Account Number: Enter the internal patient tracking number; if entered, this information will appear on the remittance advice. |
| **27** | Required | Accept Assignment?: Oklahoma SoonerCare only accepts assigned claims. |
| **28** | Required | Total Charge: Add all amounts/charges in column 24F; enter the total amount/charge in this field. Each page must have a total. Claims cannot be continued to two or more pages. |
| **29** | Situational | Amount Paid: Enter the total dollar amount paid by a primary insurance carrier (for example, 45.00). You do not need to enter a dollar sign ($). Do not include amount paid by Medicare. |
| **30** | Not Captured | Reserved for NUCC Use |
| **31** | Required | Signature of Physician or Supplier including degrees or credentials: The billing provider or authorized representative must sign and date this field. Include the date the claim was created. A signature stamp is acceptable; however, the statement “Signature on File” is not allowed.  
*Date* – Enter the date the claim was filed. Be sure not to write any portion of the date outside the designated box. The date billed must be on or after the date(s) of service. |
| **32** | Not Required | Service Facility Location Information: Enter the name and full address of the location where service was rendered. |
| **32A** | Not Required | Enter the 10-digit NPI number of the facility where the services were rendered. |
| **32B** | Not Required | Enter the 2-character qualifier “1D” and 10-character Oklahoma SoonerCare provider ID number of the facility where the services were rendered. No spaces or dashes should be used. |
33  Required  Billing Provider Info & Phone Number: Enter the name, full address, ZIP code and phone number of provider requesting payment for services listed on claim form. If the provider furnished the services as part of a group practice organization, enter the name, full address, ZIP code and phone number of the group practice organization.

33A  Not Required  Enter the 10-digit NPI number of the billing provider or group.

33B  Required  Enter the 10-character Oklahoma SoonerCare provider ID number of the billing provider. No spaces or dashes should be used. Use of the 1D Medicaid qualifier is optional.

Direct Data Entry (DDE) Claim Submission – Professional

Use the Professional claim form example and directions below as a guide when submitting claims through DDE on the SoonerCare Provider Portal. Choose the Submit Claim Prof (see screen sample below) claim option from the Claims menu to open the form (see screen sample below).
Select **Crossover Professional** from the Claim Type drop-down list above the Provider Information heading. The Crossover Details section should now be visible (see screen sample below).
### Medicare Crossover Details

<table>
<thead>
<tr>
<th>Medicare Crossover Instructions</th>
<th>Co-insurance Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Allowed Medicare Amount</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Deductible Amount</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Medicare Payment Amount</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Psychiatric Services Amount</strong></td>
<td></td>
</tr>
</tbody>
</table>

Enter the Medicare allowed amount in the **Allowed Medicare Amount** field located under the Medicare Crossover Details heading.

### DDE Professional Claim Submission Instructions

#### Provider Information

<table>
<thead>
<tr>
<th>Form Locator</th>
<th>DDE Professional Claim Submission Instructions</th>
<th>Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Billing Provider ID</td>
<td>Your Provider ID number and provider information should auto-populate. Verify it is correct; if it is not, you may need to log out and access the correct provider.</td>
<td>Required</td>
</tr>
<tr>
<td>Referring Provider ID</td>
<td>Enter the 10-character referral number from the referral form, if the member is enrolled in the SoonerCare Choice program. <em>See 1500 form locator 17A.</em></td>
<td>Required, if applicable</td>
</tr>
<tr>
<td>Ordering Provider ID</td>
<td>Enter the ordering provider ID number.</td>
<td>Required, if applicable</td>
</tr>
<tr>
<td>ID Type</td>
<td>Select the applicable ID type from the drop-down list.</td>
<td></td>
</tr>
<tr>
<td>Ordering ZIP Code</td>
<td>Enter the ZIP Code.</td>
<td></td>
</tr>
</tbody>
</table>

#### Patient Information

<table>
<thead>
<tr>
<th>Form Locator</th>
<th>DDE Professional Claim Submission Instructions</th>
<th>Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member ID</td>
<td>Enter the member's SoonerCare ID number. The patient's last and first name, and birth date will auto-populate if the member's ID number is in the system.</td>
<td>Required</td>
</tr>
</tbody>
</table>

#### Claim Information

<table>
<thead>
<tr>
<th>Form Locator</th>
<th>DDE Professional Claim Submission Instructions</th>
<th>Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date Type</td>
<td>Select the applicable date type from the drop-down list.</td>
<td>Required, if applicable</td>
</tr>
<tr>
<td>Date of Current</td>
<td>Enter the date of current status from the date type selected.</td>
<td>Required, if applicable</td>
</tr>
<tr>
<td>Accident Related</td>
<td>Select the applicable option to describe the accident.</td>
<td></td>
</tr>
<tr>
<td>Admission Date</td>
<td>Enter the date of admission.</td>
<td></td>
</tr>
<tr>
<td>Patient Account #</td>
<td>The patient account number will be captured and appear on the remittance advice if entered into this field.</td>
<td>Not Required</td>
</tr>
<tr>
<td>Expected Delivery Date</td>
<td>Enter the expected delivery date if the claim is related to pregnancy.</td>
<td></td>
</tr>
<tr>
<td>Field</td>
<td>Description</td>
<td>Required</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>-----------------------------------------------------------------------------</td>
<td>----------</td>
</tr>
<tr>
<td>From Date</td>
<td>This field will auto-populate.</td>
<td></td>
</tr>
<tr>
<td>To Date</td>
<td>This field will auto-populate.</td>
<td></td>
</tr>
<tr>
<td>CLIA Number</td>
<td>Required when billing for laboratory services.</td>
<td></td>
</tr>
<tr>
<td>Other Insurance</td>
<td>Select the applicable option for other insurance.</td>
<td></td>
</tr>
<tr>
<td>Total Charged Amount</td>
<td>This field will auto-populate.</td>
<td></td>
</tr>
</tbody>
</table>

**Medicare Crossover Details (when Crossover Professional is selected)**

<table>
<thead>
<tr>
<th>Form Locator</th>
<th>DDE Professional Claim Submission Instructions</th>
<th>Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allowed Medicare Amount</td>
<td>Enter the allowed Medicare amount.</td>
<td></td>
</tr>
<tr>
<td>Coinsurance Amount</td>
<td>Enter the coinsurance amount.</td>
<td></td>
</tr>
<tr>
<td>Deductible Amount</td>
<td>Enter the deductible amount.</td>
<td></td>
</tr>
<tr>
<td>Psychiatric Services Amount</td>
<td>Enter the psychiatric services amount.</td>
<td></td>
</tr>
<tr>
<td>Medicare Payment Amount</td>
<td>Enter the Medicare payment amount.</td>
<td></td>
</tr>
<tr>
<td>Medicare Payment Date</td>
<td>Enter the Medicare payment date.</td>
<td>Required</td>
</tr>
</tbody>
</table>

**Diagnosis Codes**

<table>
<thead>
<tr>
<th>Form Locator</th>
<th>DDE Professional Claim Submission Instructions</th>
<th>Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>ICD Version</td>
<td>Use the drop-down list to select a diagnosis type.</td>
<td>Required</td>
</tr>
<tr>
<td>Diagnosis Code</td>
<td>Enter at least three (3) characters to begin searching for a diagnosis code.</td>
<td>Required</td>
</tr>
</tbody>
</table>

**Other Insurance Details (when Other Insurance-Include is selected)**

<table>
<thead>
<tr>
<th>Form Locator</th>
<th>DDE Professional Claim Submission Instructions</th>
<th>Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>TPL Amount</td>
<td>Enter the TPL amount.</td>
<td></td>
</tr>
</tbody>
</table>

**Service Information**

<table>
<thead>
<tr>
<th>Form Locator</th>
<th>DDE Professional Claim Submission Instructions</th>
<th>Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>From Date</td>
<td>Enter the beginning date of service.</td>
<td>Required</td>
</tr>
<tr>
<td>To Date</td>
<td>Enter the end date of service.</td>
<td>Required</td>
</tr>
<tr>
<td>Place of Service</td>
<td>Select the place of service code using the drop-down list.</td>
<td>Required</td>
</tr>
<tr>
<td>EMG</td>
<td>If the claim is related to an emergency, select from the drop-down list.</td>
<td>Required, if applicable</td>
</tr>
<tr>
<td>Procedure Code</td>
<td>Enter the CPT or HCPCS procedure code in the Procedure field. See 1500 form locator 24D for additional information.</td>
<td>Required</td>
</tr>
<tr>
<td>Modifiers</td>
<td>Enter modifier code(s) in the Modifier field(s).</td>
<td>Required, if applicable</td>
</tr>
<tr>
<td>Diagnosis Pointers</td>
<td>Use the drop-down lists to select the numeric codes (1, 2, 3 or 4) in order of importance, which correspond to the ICD diagnosis code listed in form locator 21. A minimum of one (1) and maximum of four (4) diagnosis code pointers can be entered on each line.</td>
<td>Required</td>
</tr>
<tr>
<td><strong>Chapter 5: Claim Completion</strong></td>
<td><strong>Provider Billing and Procedures Manual</strong></td>
<td></td>
</tr>
<tr>
<td>--------------------------------</td>
<td>------------------------------------------</td>
<td></td>
</tr>
</tbody>
</table>

| **Charge Amount** | Enter the total dollar ($) amount of charges for that specific detail in the Charges field. If units are greater than one (1), multiply the number of units by the amount billed per unit. This action will auto-populate the Total Charges field. | **Required** |
| **Units** | Enter number of units billed. | **Required** |
| **Unit Type** | Field is auto-populated by default. | |
| **EPSDT** | If claim is related to an EPSDT service, select the appropriate referral type from the drop-down list. If nothing is entered, field will default to No. | **Required, if applicable** |
| **ID Type** | Select from the drop-down list to determine ID type. | |
| **ZIP Code** | Enter rendering provider’s ZIP code +4, if applicable. | |
| **Contract Code** | Select from drop-down list, if applicable. | |
| **Taxonomy** | Enter rendering provider’s taxonomy, if applicable. | |
| **SC Provider Number** | Enter the Oklahoma SoonerCare provider number. | |

### NDC for Item #

<table>
<thead>
<tr>
<th><strong>Form Locator</strong></th>
<th><strong>DDE Professional Claim Submission Instructions</strong></th>
<th><strong>Requirement</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Code Type</strong></td>
<td>This field is auto-populated by default.</td>
<td></td>
</tr>
<tr>
<td><strong>NDC/UPN</strong></td>
<td>Enter NDC or UPN code in the Procedure field.</td>
<td></td>
</tr>
<tr>
<td><strong>Quantity</strong></td>
<td>Enter quantity.</td>
<td></td>
</tr>
<tr>
<td><strong>Unit of Measure</strong></td>
<td>Select type of measurement from drop-down list.</td>
<td></td>
</tr>
</tbody>
</table>

### Attachments

<table>
<thead>
<tr>
<th><strong>Form Locator</strong></th>
<th><strong>DDE Professional Claim Submission Instructions</strong></th>
<th><strong>Requirement</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Transmission Method</strong></td>
<td>Select from the drop-down list how the attachment(s) will be sent.</td>
<td><strong>Required, if applicable</strong></td>
</tr>
<tr>
<td><strong>Upload File</strong></td>
<td>Click Browse to locate file to be uploaded; <em>available when FT-File Transfer is selected.</em></td>
<td><strong>Required, if applicable</strong></td>
</tr>
<tr>
<td><strong>Attachment Type</strong></td>
<td>Select file type of the attachment from the drop-down list.</td>
<td><strong>Required, if applicable</strong></td>
</tr>
<tr>
<td><strong>Description</strong></td>
<td>Enter description of the attachment.</td>
<td></td>
</tr>
<tr>
<td><strong>HCA-13</strong></td>
<td>If a hard-copy attachment is to be added, a system-generated HCA-13 Paper Attachment form will be available to print once the claim has been submitted by selecting BM-By Mail or FX-By Fax from the Transmission Method drop-down list. (See section F in this chapter for instructions on sending form HCA-13 by fax or mail.) Unique attachment control numbers (Control #) are generated once an attachment is added.</td>
<td><strong>Required, if applicable</strong></td>
</tr>
<tr>
<td><strong>Submit</strong></td>
<td>When finished, click Submit.</td>
<td><strong>Required</strong></td>
</tr>
</tbody>
</table>
Section C: UB-04, Institutional, 837I

UB-04 Claim Form Instructions
The **UB-04**, Universal Billing Claim Form, is used to bill for facility services covered under the OHCA’s Medical Program, unless otherwise specified in this chapter. The provider must purchase these forms. This section explains how to complete the paper UB-04 claim form. The form locator chart indicates which fields are optional; required; required, if applicable or not captured.

Providers should use the UB-04 billing manual instructions unless otherwise specified. The UB-04 manual can be obtained by contacting the National Uniform Billing Committee at [www.nubc.org](http://www.nubc.org). Please mail paper claims to the appropriate mailbox address below.

**UB-04 Claims Mailing Address**

**UB-04 (Hospital or Home Health)**  
DXC Technology  
P.O. Box 18430  
Oklahoma City, OK 73154

**HMO Copay**  
DXC Technology  
P.O. Box 18500  
Oklahoma City, OK 73154

**Long-Term Care Nursing Facility**  
DXC Technology  
P.O. Box 54200  
Oklahoma City, OK 73154
# UB-04 Claim Field Descriptions

<table>
<thead>
<tr>
<th>Field</th>
<th>Requirement</th>
<th>UB-04 Field Description/Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Required</td>
<td>Please Remit Payment To/Billing Provider Name and Address: Enter the name, full address and telephone number of the billing provider.</td>
</tr>
<tr>
<td>2</td>
<td>Not Captured</td>
<td>Unlabeled field</td>
</tr>
<tr>
<td>3A</td>
<td>Required</td>
<td>PAT CNTL # (Patient Control Number): Enter the internal patient account number (24 characters max). This number will also appear on the remittance advice.</td>
</tr>
<tr>
<td>3B</td>
<td>Required</td>
<td>MED REC # (Medical/Health Record Number): HIPAA-required number (24 characters max). This number is assigned by the provider to identify the medical health records of the patient.</td>
</tr>
</tbody>
</table>
| 4     | Required    | Type of Bill: Enter the 4-digit code indicating the specific type of bill.  
  The 4-digit code requires one digit from each of the following categories:  
  1\textsuperscript{st} digit – leading zero (0) – optional  
  2\textsuperscript{nd} digit – type of facility  
  3\textsuperscript{rd} digit – bill classification  
  4\textsuperscript{th} digit – frequency  
  Please refer to the National UB-04 Uniform Billing Manual for type of bill codes. |
<p>| 5     | Not Captured| FED TAX NO (Federal Tax Number)       |
| 6     | Required    | Statement Covers Period, From/Through: Enter the beginning (from) and ending (through) service dates included in this bill. For services rendered on a single day, use the same From and Through dates. Total days must equal days indicated in fields 39-41 and total units located in field 46, with the exception of discharge day. (MMDDYY) |
| 7     | Not Captured| Unlabeled field                      |
| 8A    | Not Captured| Patient Name (a)                     |
| 8B    | Required    | Patient Name: Enter member’s name. (last name, first name, middle initial) |
| 9A-E  | Not Captured| Patient Address                      |
| 10    | Not Captured| Birthdate (Patient)                  |
| 11    | Not Captured| Sex (Patient)                        |
| 12    | Required    | Admission Date: Enter the date the patient was admitted for inpatient care. (MMDDYY) |
| 13    | Required    | Admission Hour: Enter the 2-digit code for the hour during which the patient was admitted for inpatient care, using the 24-hour format (e.g., 7:00 pm = 19). |
| 14    | Required    | Admission Type: Enter the code indicating the priority of this admission. Type must be numeric; refer to NUBC’s UB-04 manual for additional detail. |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>15</td>
<td>Required</td>
<td>Source of Admission: Enter the code indicating how the patient was admitted; refer to NUBC’s UB-04 manual for additional detail.</td>
</tr>
<tr>
<td>16</td>
<td>Not Captured</td>
<td>DHR (Discharge Hour)</td>
</tr>
<tr>
<td>17</td>
<td>Required</td>
<td>STAT (Patient Discharge Status): Enter the code indicating the member status at the end of service for the period covered on this bill. This is a 2-digit 01-99 code. Codes for patient status are detailed in the National UB-04 Uniform Billing Manual and indicate if the member is still a patient, deceased, discharged and other statuses; refer to NUBC’s UB-04 manual for additional detail.</td>
</tr>
<tr>
<td>18-28</td>
<td>Not Required</td>
<td>Condition Codes: Enter the appropriate code(s); refer to NUBC’s UB-04 manual for additional detail.</td>
</tr>
<tr>
<td>29</td>
<td>Not Captured</td>
<td>ACDT State</td>
</tr>
<tr>
<td>30</td>
<td>Required, if applicable</td>
<td>Referring Provider ID Number: Enter the 10-character referral number from the referral form if the member is enrolled in the SoonerCare Choice or Insure Oklahoma programs (e.g., 123456789A). Referral form submission with the claim is not required.</td>
</tr>
<tr>
<td>31-34 (A-B)</td>
<td>Required, if applicable</td>
<td>Occurrence Code and Date: Enter the applicable code and associated date to identify significant events related to this bill that may affect processing. Dates are entered in a MMDDYY format. A maximum of eight (8) codes and associated dates can be entered; refer to NUBC’s UB-04 manual for additional detail.</td>
</tr>
<tr>
<td>35-36 (A-B)</td>
<td>Required, if applicable</td>
<td>Occurrence Span Code, From/Through: Enter the code and associated dates for significant events related to this bill. Each Occurrence Span Code must be accompanied by the span from and through date.</td>
</tr>
<tr>
<td>37</td>
<td>Not Captured</td>
<td>Unlabeled field</td>
</tr>
<tr>
<td>38</td>
<td>Not Captured</td>
<td>Unlabeled field</td>
</tr>
<tr>
<td>39-41 (A-D)</td>
<td>Required, if applicable</td>
<td>Value Codes: Enter code(s) and amount(s), as applicable. Value Code 80 specifies the number of covered days. Days need to be listed in whole numbers; no decimals.</td>
</tr>
<tr>
<td>42, lines 1-22</td>
<td>Required</td>
<td>Revenue Codes: Enter the applicable revenue code(s) identifying the specific accommodation(s), ancillary service(s), or billing calculation(s). The use of revenue code 001 is not required to indicate total billed; if programmed, please put 001 in field 42, line 23.</td>
</tr>
<tr>
<td>42, line 23</td>
<td>Not Required</td>
<td>Unlabeled; Enter the revenue code 001.</td>
</tr>
<tr>
<td>43, lines 1-22</td>
<td>Required, if applicable</td>
<td>Description: Using no spaces or dashes, enter NDC qualifier &quot;N4&quot;; the 11-digit NDC number; the unit of measurement: &quot;UN&quot; for unit, &quot;F2&quot; for international unit, &quot;ML&quot; for milliliter or &quot;GR&quot; for gram; and the metric decimal quantity. For example: N49999999999UN999.99. Corresponding HCPCS code(s) should be placed on the same line as NDC.</td>
</tr>
</tbody>
</table>
| 43, line 23 | Not Used | Page____ of_____; The OHCA does not accept multiple-page claims.  

### Chapter 5: Claim Completion

#### Provider Billing and Procedures Manual

<table>
<thead>
<tr>
<th>Line</th>
<th>Required/Not Required</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>44, lines 1-22</td>
<td>Required, if applicable*</td>
<td>HCPSC/Rates: Enter the Health Care Procedure Coding System (HCPCS) code(s) applicable to the service provided. Only one service code per line is permitted. *Required for DME, outpatient, X-ray, lab, rural health, EKG, EEG and pharmacy</td>
</tr>
<tr>
<td>45, lines 1-22</td>
<td>Required, if applicable*</td>
<td>Service Date: The date the indicated outpatient service was provided on a series bill. *Required for all services except inpatient and long-term care</td>
</tr>
<tr>
<td>45, line 23</td>
<td>Required</td>
<td>Creation Date: Enter the date billed.</td>
</tr>
<tr>
<td>46, lines 1-22</td>
<td>Required</td>
<td>Units of Service: Enter the number of units corresponding to the revenue code and/or HCPCS code billed.</td>
</tr>
<tr>
<td>47, lines 1-22</td>
<td>Required</td>
<td>Total Charges: Enter the total charges pertaining to the related revenue code detail line. On the detail line that has the revenue code 001, add all of the charge details together and enter the sum of all charges billed in form locater 47.</td>
</tr>
<tr>
<td>47, line 23</td>
<td>Required</td>
<td>Total: Enter the total charges from lines 1-22 combined.</td>
</tr>
<tr>
<td>48</td>
<td>Not Captured</td>
<td>Non-Covered Charges</td>
</tr>
<tr>
<td>48, line 23</td>
<td>Not Captured</td>
<td>Unlabeled; Total non-covered charges from lines 1-22.</td>
</tr>
<tr>
<td>49</td>
<td>Not Captured</td>
<td>Unlabeled field</td>
</tr>
<tr>
<td>50-55 (A-C)</td>
<td>Required</td>
<td>Enter the appropriate order of insurance coverage: A, Primary; B, Secondary; and C, Tertiary; for example, A, Medicare; B, Medicare Supplement; and C, SoonerCare. If the member only has SoonerCare coverage, it should be listed in A.</td>
</tr>
<tr>
<td>50A-C</td>
<td>Required</td>
<td>Payer Name: As applicable, enter the name of the recipient's primary, secondary and tertiary insurance on lines A, B and C. On claims with no TPL, SoonerCare information is entered on line A.</td>
</tr>
<tr>
<td>51A-C</td>
<td>Not Captured</td>
<td>Health Plan ID</td>
</tr>
<tr>
<td>52A-C</td>
<td>Not Captured</td>
<td>REL INFO (Release of Information Certification Indicator)</td>
</tr>
<tr>
<td>53A-C</td>
<td>Not Captured</td>
<td>ASG BEN (Assignment of Benefits Certification Indicator)</td>
</tr>
<tr>
<td>54A-C</td>
<td>Required, if applicable*</td>
<td>Prior Payments: Enter the amount paid by the insurance carrier identified in form locaters 50 A-B, as applicable. *Required, if TPL applies</td>
</tr>
<tr>
<td></td>
<td></td>
<td>When a TPL carrier makes payment of a claim, the Explanation of Benefits (EOB) is not required. The EOB is always required if the TPL carrier denies the claim.</td>
</tr>
<tr>
<td>55A-C</td>
<td>Required, if applicable*</td>
<td>Estimated Amount Due: The amount estimated by the provider to be due from the indicated payer (estimated responsibility less prior payments). *Used for HMO Copays only</td>
</tr>
<tr>
<td>56</td>
<td>Not Required</td>
<td>NPI (National Provider Identifier): Enter the NPI of the billing provider.</td>
</tr>
</tbody>
</table>
### 57A-C
**Required**
OTHER PRV ID (Other Billing Provider Identifier): Enter the 10-character SoonerCare provider ID for the billing provider in the corresponding line 50A-C that indicates SoonerCare/Medicaid.

### 58A-C
**Not Captured**
*Insured’s Name: Enter insured’s last name, first name and middle initial.*

### 59A-C
**Not Captured**
P REL (Patient’s Relationship to Insured)

### 60A-C
**Required**
*Insured’s Unique ID: Enter the member’s identification number for the respective payers entered in field 50A-C. The member’s 9-digit SoonerCare identification number is required and should be listed in the same order as field 50A-C. Other carriers are optional.*

### 61A-C
**Not Captured**
*Group Name*

### 62A-C
**Not Captured**
*Insurance Group No.*

### 63A-C
**Not Captured**
*Treatment Authorization Codes*

### 64A-C
**Not Captured**
*Document Control Number*

### 65A-C
**Not Captured**
*Employer Name*

### 66
**Not Captured**
*DX*

### 67
**Required**
PRIN DIAG CD (Principal Diagnosis Code): Enter the ICD diagnosis code describing the principal diagnosis.

### 67A-Q
**Required, if applicable**
*Other Diag. Codes: Enter the ICD diagnosis codes corresponding to additional conditions existing at the time of admission or that developed subsequently and have an effect on the treatment received or the length of stay. When submitting an inpatient claim, enter the Point of Admission (POA) codes for each diagnosis entered.*

### 68
**Not Captured**
*Unlabeled field*

### 69
**Required**
ADM DIAG CD (Admitting Diagnosis Code): Enter the ICD diagnosis code provided at the time of admission as stated by the physician.

### 70
**Not Captured**
*Patient Reason DX*

### 71
**Not Captured**
*PPS Code*

### 72A
**Not Required**
*ECI*

### 72B-C
**Not Captured**
*ECI*

### 73
**Not Captured**
*Unlabeled field*

### 74
**Required, if applicable**
Principal Procedure Code/Date: Enter the ICD procedure code that identifies the principal procedure performed during the period covered by this bill and the date on which the principal procedure described on the bill was performed. Do not use HCPCS or CPT codes.

### 74A-E
**Not Required**
Other Procedure Code/Date: Enter the ICD procedure codes identifying the significant procedures, other than the principal procedure, and the dates identified by codes on which the procedures were performed. Report the most important for the encounter and specifically any therapeutic procedures closely related to the principal diagnosis. Do not use HCPCS or CPT codes.
<table>
<thead>
<tr>
<th></th>
<th>Not Captured</th>
<th>Unlabeled field</th>
</tr>
</thead>
<tbody>
<tr>
<td>75</td>
<td></td>
<td></td>
</tr>
<tr>
<td>76</td>
<td>Required, if applicable</td>
<td>ATTENDING (Attending Provider ID/Name): NPI</td>
</tr>
<tr>
<td>77</td>
<td>Required, if applicable</td>
<td>OPERATING (Operating Provider ID/Name): NPI</td>
</tr>
<tr>
<td>78-79</td>
<td>Not Captured</td>
<td>Other</td>
</tr>
<tr>
<td>80-81</td>
<td>Not Captured</td>
<td>Remarks/CC</td>
</tr>
</tbody>
</table>
Direct Data Entry (DDE) Claim Submission – Institutional

Use the Institutional claim form example and the directions below as a guide when submitting a claim through DDE on the SoonerCare Provider Portal. Required fields are indicated. To access this form, choose the Submit Claim Inst claim option (see screen sample below) from the Claims menu. Fields with an asterisk (*) are always required. Other fields may be required under certain circumstances.

Detailed instructions on specific OHCA requirements on acceptable codes are located in the corresponding UB-04 form (see screen samples below) locator information. Choose the Institutional option to obtain the fields.
# Diagnostic Codes
Select the row number to edit the row. Click the Remove link to remove the entire row.

<table>
<thead>
<tr>
<th>#</th>
<th>ICD Version</th>
<th>Diagnosis Code</th>
<th>POA</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td><em>ICD Version</em></td>
<td><em>Diagnosis Code</em></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Present on Admission

Add | Reset

# Emergency Diagnosis Code
Only one emergency diagnosis code is allowed per claim.

<table>
<thead>
<tr>
<th>ICD Version</th>
<th>Diagnosis Code</th>
</tr>
</thead>
</table>

Other Insurance Details
Select the row number to edit the row. Click the Remove link to remove the entire row.

<table>
<thead>
<tr>
<th>#</th>
<th>Payer Code</th>
<th>Prior Amount</th>
<th>Estimated Amount Due</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td><em>Payer Code</em></td>
<td><em>Prior Amount</em></td>
<td>Estimated Amount Due</td>
<td></td>
</tr>
</tbody>
</table>

Add | Reset

# Condition Codes
Click the Remove link to remove the entire row.

<table>
<thead>
<tr>
<th>#</th>
<th>Condition Code</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td><em>Condition Code</em></td>
<td></td>
</tr>
</tbody>
</table>

Add | Reset

# Occurrence Codes
Select the row number to edit the row. Click the Remove link to remove the entire row.

<table>
<thead>
<tr>
<th>#</th>
<th>Occurrence Code</th>
<th>From Date</th>
<th>To Date</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td><em>Occurrence Code</em></td>
<td><em>From Date</em></td>
<td><em>To Date</em></td>
<td></td>
</tr>
</tbody>
</table>

Add | Reset

# Value Codes
Select the row number to edit the row. Click the Remove link to remove the entire row.

<table>
<thead>
<tr>
<th>#</th>
<th>Value Code</th>
<th>Amount</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td><em>Value Code</em></td>
<td><em>Amount</em></td>
<td></td>
</tr>
</tbody>
</table>

Add | Reset

# Surgical Procedures
Select the row number to edit the row. Click the Remove link to remove the entire row.

*Please note that the 1st surgical procedure code entered is considered to be the principal (primary) Surgical Procedure Code.*

<table>
<thead>
<tr>
<th>#</th>
<th>Surgical Procedure Type</th>
<th>Surgical Procedure Code</th>
<th>Date</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td><em>Surgical Procedure Type</em></td>
<td><em>Surgical Procedure Code</em></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Add | Reset

Back to Step 1 | Continue | Cancel
Select the **Inpatient** or **Outpatient Crossover** claim type from the **Claim Type** drop-down list above the Service Information heading. The **Crossover Details** section should now be visible (see screen sample below).

Under the **Crossover Details** heading, enter the payment date in the **Medicare Payment Date** field, if applicable.
### DDE Institutional Claim Submission Instructions

#### Provider Information

<table>
<thead>
<tr>
<th>Form Locator</th>
<th>DDE Institutional Claim Submission Instructions</th>
<th>Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Billing Provider ID</td>
<td>Your Provider ID Number and provider information should auto-populate. Verify this information is correct; if it is not, you may need to log out and access the correct provider.</td>
<td>Required</td>
</tr>
<tr>
<td>Institutional Provider ID</td>
<td>Enter the institutional provider ID number/NPI.</td>
<td></td>
</tr>
<tr>
<td>Attending Provider ID</td>
<td>Enter the provider ID/NPI of the attending physician.&lt;br&gt;&lt;br&gt;<strong>ID Type:</strong> Select NPI from the ID Type drop-down list</td>
<td></td>
</tr>
<tr>
<td>Operating Provider ID</td>
<td>Enter the Prescriber ID number/NPI of the operating provider.&lt;br&gt;&lt;br&gt;*Required for submitting surgical procedures&lt;br&gt;&lt;br&gt;<strong>ID Type:</strong> Select NPI from the ID Type drop-down list</td>
<td>Required, if applicable*</td>
</tr>
<tr>
<td>Referring Provider ID</td>
<td>Enter the NPI of the referring provider, if the member is enrolled in SoonerCare Choice. See UB-04 form locator 7 for additional information.&lt;br&gt;&lt;br&gt;<strong>ID Type:</strong> Select NPI from the ID Type drop-down list</td>
<td>Required, if applicable</td>
</tr>
</tbody>
</table>

#### Patient Information

<table>
<thead>
<tr>
<th>Form Locator</th>
<th>DDE Institutional Claim Submission Instructions</th>
<th>Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member ID</td>
<td>Enter the member's Oklahoma SoonerCare ID number in the client ID field. The patient's last and first name, and birth date will auto-populate if the member's ID number is in the system.</td>
<td>Required</td>
</tr>
</tbody>
</table>

#### Claim Information

<table>
<thead>
<tr>
<th>Form Locator</th>
<th>DDE Institutional Claim Submission Instructions</th>
<th>Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Dates</td>
<td>Enter the dates of coverage.</td>
<td>Required</td>
</tr>
<tr>
<td>Covered Days</td>
<td>Enter the number of eligible days. UB-04 form locator 7 for additional information.&lt;br&gt;&lt;br&gt;*Required for inpatient and nursing home facilities</td>
<td>Required, if applicable*</td>
</tr>
<tr>
<td>Admission Date/Time</td>
<td>Enter the date and time of admission, using 24-hour format (e.g., 7:00 PM = 19:00).</td>
<td>Required, if applicable</td>
</tr>
<tr>
<td>Discharge Time</td>
<td>Enter the time of discharge, using 24-hour format (e.g., 7:00 PM = 19:00).</td>
<td>Required, if applicable</td>
</tr>
<tr>
<td>Admission Type</td>
<td>Enter at least one (1) character to begin searching for an admission type.</td>
<td>Required, if applicable</td>
</tr>
<tr>
<td>Admission Source</td>
<td>Enter at least one (1) character to begin searching for an admission source.</td>
<td>Required, if applicable</td>
</tr>
<tr>
<td>Admitting ICD Code</td>
<td>Use the drop-down list to select a diagnosis type.</td>
<td>Required, if applicable</td>
</tr>
<tr>
<td>Admitting Diagnosis</td>
<td>Enter a diagnosis code. See UB-04 form locators 67-75 for additional information.&lt;br&gt;&lt;br&gt;*Admission and Primary diagnosis are required for inpatient and nursing home services</td>
<td>Required, if applicable*</td>
</tr>
<tr>
<td>Field</td>
<td>Description</td>
<td>Required</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>----------</td>
</tr>
<tr>
<td>Patient Status</td>
<td>Enter at least two (2) characters to begin searching for a patient status.</td>
<td>Required</td>
</tr>
<tr>
<td>Type of Bill</td>
<td>Enter the 3-digit bill code number. All positions must be fully coded; consult the National UB-04 Uniform Billing Manual for bill code types. 1st digit – identifies facility type 2nd digit – identifies bill classification 3rd digit – identifies frequency.</td>
<td>Required</td>
</tr>
<tr>
<td>Patient Account Number</td>
<td>Patient account number will be captured if entered in this field.</td>
<td>Not Required</td>
</tr>
<tr>
<td>Other Insurance</td>
<td>Select the applicable option for other insurance.</td>
<td></td>
</tr>
<tr>
<td>Total Charged Amount</td>
<td>This field will automatically populate.</td>
<td>Auto</td>
</tr>
</tbody>
</table>

**Medicare Crossover Details (when applicable)**

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
<th>Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Form Locator</td>
<td>DDE Institutional Claim Submission Instructions</td>
<td>Requirement</td>
</tr>
<tr>
<td>Deductible Amount</td>
<td>Enter the deductible amount.</td>
<td></td>
</tr>
<tr>
<td>Coinurance Amount</td>
<td>Enter the coinsurance amount.</td>
<td></td>
</tr>
<tr>
<td>Blood Deductible Amount</td>
<td>Enter the blood deductible amount.</td>
<td></td>
</tr>
<tr>
<td>Medicare Payment Date</td>
<td>Enter the Medicare payment date.</td>
<td>Required</td>
</tr>
</tbody>
</table>

**Diagnosis Codes**

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
<th>Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Form Locator</td>
<td>DDE Institutional Claim Submission Instructions</td>
<td>Requirement</td>
</tr>
<tr>
<td>ICD Version</td>
<td>Use the drop-down list to select a diagnosis type.</td>
<td>Required</td>
</tr>
<tr>
<td>Diagnosis Code</td>
<td>Enter at least three (3) characters to begin searching for a diagnosis code.</td>
<td>Required</td>
</tr>
<tr>
<td>Present on Admission</td>
<td>Use the drop-down list to select the applicable response. *Inpatient only</td>
<td></td>
</tr>
</tbody>
</table>

**Emergency Diagnosis Codes**

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
<th>Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Form Locator</td>
<td>DDE Institutional Claim Submission Instructions</td>
<td>Requirement</td>
</tr>
<tr>
<td>ICD Version</td>
<td>Use the drop-down list to select a diagnosis type.</td>
<td></td>
</tr>
<tr>
<td>Diagnosis Code</td>
<td>Enter at least three (3) characters to begin searching for a diagnosis code.</td>
<td></td>
</tr>
</tbody>
</table>

**Other Insurance Details (when Other Insurance is selected)**

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
<th>Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Form Locator</td>
<td>DDE Institutional Claim Submission Instructions</td>
<td>Requirement</td>
</tr>
<tr>
<td>Payer Code</td>
<td>Use the drop-down list to select the other insurance type.</td>
<td></td>
</tr>
<tr>
<td>Prior Amount</td>
<td>Enter the prior amount.</td>
<td></td>
</tr>
<tr>
<td>Estimated Amount Due</td>
<td>Enter the estimated amount due.</td>
<td></td>
</tr>
</tbody>
</table>

**Condition Codes**

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
<th>Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Form Locator</td>
<td>DDE Institutional Claim Submission Instructions</td>
<td>Requirement</td>
</tr>
<tr>
<td>Condition Code</td>
<td>Enter at least two (2) characters to begin searching for a condition code.</td>
<td>Not Required</td>
</tr>
</tbody>
</table>

**Occurrence Codes**
### Form Locator | DDE Institutional Claim Submission Instructions | Requirement
---|---|---
Occurrence | Enter at least two (2) characters to begin searching for an occurrence code; see UB-04 form locators 32-36 for specific code information. | Required, if applicable
From Date | Enter a beginning date. | Required, if applicable
To Date | Enter an end date. | Required, if applicable

### Value Codes

| Form Locator | DDE Institutional Claim Submission Instructions | Requirement |
---|---|---
Value Code | Enter at least two (2) characters to begin searching for a value code. | Required, if applicable
Amount | Enter a dollar amount including cents, e.g., Correct—$45.00, Incorrect—$45 | Required, if applicable

### Surgical Procedures (when Operating Provider NPI is entered in Provider Information)

| Form Locator | DDE Institutional Claim Submission Instructions | Requirement |
---|---|---
Surgical Procedure Type | Use the drop-down list to select a procedure type. | Required, if applicable
Surgical Procedure Code | Enter at least three (3) characters to begin searching for a surgical procedure code. | Required, if applicable
Date | Enter a date. | Required, if applicable

### Service Details

| Form Locator | DDE Institutional Claim Submission Instructions | Requirement |
---|---|---
Revenue Code | Enter the 3-digit revenue code; do not use the 001 revenue code for DDE claims. | Required
HCPCS/Proc Code | Enter the 5-digit HCPCS or CPT procedure code; see UB-04 form locator 44 for additional information. | Required, if applicable
Modifiers | Enter modifiers. | Required, if applicable
From Date | Enter the date on which the service performed started. | Required
To Date | Enter the date on which the service performed ended. |
Units | Enter the number of units billed at the detail level; see UB-04 form locator 46 for additional information. | Required
Unit Type | Select the unit of measurement type from the drop-down list. | Required
DMH Contract Source | Enter a contract source. | Required, if applicable
Charge Amount | Enter the amount billed (units billed multiplied by the rate). | Required

### NDC for Item # (Outpatient and Home Health)

| Form Locator | DDE Institutional Claim Submission Instructions | Requirement |
---|---|---
Code Type | Select the applicable code type from the drop-down list. |
### Chapter 5: Claim Completion

<table>
<thead>
<tr>
<th>NDC/UPN</th>
<th>Enter the National Drug Code (NDC) or UPN code in the Procedure field.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quantity</td>
<td>Enter the quantity</td>
</tr>
<tr>
<td>Unit of Measure</td>
<td>Select the unit of measurement type from the drop-down list.</td>
</tr>
</tbody>
</table>

If additional items are to be billed on this submission, click Add next to the line item window and repeat process. Click Remove to remove a line entry.

#### Attachments

<table>
<thead>
<tr>
<th>Form Locator</th>
<th>DDE Institutional Claim Submission Instructions</th>
<th>Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transmission Method</td>
<td>Select from the drop-down list how attachments will be sent.</td>
<td>Required, if applicable</td>
</tr>
<tr>
<td>Upload File</td>
<td>Click Browse to locate file being uploaded; available when selecting FT-File Transfer.</td>
<td>Required, if applicable</td>
</tr>
<tr>
<td>Attachment Type</td>
<td>Select the type of file from the drop-down list.</td>
<td>Required, if applicable</td>
</tr>
</tbody>
</table>

**HCA-13**

- If a hard-copy attachment is to be added, a system-generated HCA-13 Paper Attachment form will be available to print once the claim has been submitted by selecting BM-By Mail or FX-By Fax from the Transmission Method drop-down list (see section F in this chapter for instructions on sending an HCA-13 form by fax or mail).
- Unique ACNs (control numbers) are generated once an attachment has been added.

**Description**
Enter a description of the attachment. Required, if applicable

**Submit**
When finished, click Submit. Required
### ADA 2012 Claim Form Instructions

**ADA American Dental Association** Dental Claim Form

**Header Information**
- Type of Claim: American Dental Association Dental Claim Form

**Policyholder/Subscriber Information**
- Name:
- Address:
- City, State, Zip Code:
- Gender:
- Date of Birth (MM/DD/YY):
- Employer Name:
- Employee Name:
- Plan/Group Number:
- Spouse:
- Dependents:
- Other:

**Other Coverage**
- Name of Policyholder/Subscriber #1 (Last, First, Middle Initial, Suffix):
- Address:
- City, State, Zip Code:
- Phone Number:

**Record of Services Provided**
- Procedure Code (MM/DD/YY):
- Date:
- Provider Name:
- NPI:
- License Number:
- SSN or EIN:

**ANCILLARY CLAIM/TREATMENT INFORMATION**
- Date of Service:
- Diagnosis Code List Qualifier:
- Diagnosis Codes:
- Professional Fees:
- Other:

**Authorization**
- Patient/Guardian Signature:
- Submitter Signature:

**Billing Dentist or Dental Entity**
- Name, Address, City, State, Zip Code:

**Treating Dentist and Treatment Location Information**
- Signed (Treating Dentist):
- Date:
- NPI:
- License Number:
- Address, City, State, Zip Code:

©2012 American Dental Association

To order call 800 947-4747
or go online at adablog.org
The **ADA 2012** paper claim form is the required claim form used by dental providers for dental service billing. The provider is responsible for purchasing the ADA 2012 paper claim form. This section explains how to complete a paper ADA 2012 claim form. Please mail paper claims to the appropriate mailbox address below: The form locator chart indicates which fields are *optional, required* or *required, if applicable*.

**ADA 2012 Claims Mailing Address**

**Dental ADA form**  
DXC Technology  
P.O. Box 18110  
Oklahoma City, OK 73154
### ADA 2012 Claims Field Descriptions

<table>
<thead>
<tr>
<th>Field</th>
<th>Requirement</th>
<th>ADA 2012 Field Description/Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Required</td>
<td>Type of Transaction: Mark the appropriate box; use the EPSDT/TXIX box for Oklahoma SoonerCare billing.</td>
</tr>
<tr>
<td>2</td>
<td>Not Required</td>
<td>Predetermination/Preauthorization Number</td>
</tr>
<tr>
<td>3</td>
<td>Not Required</td>
<td>Insurance Company/Dental Benefit Plan Information: Company/Plan Name, Address, City, State, Zip Code</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Enter the following information:</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>SoonerCare</td>
</tr>
<tr>
<td></td>
<td></td>
<td>P.O. Box 18110, Oklahoma City, OK, 73154</td>
</tr>
<tr>
<td>4</td>
<td>Required, if applicable</td>
<td>Other Coverage (Dental/Medical): Mark the appropriate box.</td>
</tr>
<tr>
<td>5</td>
<td>Required, if applicable</td>
<td>Name of Policyholder/Subscriber in #4: The dental insurance carrier name goes in this field; this carrier must be billed before billing SoonerCare.</td>
</tr>
<tr>
<td>6</td>
<td>Not Used</td>
<td>Date of Birth; this field is not used for Oklahoma SoonerCare billing.</td>
</tr>
<tr>
<td>7</td>
<td>Not Required</td>
<td>Gender: Mark the appropriate box.</td>
</tr>
<tr>
<td>8</td>
<td>Not Used</td>
<td>Policyholder/Subscriber ID (SSN or ID#); this field is not used for Oklahoma SoonerCare billing.</td>
</tr>
<tr>
<td>9</td>
<td>Not Required</td>
<td>Plan/Group Number: Enter the number of the insurance company.</td>
</tr>
<tr>
<td>10</td>
<td>Not Required</td>
<td>Patient’s Relationship to Person Named in #5: Mark the appropriate box.</td>
</tr>
<tr>
<td>11</td>
<td>Required, if applicable</td>
<td>Other Insurance Company/Dental Benefit Plan Name, Address, City, State, ZIP Code: This field is used for payment and/or denial information from the patient’s other dental insurance. If a payment is received from patient’s primary insurance, enter the amount of the payment in this field (e.g., 45.00; you do not need to use a dollar sign/$). If the primary insurance carrier did not make reimbursement, write the words “Carrier Denied” in this box. A copy of the insurance payment detail or insurance denial must be attached to paper claims.</td>
</tr>
<tr>
<td>12</td>
<td>Not Required</td>
<td>Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, ZIP Code: Enter the member’s name as it appears on their eligibility file. (Last, First, Middle)</td>
</tr>
<tr>
<td>13</td>
<td>Not Used</td>
<td>Date of Birth; this field is not used for Oklahoma SoonerCare billing.</td>
</tr>
<tr>
<td>14</td>
<td>Not Required</td>
<td>Gender: Mark the appropriate box.</td>
</tr>
<tr>
<td>15</td>
<td>Required</td>
<td>Insured's ID Number: Enter the member's 9-digit SoonerCare ID number.</td>
</tr>
<tr>
<td>16</td>
<td>Not Required</td>
<td>Plan/Group Number: Enter the member or employer group plan or policy/certificate number.</td>
</tr>
<tr>
<td>17</td>
<td>Not Required</td>
<td>Employer Name: Enter SoonerCare.</td>
</tr>
<tr>
<td>18</td>
<td>Not Required</td>
<td>Relationship to Policyholder/Subscriber in #12 Above: Mark the box for “Self”.</td>
</tr>
<tr>
<td>Chapter 5: Claim Completion</td>
<td>Provider Billing and Procedures Manual</td>
<td></td>
</tr>
<tr>
<td>-----------------------------</td>
<td>----------------------------------------</td>
<td></td>
</tr>
<tr>
<td>19</td>
<td>Not Captured</td>
<td>Reserved for Future Use</td>
</tr>
<tr>
<td>20</td>
<td>Required</td>
<td>Name (Last, First, Middle Initial, Suffix), Address, City, State, ZIP Code: Enter the member’s name and full address.</td>
</tr>
<tr>
<td>21</td>
<td>Not Required</td>
<td>Date of Birth (MM/DD/CCYY): Enter member’s date of birth. (MM/DD/CCYY)</td>
</tr>
<tr>
<td>22</td>
<td>Not Required</td>
<td>Gender: Mark the appropriate box.</td>
</tr>
<tr>
<td>23</td>
<td>Not Required</td>
<td>Patient ID/Account # (Assigned by Dentist): Enter the patient ID assigned by the dental office</td>
</tr>
<tr>
<td><strong>Fields 24-31</strong>: Only one (1) unit may be billed per detail line.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>24</td>
<td>Required</td>
<td>Procedure Date: Enter the date the service was provided. (MM/DD/CCYY)</td>
</tr>
<tr>
<td>25</td>
<td>Required, if applicable</td>
<td>Area of Oral Cavity: The following are the only acceptable quadrants: UL—Upper Left, UR—Upper Right, LL—Lower Left, LR—Lower Right, Maxillary Arch 01, Mandibular Arch 02, L &amp; R</td>
</tr>
<tr>
<td>26</td>
<td>Not Required</td>
<td>Tooth System</td>
</tr>
<tr>
<td>27</td>
<td>Required, if applicable</td>
<td>Tooth Number(s) or Letter(s): The International Tooth Numbering System for permanent, primary and supernumerary teeth.</td>
</tr>
<tr>
<td>28</td>
<td>Required, if applicable</td>
<td>Tooth Surface: The following are the only acceptable surfaces: M—Mesial, D—Distal, O—Occlusal, L—Lingual, F—Facial, B—Buccal, I—Incisal</td>
</tr>
<tr>
<td>29</td>
<td>Required</td>
<td>Procedure Code: This is the 5-digit HCPCS code listed in the current HCPCS Level II code book.</td>
</tr>
<tr>
<td>29A</td>
<td>Required, if applicable</td>
<td>Diagnosis Code Pointer: Enter the letter(s) from field 34 that identify the diagnosis code(s) applicable to the dental procedure. List the primary diagnosis pointer first.</td>
</tr>
<tr>
<td>29B</td>
<td>Required</td>
<td>Quantity: Enter the number of times (01-99) the procedure identified in field 29 is delivered to the member on the date of service shown in field 24.</td>
</tr>
<tr>
<td>30</td>
<td>Not Required</td>
<td>Description: Use this field to enter any additional information.</td>
</tr>
<tr>
<td>31</td>
<td>Required</td>
<td>Fee: Enter your customary fee for the procedure.</td>
</tr>
<tr>
<td>31A</td>
<td>Not Used</td>
<td>Other Fee(s): Payment amounts made by other insurance plans. This field is not used for Oklahoma SoonerCare billing.</td>
</tr>
<tr>
<td>32</td>
<td>Required</td>
<td>Total Fee: Enter the total of column 31 charges. Each page must have a total. Claims cannot be continued to two or more pages.</td>
</tr>
<tr>
<td>33</td>
<td>Not Required</td>
<td>Missing Teeth Information: Place an X on each missing tooth. Identify the missing teeth by using the international tooth numbering system for permanent and primary teeth to mark an X on numbers and letters corresponding with those teeth.</td>
</tr>
<tr>
<td>34</td>
<td>Not Required</td>
<td>Diagnosis Code List Qualifier: Enter the appropriate code to identify the diagnosis code source: B=ICD-9, AB=ICD-10</td>
</tr>
<tr>
<td>34A</td>
<td>Required, if applicable</td>
<td>Diagnosis Code(s): Enter up to four (4) applicable diagnosis codes after each letter (A-D). The primary diagnosis code is entered in the first field (A).</td>
</tr>
<tr>
<td>35</td>
<td>Not Required</td>
<td>Remarks</td>
</tr>
</tbody>
</table>
### 36  Not Used
**Patient/Guardian Signature, Date:** Signature and date are entered here. This field is not used for Oklahoma SoonerCare billing.

### 37  Not Used
**Subscriber Signature, Date:** Signature and date are entered here. This field is not used for Oklahoma SoonerCare billing.

### 38  Required, if applicable
**Place of Treatment:** Enter the 2-digit Place of Service Code for Professional Claims. Frequently used codes are: 11—Office, 12—Home, 21—Inpatient Hospital, 22—Outpatient Hospital, 31—Skilled Nursing Facility, 32—Nursing Facility

### 39  Not Required
**Enclosures (Y or N)**

### 40  Not Required
**Is Treatment for Orthodontics? (No/Yes):** Check the appropriate box. If “No” is selected, skip fields 41 and 42.

### 41  Not Required
**Date Appliance Placed (MM/DD/CCYY):** Enter date orthodontic appliance was placed.

### 42  Not Required
**Months of Treatment:** Enter number of months of treatment remaining for appliance.

### 43  Not Required
**Replacement of Prosthesis (No/Yes):** Check Yes if requesting replacement for an existing prosthesis. Otherwise, check No.

### 44  Not Required
**Date of Prior Placement (MM/DD/CCYY):** Enter date of previous placement.

### 45  Required, if applicable
**Treatment Resulting From:** Select the appropriate box, if applicable. If any boxes were selected in this field, complete fields 46 and 47 (if applicable).

### 46  Not Required
**Date of Accident (MM/DD/CCYY):** Enter date accident occurred.

### 47  Not Required
**Auto Accident State:** Enter the state in which the auto accident noted in field 45 occurred.

### 48  Required
**Name, Address, City, State, Zip Code:** Enter the name and information of dentist requesting payment for services listed on claim form. If the dentist furnished the services as part of a dental group practice, enter the name and information of the dental group practice.

### 49  Not Required
**NPI (National Provider Identifier):** Enter the NPI for the pay-to provider, if the services were furnished as part of a group practice.

### 50  Not Required
**License Number**

### 51  Not Required
**SSN or TIN**

### 52  Not Required
**Phone Number:** Enter the phone number, including area code, of the billing dentist/provider’s office.

### 52A  Required, if applicable*
**Additional Provider ID:** Enter the 10-character Oklahoma SoonerCare provider number for the billing group. *Required if dentist is part of a group

### 53  Required
**Signature, Date:** The provider/treating dentist who rendered the service(s) must sign and date this field. Rubber-stamped signatures are acceptable. Writing “Signature on File” is not acceptable.

### 54  Not Required
**NPI (National Provider Identifier):** Enter the NPI of the individual dentist providing the service.
<table>
<thead>
<tr>
<th></th>
<th>Required/Not Required</th>
<th>Field Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>55</td>
<td>Not Required</td>
<td>License Number: Enter the license number of the billing dentist.</td>
</tr>
<tr>
<td>56</td>
<td>Required, if applicable</td>
<td>Address, City, State, Zip Code: Enter the full address at which the services were rendered, if different from the address information indicated in field 48.</td>
</tr>
<tr>
<td>56A</td>
<td>Not Required</td>
<td>Provider Specialty Code: Enter the treating provider’s specialty area.</td>
</tr>
<tr>
<td>57</td>
<td>Not Required</td>
<td>Phone Number: Enter the phone number of the office where treatment was performed.</td>
</tr>
<tr>
<td>58</td>
<td>Required</td>
<td>Additional Provider ID: Enter the rendering dentist’s 10-character Oklahoma SoonerCare provider number.</td>
</tr>
</tbody>
</table>

**Direct Data Entry (DDE) Claim Submission – Dental**

Use the Dental claim form example and directions below as guides when submitting a claim through DDE on the SoonerCare Provider Portal. Required fields are indicated in the directions. Choose the Submit Dental Claim (see screen sample below) claim option from the Claims menu to open the form (see screen sample below).
## Chapter 5: Claim Completion

### Provider Billing and Procedures Manual

#### Diagnostic Codes

Select the row number to edit the row. Click the **Remove** link to remove the entire row.

<table>
<thead>
<tr>
<th>#</th>
<th>ICD Version</th>
<th>Diagnosis Code</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>ICD-9-CM</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- **Add**
- **Reset**

#### Other Insurance Details

- **TPI Amount**

- **Back to Step 1**
- **Continue**
- **Cancel**

#### Service Details

Select the row number to edit the row. Click the **Remove** link to remove the entire row.

<table>
<thead>
<tr>
<th>Svc #</th>
<th>Svc Date</th>
<th>Oral Cavity Area</th>
<th>Tooth Number</th>
<th>Procedure Code</th>
<th>Units</th>
<th>Charge Amount</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- **Add**
- **Reset**

#### Attachments

- **Click the Remove link to remove the entire row.**

<table>
<thead>
<tr>
<th>#</th>
<th>Transmission Method</th>
<th>File</th>
<th>Control #</th>
<th>Attachment Type</th>
<th>Action</th>
</tr>
</thead>
</table>

- **Add**
- **Cancel**
## DDE Dental Claim Submission Instructions

### Billing Information

<table>
<thead>
<tr>
<th>Form Locator</th>
<th>DDE Dental Claim Submission Instructions</th>
<th>Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Billing Provider ID</td>
<td>Your Provider ID Number should appear in the first box. Confirm it is correct; if it is not, you may need to log out and access the correct provider.</td>
<td>Required</td>
</tr>
</tbody>
</table>

### Patient Information

<table>
<thead>
<tr>
<th>Form Locator</th>
<th>DDE Dental Claim Submission Instructions</th>
<th>Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member ID</td>
<td>Enter the member's Oklahoma SoonerCare ID number in this field. The patient's last and first name, and birth date will auto-populate if the member ID number entered is found in the system.</td>
<td>Required</td>
</tr>
</tbody>
</table>

### Diagnosis Codes

<table>
<thead>
<tr>
<th>Form Locator</th>
<th>DDE Dental Claim Submission Instructions</th>
<th>Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>ICD Version</td>
<td>Use the drop-down list to select a diagnosis type.</td>
<td>Required, if applicable</td>
</tr>
<tr>
<td>Diagnosis Code</td>
<td>Enter at least three (3) characters to begin searching for a diagnosis code.</td>
<td>Required, if applicable</td>
</tr>
</tbody>
</table>

### Claim Information

<table>
<thead>
<tr>
<th>Form Locator</th>
<th>DDE Dental Claim Submission Instructions</th>
<th>Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accident Related</td>
<td>Use the drop-down list to further describe the accident.</td>
<td>Required, if applicable</td>
</tr>
<tr>
<td>Emergency</td>
<td>Specify whether the claim was an emergency by selecting Yes or No from the drop-down list.</td>
<td>Not Required</td>
</tr>
<tr>
<td>Place of Treatment</td>
<td>Select the appropriate place of treatment from the drop-down list.</td>
<td>Required</td>
</tr>
<tr>
<td>Patient Account Number</td>
<td>The Patient Account Number will be captured and appear on the remittance advice (RA), if entered in this field.</td>
<td></td>
</tr>
<tr>
<td>Other Insurance</td>
<td>Select the applicable option for other insurance.</td>
<td></td>
</tr>
<tr>
<td>Total Charged Amount</td>
<td>Total charges are automatically populated.</td>
<td>Auto</td>
</tr>
</tbody>
</table>

### Other Insurance Details (when Other Insurance-Include is selected)

<table>
<thead>
<tr>
<th>Form Locator</th>
<th>DDE Dental Claim Submission Instructions</th>
<th>Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>TPL Amount</td>
<td>Enter the TPL amount.</td>
<td></td>
</tr>
</tbody>
</table>

### Service Details

<table>
<thead>
<tr>
<th>Form Locator</th>
<th>DDE Dental Claim Submission Instructions</th>
<th>Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Svc Date</td>
<td>Enter the date of service here.</td>
<td>Required</td>
</tr>
<tr>
<td>Oral Cavity Area</td>
<td>Use the drop-down list to select the cavity area.</td>
<td></td>
</tr>
<tr>
<td>Tooth Number</td>
<td>Use the drop-down list to select a tooth number.</td>
<td>Required, if applicable</td>
</tr>
<tr>
<td>Tooth Surface</td>
<td>Use the drop-down list to select a surface type.</td>
<td>Required, if applicable</td>
</tr>
<tr>
<td>Prosthesis</td>
<td>Use the drop-down list to select a prosthesis type.</td>
<td></td>
</tr>
<tr>
<td><strong>Procedure Code</strong></td>
<td>Enter the procedure code.</td>
<td>Required</td>
</tr>
<tr>
<td>--------------------</td>
<td>----------------------------</td>
<td>----------</td>
</tr>
<tr>
<td><strong>Modifiers</strong></td>
<td>Enter up to four (4) modifiers.</td>
<td>Required</td>
</tr>
<tr>
<td><strong>Units</strong></td>
<td>Enter the number of units billed.</td>
<td>Required</td>
</tr>
<tr>
<td><strong>Charge Amount</strong></td>
<td>Enter the total dollar amount of charges for this line of service. <em>This action will auto-populate the Total Charges field, but will not multiply the amount by the number of units.</em></td>
<td>Required</td>
</tr>
<tr>
<td><strong>Rendering Provider ID Number</strong></td>
<td>Enter the NPI of the dentist performing the services. The Rendering Provider field displays for the first service line only.</td>
<td></td>
</tr>
<tr>
<td><strong>ID Type</strong></td>
<td>Use the ID Type drop-down list to select NPI as the Rendering Provider ID type.</td>
<td>Required, if applicable</td>
</tr>
<tr>
<td><strong>Zip Code</strong></td>
<td>Enter the ZIP code of the rendering provider.</td>
<td></td>
</tr>
<tr>
<td><strong>SC Provider Number</strong></td>
<td>Enter the Oklahoma SoonerCare provider number.</td>
<td></td>
</tr>
</tbody>
</table>

If additional items are to be billed on this submission, click Add next to the line item window and repeat process. Click Remove to remove a line entry.

### Attachments

<table>
<thead>
<tr>
<th><strong>Form Locator</strong></th>
<th><strong>DDE Dental Claim Submission Instructions</strong></th>
<th><strong>Requirement</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Transmission Method</strong></td>
<td>Select from the drop-down list how attachments will be sent.</td>
<td>Required, if applicable</td>
</tr>
<tr>
<td><strong>Upload File</strong></td>
<td>Click Browse to locate file being uploaded; available when selecting FT-File Transfer.</td>
<td>Required, if applicable</td>
</tr>
<tr>
<td><strong>Attachment Type</strong></td>
<td>Select the type of file from the drop-down list.</td>
<td>Required, if applicable</td>
</tr>
<tr>
<td><strong>Description</strong></td>
<td>Enter a description of the attachment.</td>
<td></td>
</tr>
<tr>
<td><strong>HCA-13D</strong></td>
<td>If a hard-copy attachment is to be added, a system-generated HCA-13D paper attachment form will be available to print once the claim has been submitted by selecting BM-By Mail or FX-By Fax from the Transmission Method drop-down list. See Section F in this chapter for instructions on sending form HCA-13D by fax or mail. Unique ACNs (control numbers) are generated once an attachment is added.</td>
<td>Required, if applicable</td>
</tr>
</tbody>
</table>

**Submit**
When finished, click Submit. | Required
Section E: Drug/Compound Prescription Drug, Pharmacy, NCPDP

Drug/Compound Prescription Drug Claim Form Instructions

<table>
<thead>
<tr>
<th>Provider Number (required)</th>
<th>Loc (req)</th>
<th>Billing NPI (optional)</th>
<th>Telephone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Patient's Name: Last, First (required)</th>
<th>Member ID (required)</th>
<th>Member's Date of Birth (Required)</th>
<th>Emergency (Y or N)</th>
<th>Pregnancy (Y or N)</th>
<th>NH PL (Y or N)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Prescription Number (Required)</th>
<th>Date Prescribed (Required)</th>
<th>Date Dispensed (required)</th>
<th>NDC Number (requested)</th>
<th>Quantity (required)</th>
<th>Days</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Brand Medically Necessary</th>
<th>Refill</th>
<th>Individual Prescriber's ID Number (Required)</th>
<th>Individual Prescriber's Name: Last, First. (Required)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Charge (Required)</th>
<th>Third Party Paid</th>
<th>Total Amount Billed (Required)</th>
<th>Usual and Customary</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Provider's Name and Address: This is to certify that the foregoing information is true, accurate, and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any falsification of claims, statements, or documents, or concealment of material fact may be prosecuted under applicable Federal or State law.

I, the undersigned, being aware of restricted funds in the Medicaid program, agree to accept as full payment for services enumerated on this claim form, for this Medicaid patient, the allowance determined by the Department or its designee. I further certify that no supplemental charges have been or will be billed to the patient. I further recognize that any difference of opinion concerning the charges and/or allowance for this claim shall be adjudicated as specified in the Provider Manual.

Signature of Provider or Representative (Required) | Date Billed (Required)
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Mail Completed Claim Form to:
EDS
P.O. Box 18650
Oklahoma City, OK 73154

OKLA HCA Revised 04/17/2007

PHARM-1
The **Drug/Compound Drug Claim Forms** are used to bill pharmacy services and are available in the Forms chapter of this manual and on the OHCA website at [www.okhca.org](http://www.okhca.org).

Pharmacy Claim submissions are done through the Drug Claim Form (Pharm-1 revised 4/17/2007) and Compound Prescription Drug Claim Form (Pharm-2). These claim forms should be used for every pharmacy paper billing, including the resubmission of a claim that is over one year past date of service. The form locator chart indicates which fields are *optional*, *required* or *required, if applicable*.

**Drug/Compound Drug Claims Mailing Address**

Please mail paper claims to:

**Pharmacy**
DXC Technology
P.O. Box 18650
Oklahoma City, OK 73154
### Pharmacy Drug Claims Field Descriptions

<table>
<thead>
<tr>
<th>Field</th>
<th>Form Locator</th>
<th>Prescription Drug (PHARM-1) Field Descriptions</th>
<th>Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Provider Number</td>
<td></td>
<td>Enter the 9-digit Oklahoma SoonerCare provider number.</td>
<td>Required</td>
</tr>
<tr>
<td>2 Loc (Location Code)</td>
<td></td>
<td>Enter the alpha-character location code from the Oklahoma SoonerCare provider number.</td>
<td>Required</td>
</tr>
<tr>
<td>3 Billing NPI</td>
<td></td>
<td>Enter the NPI of the billing provider.</td>
<td>Not Required</td>
</tr>
<tr>
<td>4 Telephone Number</td>
<td></td>
<td>Telephone number</td>
<td>Not Required</td>
</tr>
<tr>
<td>5 Patient’s Name</td>
<td></td>
<td>Enter the patient’s name. <em>(Last name, First name)</em></td>
<td>Required</td>
</tr>
<tr>
<td>6 Member ID Number</td>
<td></td>
<td>Enter the member’s 9-character Oklahoma SoonerCare identification number.</td>
<td>Required</td>
</tr>
<tr>
<td>7 Member’s Date of Birth</td>
<td></td>
<td>Enter the member’s date of birth. <em>(MMDDCCYY)</em></td>
<td>Required</td>
</tr>
<tr>
<td>8 Emergency (Y or N)</td>
<td></td>
<td>Enter Y (yes) or N (no) to indicate if the prescription is related to an accident.</td>
<td>Not Required</td>
</tr>
<tr>
<td>9 Pregnancy (Y or N)</td>
<td></td>
<td>Enter Y (yes) or N (no) to indicate if the prescription is related to a pregnancy.</td>
<td>Not Required</td>
</tr>
<tr>
<td>10 NH Pt.</td>
<td></td>
<td>Enter Y (yes) or N (no) to indicate if the prescription was dispensed to a resident of a nursing home facility.</td>
<td>Not Required</td>
</tr>
<tr>
<td>11 Prescription Number</td>
<td></td>
<td>Prescription Number: Enter the pharmacy’s prescription number; may include up to seven (7) characters.</td>
<td>Required</td>
</tr>
<tr>
<td>12 Date Prescribed</td>
<td></td>
<td>Enter the date the prescription was written; must be on or before receipt date, not a future date.</td>
<td>Required</td>
</tr>
<tr>
<td>13 Date Dispensed</td>
<td></td>
<td>Enter the date the prescription was dispensed; must be on or before receipt date, not a future date.</td>
<td>Required</td>
</tr>
<tr>
<td>14 NDC Number</td>
<td></td>
<td>Enter the 11-digit National Drug Code (NDC) number of the drug dispensed.</td>
<td>Required</td>
</tr>
<tr>
<td>15 Quantity</td>
<td></td>
<td>Enter the metric quantity to three (3) decimal places, up to 11 characters. <em>(e.g., 999999999.999)</em></td>
<td>Required</td>
</tr>
<tr>
<td>16 Days</td>
<td></td>
<td>Enter the number of days’ supply dispensed; may be up to three (3) digits</td>
<td>Required</td>
</tr>
<tr>
<td>17 Brand Medically Necessary</td>
<td></td>
<td>Enter the appropriate brand name indicator as indicated below: 0—No product selection indicated 1—Substitution not allowed by prescriber—dispense as written</td>
<td>Required, if applicable</td>
</tr>
<tr>
<td>18 Refill</td>
<td></td>
<td>Enter two (2) digits to indicate the number of times the prescription has been dispensed. 00—original dispensing, 01 to 99—refill number</td>
<td>Required</td>
</tr>
<tr>
<td>19 Individual Prescriber’s NPI Number</td>
<td></td>
<td>Enter the 10-digit NPI number of the prescriber.</td>
<td>Required</td>
</tr>
<tr>
<td>20 Individual Prescriber’s Name</td>
<td></td>
<td>Enter the prescriber’s name. <em>(Last name, First name)</em></td>
<td>Required</td>
</tr>
<tr>
<td></td>
<td>Field</td>
<td>Description</td>
<td>Required</td>
</tr>
<tr>
<td>---</td>
<td>-----------------------------</td>
<td>-----------------------------------------------------------------------------</td>
<td>----------</td>
</tr>
<tr>
<td>21</td>
<td>Charge</td>
<td>Enter the charge for this prescription.</td>
<td>Required</td>
</tr>
<tr>
<td>22</td>
<td>Third Party Paid</td>
<td>Enter the amount paid by the primary insurance (TPL).</td>
<td>Required, if applicable</td>
</tr>
<tr>
<td>23</td>
<td>Total Amount Billed</td>
<td>Enter the total amount billed. (e.g., Charge – TPL = Total Amount Billed)</td>
<td>Required</td>
</tr>
<tr>
<td>24</td>
<td>Usual and Customary</td>
<td>Enter the usual and customary charge for the quantity and NDC provided.</td>
<td>Required</td>
</tr>
<tr>
<td>25</td>
<td>Provider's Name and Address</td>
<td>Enter the billing provider's name, address and telephone number.</td>
<td>Not Required</td>
</tr>
<tr>
<td>26</td>
<td>Signature of Provider or Representative</td>
<td>This must be an authorized name of a person indicating the information entered in the face of this bill is in conformance with the certifications listed on the form. A stamped signature is acceptable; writing Signature on File is not acceptable.</td>
<td>Required</td>
</tr>
<tr>
<td>27</td>
<td>Date Billed</td>
<td>Enter the date the bill is submitted. (MMDDYY)</td>
<td>Required</td>
</tr>
</tbody>
</table>
# Chapter 5: Claim Completion

## Provider Billing and Procedures Manual

### Compound Prescription Drug Claim Form

<table>
<thead>
<tr>
<th>Line</th>
<th>NDC Number</th>
<th>Description of Ingredient</th>
<th>Quantity</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Provider's Name and Address:

Provider or Representative

Signature

Date Billed

MAIL COMPLETED CLAIM FORM TO:

EDS

P.O. Box 18650

Oklahoma City, OK 73154

OMCA Revision: 09/25/2014

Library Reference: OKPBPM

Revision Date: November 2017

Version 6.1
## Compound Prescription Drug Claim Form Instructions

<table>
<thead>
<tr>
<th>Field</th>
<th>Requirement</th>
<th>Compound Drug (PHARM-2) Field Descriptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Required</td>
<td><strong>Provider Number</strong>: Enter the 9-digit Oklahoma Soonercare provider number. <strong>Loc (Location Code)</strong>: Enter the alpha-character location code from the Oklahoma Soonercare provider number.</td>
</tr>
<tr>
<td>2</td>
<td>Not Required</td>
<td>Telephone Number</td>
</tr>
<tr>
<td>3</td>
<td>Required</td>
<td>Patient’s Name (Last, First): Enter the member’s name.</td>
</tr>
<tr>
<td>4</td>
<td>Required</td>
<td>Client No: Enter the member's 9-character Oklahoma Soonercare identification number.</td>
</tr>
<tr>
<td>5</td>
<td>Required</td>
<td>Prescriber’s ID Number: Enter the 7-digit Oklahoma Prescriber ID number of the prescribing physician.</td>
</tr>
<tr>
<td>6</td>
<td>Not Required</td>
<td>Emerg: Enter Yes or No to indicate if the prescription is related to an emergency.</td>
</tr>
<tr>
<td>7</td>
<td>Not Required</td>
<td>Preg: Enter Yes or No to indicate if the prescription is related to a pregnancy.</td>
</tr>
<tr>
<td>8</td>
<td>Not Required</td>
<td>N.H. PAT: Enter Yes or No to indicate if the prescription was dispensed to a resident of a nursing home facility.</td>
</tr>
<tr>
<td>9</td>
<td>Required, if applicable</td>
<td>Brand: Brand Name Indicator 0—No product selection indicated 1—Substitution not allowed by prescriber, dispense as written</td>
</tr>
<tr>
<td>10</td>
<td>Required</td>
<td>Refill: Refill Indicator; enter two (2) digits to indicate the number of times the prescription has been dispensed. Example: 00—original dispensing, 01-99—refill number</td>
</tr>
<tr>
<td>11</td>
<td>Required</td>
<td>Prescription Number: Enter the pharmacy’s prescription number; may include up to seven (7) characters.</td>
</tr>
<tr>
<td>12</td>
<td>Required</td>
<td>Date Prescribed: Enter the date the prescription was written; must be on or before receipt date, not a future date.</td>
</tr>
<tr>
<td>13</td>
<td>Required</td>
<td>Date Dispensed: Enter the date the prescription was dispensed; must be on or before receipt date, not a future date.</td>
</tr>
<tr>
<td>14</td>
<td>Not Used</td>
<td>Local Use Only</td>
</tr>
<tr>
<td>15</td>
<td>Required</td>
<td>Days: Enter the number of days’ supply dispensed; may include up to three (3) characters.</td>
</tr>
<tr>
<td>16</td>
<td>Not Required</td>
<td>Charge: Enter the total charges for this claim; may include up to nine (9) digits.</td>
</tr>
<tr>
<td>17</td>
<td>Required, if applicable</td>
<td>3rd Party Paid (TPL): Enter the amount paid by the primary insurance; may include up to eight (8) digits.</td>
</tr>
</tbody>
</table>

### Billing Information

<table>
<thead>
<tr>
<th>Field</th>
<th>Requirement</th>
<th>Compound Drug (PHARM-2) Field Descriptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>18</td>
<td>Not Required</td>
<td>Provider’s Name and Address: Provider’s name, address and telephone number.</td>
</tr>
<tr>
<td>19</td>
<td>Required</td>
<td>Signature of Provider or Representative: This must be an authorized name of a person indicating that the information entered in the face of this bill is in conformance with the certifications listed on the form. A stamped signature is acceptable, but writing &quot;signature on file&quot; is not acceptable.</td>
</tr>
<tr>
<td>20</td>
<td>Required</td>
<td>Date Billed: Enter the date the bill is submitted (MM/DD/YY)</td>
</tr>
</tbody>
</table>
### Service Lines

<table>
<thead>
<tr>
<th>Field</th>
<th>Requirement</th>
<th>Compound Drug (PHARM-2) Field Descriptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>21, lines 1-15</td>
<td>Required</td>
<td><strong>NDC Number</strong>: Enter the 11-digit National Drug Code (NDC) number of each of the drugs dispensed.</td>
</tr>
<tr>
<td>22, lines 1-15</td>
<td>Required</td>
<td><strong>Description of Ingredient</strong>: List each ingredient with the corresponding NDC.</td>
</tr>
<tr>
<td>23, lines 1-15</td>
<td></td>
<td><strong>Quantity</strong>: Metric unit quantity (e.g., 9999999.999).</td>
</tr>
</tbody>
</table>

### Direct Data Entry (DDE) Claim Submission – Pharmacy, including compounds

Use the Pharmacy claim form example and directions below as guides when submitting a claim through DDE the SoonerCare Provider Portal. Choose the Submit Pharmacy claim option (see screen sample below) from the Claims drop-down menu to access the form (see screen sample below).

![Submit Pharmacy Claim: Step 1](screen_sample.png)
**Chapter 5: Claim Completion**

**Provider Billing and Procedures Manual**

### Submit Pharmacy Claim: Step 1

**Provider Information**

General Provider Header Instructions:

- Service Provider ID
- Provider NPI
- Name
- SC Provider Number
- Rendering Provider NPI
- Rendering Provider Number

### Patient and Claim Information

General Patient and Claim Header Instructions:

- Member ID
- Last Name
- Birth Date
- Transaction Code
- Claim Type
- Other Coverage Code
- Pregnancy
- Emergency
- Nursing Facility

### Claim Information

General Claim Information Instructions:

- Prescriber ID
- Prescription #
- Days Supply
- Dispense/Written
- Prescriber #
- Date Written
- Date of Service

### Compound Information

General Compound Information Instructions

### Compound Details

Select the row number to edit the row. Click the Delete link to remove the entire row.

<table>
<thead>
<tr>
<th>#</th>
<th>Compound NDC</th>
<th>Ingredient Quantity</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Pricing Information

General Pricing Information Instructions:

- Total Charges

**DUH Override Codes**

Click the Remove link to remove the row.

<table>
<thead>
<tr>
<th>#</th>
<th>Reason for Service</th>
<th>Professional Service</th>
<th>Result of Service</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Other Insurance Details**

General Other Insurance Detail Instructions:

- IPL Amount

**Back to Step 1**

5-97

Library Reference: OKPBPM
Revision Date: November 2017
Version 6.1
### DDE Pharmacy Claim Submission Instructions

#### Provider Information

<table>
<thead>
<tr>
<th>Form Locator</th>
<th>DDE Pharmacy Claim Submission Instructions</th>
<th>Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Provider ID</td>
<td>Your Provider ID Number should appear in the first box. Confirm it is correct; if it is not, you may need to log out and access the correct provider.</td>
<td>Required</td>
</tr>
<tr>
<td>Rendering Provider NPI</td>
<td>Display only</td>
<td></td>
</tr>
<tr>
<td>Rendering Provider Number</td>
<td>Display only; will default to the service provider.</td>
<td></td>
</tr>
</tbody>
</table>

#### Patient and Claim Information

<table>
<thead>
<tr>
<th>Form Locator</th>
<th>DDE Pharmacy Claim Submission Instructions</th>
<th>Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member ID</td>
<td>Enter the member's Oklahoma SoonerCare ID number in the client ID field. <em>The member’s last and first name will auto-populate if the member ID number entered is found in the system.</em></td>
<td>Required</td>
</tr>
<tr>
<td>Birth Date</td>
<td>Enter the date of birth of the recipient.</td>
<td>Required</td>
</tr>
<tr>
<td>Claim Type</td>
<td>Use the drop-down list to select whether or not the prescription is a regular pharmacy claim or a compound drug pharmacy claim.</td>
<td>Required</td>
</tr>
<tr>
<td>Other Coverage Code</td>
<td>Use the drop-down list to determine if other insurance exists or coverage has been denied.</td>
<td></td>
</tr>
<tr>
<td>Pregnancy</td>
<td>Use the drop-down list to select the appropriate response of Yes or No to indicate whether or not the prescription was related to a pregnancy.</td>
<td>Not Required</td>
</tr>
<tr>
<td>Emergency</td>
<td>Use the drop-down list to select the appropriate response of Yes or No to indicate whether or not this prescription was related to an emergency.</td>
<td>Not Required</td>
</tr>
<tr>
<td>Nursing Facility</td>
<td>Use the drop-down list to select the appropriate response of Yes or No to indicate whether or not this prescription was dispensed to a resident of a nursing home facility.</td>
<td>Not Required</td>
</tr>
</tbody>
</table>

#### Claim Information

<table>
<thead>
<tr>
<th>Form Locator</th>
<th>DDE Pharmacy Claim Submission Instructions</th>
<th>Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescriber ID</td>
<td>Enter the Oklahoma Prescriber ID number of the prescribing physician.</td>
<td>Required</td>
</tr>
<tr>
<td>ID Type</td>
<td>This field will automatically populate.</td>
<td>Auto</td>
</tr>
<tr>
<td>Last Name</td>
<td>Enter the last name of the prescribing physician.</td>
<td>Required</td>
</tr>
<tr>
<td>Prescription Number</td>
<td>Enter the pharmacy-assigned prescription number (up to seven digits) for the current prescription.</td>
<td>Required</td>
</tr>
<tr>
<td>Fill Number</td>
<td>Enter two (2) digits to indicate the number of times the prescription has been dispensed. <em>00—original dispensing, 01-99—refill number</em></td>
<td>Required</td>
</tr>
<tr>
<td>Date Written</td>
<td>Enter the date the prescription was prescribed by the physician.</td>
<td>Required</td>
</tr>
<tr>
<td><strong>Date of Service</strong></td>
<td>Enter the date the prescription was dispensed by the pharmacy.</td>
<td><strong>Required</strong></td>
</tr>
<tr>
<td>---------------------</td>
<td>---------------------------------------------------------------</td>
<td>--------------</td>
</tr>
<tr>
<td><strong>NDC</strong></td>
<td>Enter the 11-digit National Drug Code (NDC) number of the drug dispensed. Compound will auto-populate to 00000000000.</td>
<td><strong>Required</strong></td>
</tr>
<tr>
<td><strong>Quantity Dispensed</strong></td>
<td>Enter the quantity being dispensed for the above NDC within the prescription.</td>
<td><strong>Required</strong></td>
</tr>
<tr>
<td><strong>Days’ Supply</strong></td>
<td>Enter the number of days the prescription will cover.</td>
<td><strong>Required</strong></td>
</tr>
<tr>
<td><strong>DAW Code</strong></td>
<td>Select the most appropriate option from the drop-down list to indicate if the prescription was dispensed as prescribed (dispensed as written) or if a generic medication was substituted.</td>
<td><strong>Required</strong></td>
</tr>
</tbody>
</table>

**Compound Details**

<table>
<thead>
<tr>
<th><strong>Form Locator</strong></th>
<th>DDE Pharmacy Claim Submission Instructions</th>
<th><strong>Requirement</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Compound NDC</strong></td>
<td>Enter the 11-digit National Drug Code (NDC) number of the drug dispensed.</td>
<td><strong>Required</strong></td>
</tr>
<tr>
<td><strong>Ingredient Quantity</strong></td>
<td>Enter the quantity of the compound.</td>
<td><strong>Required</strong></td>
</tr>
<tr>
<td><strong>Ingredient Drug Cost</strong></td>
<td>Enter the cost amount of the ingredient.</td>
<td><strong>Required</strong></td>
</tr>
<tr>
<td><strong>Basis of Cost Determination</strong></td>
<td>Use the drop-down list to select the source behind the cost determination.</td>
<td><strong>Not Required</strong></td>
</tr>
</tbody>
</table>

**Pricing Information**

<table>
<thead>
<tr>
<th><strong>Form Locator</strong></th>
<th>DDE Pharmacy Claim Submission Instructions</th>
<th><strong>Requirement</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total Charge</strong></td>
<td>Enter the usual and customary charge.</td>
<td><strong>Required</strong></td>
</tr>
</tbody>
</table>

**DUR Overrides**

<table>
<thead>
<tr>
<th><strong>Form Locator</strong></th>
<th>DDE Pharmacy Claim Submission Instructions</th>
<th><strong>Requirement</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Reason for Service</strong></td>
<td>Use the drop-down list to select the appropriate Prospective DUR intervention used to determine outcome of claim.</td>
<td><strong>Required, if applicable</strong></td>
</tr>
<tr>
<td><strong>Professional Service</strong></td>
<td>Use the drop-down list to select the appropriate Prospective DUR conflict message.</td>
<td><strong>Required, if applicable</strong></td>
</tr>
<tr>
<td><strong>Result of Service</strong></td>
<td>Use the drop-down list to select the appropriate Prospective DUR outcome that was made using the intervention.</td>
<td><strong>Required, if applicable</strong></td>
</tr>
</tbody>
</table>

**Diagnosis Codes**

<table>
<thead>
<tr>
<th><strong>Form Locator</strong></th>
<th>DDE Pharmacy Claim Submission Instructions</th>
<th><strong>Requirement</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Diagnosis Code Type</strong></td>
<td>Use the drop-down list to select a diagnosis type.</td>
<td><strong>Required</strong></td>
</tr>
<tr>
<td><strong>Diagnosis Code</strong></td>
<td>Enter at least three (3) characters to begin searching for a diagnosis code.</td>
<td><strong>Required</strong></td>
</tr>
</tbody>
</table>

**Other Insurance Details (when Other Coverage Code/Exists is selected)**

<table>
<thead>
<tr>
<th><strong>Form Locator</strong></th>
<th>DDE Pharmacy Claim Submission Instructions</th>
<th><strong>Requirement</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>TPL Amount</strong></td>
<td>Enter an amount in dollars and cents.</td>
<td><strong>Required</strong></td>
</tr>
<tr>
<td><strong>Submit</strong></td>
<td>Click Submit when finished.</td>
<td><strong>Required</strong></td>
</tr>
</tbody>
</table>
Section F: Electronic Claim Attachments

Proper filing of attachments to electronic claims is essential to the successful payment of submitted claims with attachments. An important part of the filing process is accurate entry of provider, member, and ACNs on the electronic claim form and the HCA-13 cover sheet. When submitting attachments, selecting Transmission Method By Mail or By Fax (see screen sample below) will generate an Electronic Claim Paper Attachment Form Cover Sheet button. The provider number, client ID number, claim number and ACN number will be auto-populated.

Claim Attachments Mailing Address

Once completed, fax the form to 405-947-3394 or mail to:

**DXC Technology**
P.O. Box 18500
Oklahoma City, OK 73154

Helpful Tips

An Attachment Form Cover Sheet will be generated for each Transmission Method added once the claim has been submitted.
Electronic Claim Paper Attachment Form
Cover Sheet

The three fields below are required and must match claim:

1. Provider Number

2. Client ID Number

3. Attachment Control Number

Purpose:
This form is to be used when a claim requiring a paper attachment is being submitted electronically. Submission of this completed form along with the required attachment and electronically submitted claim will allow the appropriate review process to be conducted by the OHCA.

Instructions:
1. In box 1, fill in the pay to Provider Number used for filing the electronic claim.
2. In box 2, fill in the 9-digit client identification number submitted on the electronic claim.
3. In box 3, fill in the Attachment Control Number (ACN) used for filing the electronic claim. The ACN on this form must be the same number entered in the control number field of the direct data entry (DDE) screen (Medicaid on the Web) or the PWK segment of the 837 transaction. Make sure the ACN is clear and legible on the HCA-13. Illegible information could delay or stop the attachment process. Numbers are the only characters that should be used in the ACN section. Do not use dashes or spaces in the ACN section.
4. Place this completed form on top of the attachment(s) for each electronic claim. (DO NOT INCLUDE ADDITIONAL COVER SHEET)
5. Mail to: Hewlett Packard Enterprise
   PO Box 18500, OKC, OK 73154
   Fax: 405-947-3394

NOTE: Do not place another fax cover sheet on top of this form.

*This form is for use with electronically filed claims requiring attachments.

Sender’s Name: ______________________ Phone Number: ______________________

This fax contains confidential information and is intended only for the individual named. If you are not the named addressee you should not disseminate, distribute or copy this fax. Please notify the sender immediately by phone if you have received this e-fax by mistake and destroy the fax you received. Fax transmissions cannot be guaranteed to be secure or error-free as information could be intercepted, corrupted, lost, destroyed, arrive late or incomplete. The sender therefore does not accept liability for any errors or omissions in the contents of this message, which arise as a result of fax transmission.
Section G: Medicare-Medicaid Crossover Invoice

For Medicare Crossover Exceptions ONLY: NO crossover paper claims will be accepted as of 02/01/2017.

HCA-28: Medicare-Medicaid Crossover Invoice Form Instructions
(for Inpatient claims or claims prior to 06/01/2016)

Medicare-to-Medicaid Crossover Invoice

IMPORTANT:
1. You must write CROSSOVER at the top of every crossover claim.
2. HCA-28 form is only to be used for Inpatient claims or claims prior to June 1, 2016.
3. Do not use this form for HMO copay or third party liability claim submissions.
4. Use one invoice for each claim.

Please check one:
- Medicare only
- Medicare supplemental claims
- Medicare replacement

SoonerCare Provider ID:

Member ID: Member Name
First: Last:

Patient Control Number:

Medicare HIC Number:

From DOS: To DOS:

Total Billed: $

Date Paid:

Coinsurance: $ Medicare Remark Code:

Deductible: $ Medicare Remark Code:

Blood Deductible: $

Total Allowed: $ Medicare Remark Code:

Medicare Remark Code:

Amount Paid: $ Medicare Remark Code:

Mail claims for payment to:
Hewlett Packard Enterprise
P.O. Box 18110
Oklahoma City, OK 73154

Provider Signature Date

OKHCA Revised 05/2016 HCA-28 pg. 1
For Medicare Crossover Exceptions ONLY; NO crossover paper claims will be accepted as of 02/01/2017.

The Medicare-Medicaid Crossover Invoice form (HCA-28) should be used when submitting Inpatient crossover claims or claims with DOS prior to 6/1/2016. Use this form as a supplement to the Medicare Explanation of Benefit (EOB) statement attachment previously required on paper crossover claims. The form was created due to multiple versions of the Medicare (EOB) statements being printed from the different software formats currently available. The information to be keyed from the Medicare EOB to process crossover claims no longer appears in a standard format when printed. This means the necessary information to be keyed appears differently and is marked with different headers on each printed electronic Medicare EOB, making crossover claim processing challenging. The Medicare-Medicaid Crossover Invoice form will allow these claim types to be keyed more quickly and accurately by removing interpretations.
# HCA-28 Form Field Descriptions

<table>
<thead>
<tr>
<th>Form Locator</th>
<th>HCA-28 Field Descriptions</th>
<th>Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>SoonerCare Provider ID</td>
<td>Enter the SoonerCare Provider ID number. This consists of nine (9) numeric characters and one (1) alpha character, or 10-character ID number.</td>
<td>Required</td>
</tr>
<tr>
<td>Member ID</td>
<td>Enter the member’s 9-character Oklahoma SoonerCare identification number.</td>
<td>Required</td>
</tr>
<tr>
<td>Member Name (First, Last)</td>
<td>Enter the member’s name. (first name, last name)</td>
<td>Required</td>
</tr>
<tr>
<td>Patient Control Number</td>
<td>Enter the internal patient account number; this number will appear on the remittance advice (RA).</td>
<td>Required</td>
</tr>
<tr>
<td>Medicare HIC Number</td>
<td>Enter the member’s Medicare HIC number; the Medicare HIC number should be the same number as submitted on the claim.</td>
<td>Required</td>
</tr>
<tr>
<td>From DOS/To DOS</td>
<td>Enter the From and To Dates of Service as indicated on the Medicare EOB for the indicated claim. (MM/DD/CCYY)</td>
<td>Required</td>
</tr>
<tr>
<td>Total Billed</td>
<td>Enter the total amount billed for all detail lines from the Medicare EOB.</td>
<td>Required</td>
</tr>
<tr>
<td>Date Paid</td>
<td>Enter the date the claim was paid by Medicare. (MM/DD/CCYY)</td>
<td>Required</td>
</tr>
<tr>
<td>Coinsurance/ MedCare Remark Code</td>
<td>Enter the amount of coinsurance for the total Medicare claim and the corresponding Medicare Remark Code(s).</td>
<td>Required, if applicable</td>
</tr>
<tr>
<td>Deductible/ MedCare Remark Code</td>
<td>Enter the amount of the deductible for the total Medicare claim and the corresponding Medicare Remark Code(s).</td>
<td>Required, if applicable</td>
</tr>
<tr>
<td>Blood Deductible</td>
<td>Enter the amount of the indicated Blood Deductibles on the Medicare claim.</td>
<td>Required, if applicable</td>
</tr>
<tr>
<td>Total Allowed</td>
<td>Enter total allowed amount for the entire Medicare claim and the corresponding Medicare Remark Code(s).</td>
<td>Required, if applicable</td>
</tr>
<tr>
<td>Amount Paid</td>
<td>Enter the Amount Paid from the Medicare EOB and the corresponding Medicare Remark Code(s).</td>
<td>Required, if applicable</td>
</tr>
<tr>
<td>Provider Signature</td>
<td>Signature of Physician or Supplier; the name of the authorized person designated by the agency or organization.</td>
<td>Required</td>
</tr>
<tr>
<td>Date Signed</td>
<td>Enter date the claim was signed. (MM/ DD/ CCYY)</td>
<td>Required</td>
</tr>
</tbody>
</table>
**HCA-28B: Medicare-Medicaid Crossover Invoice Form Instructions**

(for Outpatient claims and HCFA claims AFTER DOS 05/31/2016)

---

### Medicare to Medicaid Crossover Invoice

(Use for Outpatient claims and HCFA 1500 claims AFTER DOS 05/31/2016)

<table>
<thead>
<tr>
<th>Please check one:</th>
<th>Medicare only</th>
<th>Medicare supplement claims</th>
<th>Medicare replacement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Medicare Provider ID</td>
<td>2. Member ID</td>
<td>3. Member ID</td>
<td>4. Member Last Name</td>
</tr>
</tbody>
</table>

#### Details Information

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
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</table>

#### Totals Information

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</tr>
</tbody>
</table>

Provider Signature: ____________________________  Date: ____________

Mail claims for payment to:

DXC Technology
P.O. Box 18110
Oklahoma City, OK 73154

---

**For Medicare Crossover Exceptions ONLY: NO crossover paper claims will be accepted as of 02/01/2017.**

The *Medicare-Medicaid Crossover Invoice* form (HCA-28B) should be used when submitting Outpatient claims and HCFA 1500 claims after DOS 5/31/2016.

Instructions

1. You must write CROSSOVER at the top of every crossover claim.

2. Use this form for Outpatient claims and HCFA 1500 claims after DOS 5/31/2016.

3. Use one invoice for each EOB claim.

4. Mail the completed form to:

   DXC Technology
   P.O. Box 18110
   Oklahoma City, OK 73154
## HCA-28B Form Field Descriptions

<table>
<thead>
<tr>
<th>Form Locator</th>
<th>HCA-28B Field Description</th>
<th>Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Check One</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Check the box for the appropriate form (claim type) to be submitted.</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>SoonerCare Provider ID</td>
<td>Required</td>
</tr>
<tr>
<td></td>
<td>Enter the 10-character Oklahoma SoonerCare provider number of the Billing Provider.</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Member ID</td>
<td>Required</td>
</tr>
<tr>
<td></td>
<td>Enter the member’s 9-digit SoonerCare identification number. Must be nine digits.</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Member Last Name</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Enter the member’s last name.</td>
<td></td>
</tr>
<tr>
<td>4a</td>
<td>Member First Name</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Enter the member’s first name.</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Patient Control Number</td>
<td>Not required</td>
</tr>
<tr>
<td></td>
<td>Patient’s Account Number – Enter your internal patient tracking number. The tracking number should be the same as the submitted claim.</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Medicare HIC Number</td>
<td>Required</td>
</tr>
<tr>
<td></td>
<td>Enter the Patient’s Medicare HIC Number. The Medicare HIC Number should be the same number as submitted on the claim.</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Detail Lines</td>
<td></td>
</tr>
<tr>
<td>7a</td>
<td>From DOS</td>
<td>Required</td>
</tr>
<tr>
<td></td>
<td>Enter the From date of service. (MM/DD/YYYY)</td>
<td></td>
</tr>
<tr>
<td>7b</td>
<td>To DOS</td>
<td>Required</td>
</tr>
<tr>
<td></td>
<td>Enter the To date of service. (MM/DD/YYYY)</td>
<td></td>
</tr>
<tr>
<td>7c</td>
<td>CPT</td>
<td>Required</td>
</tr>
<tr>
<td></td>
<td>Enter the appropriate Current Procedural Terminology (CPT) procedure code for each procedure/service listed.</td>
<td></td>
</tr>
<tr>
<td>7d</td>
<td>Charges</td>
<td>Required</td>
</tr>
<tr>
<td></td>
<td>Enter the Medicare charges (billed amount) listed on the MAP EOB for each detail.</td>
<td></td>
</tr>
<tr>
<td>7e</td>
<td>Allow Amt</td>
<td>Required, if applicable</td>
</tr>
<tr>
<td></td>
<td>Enter the Medicare Allowed amount listed on the EOB for each detail.</td>
<td></td>
</tr>
<tr>
<td>7f</td>
<td>Ded</td>
<td>Required, if applicable</td>
</tr>
<tr>
<td></td>
<td>Enter the Medicare deductible amount listed on the EOB for each detail.</td>
<td></td>
</tr>
<tr>
<td>7g</td>
<td>Coins</td>
<td>Required, if applicable</td>
</tr>
<tr>
<td></td>
<td>Enter the Medicare Coinsurance amount listed on the MAP EOB for each detail.</td>
<td></td>
</tr>
<tr>
<td>7h</td>
<td>Blood Ded</td>
<td>Required, if applicable</td>
</tr>
<tr>
<td></td>
<td>Enter the Blood Deductible listed on the EOB, if applicable.</td>
<td></td>
</tr>
<tr>
<td>7i</td>
<td>Paid</td>
<td>Required, if applicable</td>
</tr>
<tr>
<td></td>
<td>Enter the Medicare Paid amount listed on the EOB for each detail.</td>
<td></td>
</tr>
<tr>
<td>7j</td>
<td>Date Paid</td>
<td>Required</td>
</tr>
<tr>
<td></td>
<td>Enter in the Date Paid. (MM/DD/YYYY)</td>
<td></td>
</tr>
<tr>
<td>7k</td>
<td>Medicare Reason Code</td>
<td>Required, if applicable</td>
</tr>
<tr>
<td></td>
<td>Enter Medicare’s reason code listed on the MAP EOB for each detail.</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Totals Information</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Enter the Medicare total charges (billed amount) listed on the EOB.</td>
<td></td>
</tr>
<tr>
<td>Note: A provider may attach additional template forms (pages) as necessary. The combined total charges for all pages should be listed on the last page. All other forms must indicate &quot;Continue&quot; in this block.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Chapter 5: Claim Completion

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>8a</td>
<td>Charges</td>
<td>Enter the total Charges amount listed on the EOB.</td>
</tr>
<tr>
<td>8b</td>
<td>Allow</td>
<td>Enter the Medicare total Allowed amount listed on the EOB.</td>
</tr>
<tr>
<td>8c</td>
<td>Ded</td>
<td>Enter the Medicare total Deductible amount listed on the EOB.</td>
</tr>
<tr>
<td>8d</td>
<td>Coins</td>
<td>Enter the Medicare total Coinsurance amount listed on the EOB.</td>
</tr>
<tr>
<td>8e</td>
<td>Blood Ded</td>
<td>Enter the Medicare total Blood Deductible amount listed on the EOB.</td>
</tr>
<tr>
<td>8f</td>
<td>Paid</td>
<td>Enter the Medicare total Paid amount listed on the EOB.</td>
</tr>
<tr>
<td>8g</td>
<td>Total Pages</td>
<td>Enter the total number of pages that are submitted, for more than one page. If the crossover claim contains more than 7 detail line items, use multiple pages to identify up to the detail line items for the claim (as necessary).</td>
</tr>
<tr>
<td>9</td>
<td>Provider Signature</td>
<td>Signature of Physician or Supplier— The name of the authorized person, someone designated by the agency or organization. Required</td>
</tr>
<tr>
<td>10</td>
<td>Date</td>
<td>Enter date the claim was signed. <em>(MM/DD/YYYY)</em> Required</td>
</tr>
</tbody>
</table>
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Chapter 6: Electronic Data Interchange

Introduction

Electronic Data Interchange (EDI) is the most efficient method of submitting and receiving large amounts of information within the Oklahoma Medicaid Management Information System (OKMMIS). Some benefits of EDI include:

- Improved accuracy
- Low operating costs
- Increased cash flow
- Shorter payment turnaround time
- Ability to check claims status electronically
- Increased accounts receivable timeliness and functionality

In addition, there is no charge to providers for EDI submission. EDI transactions are sent in envelope information structures as detailed below:

The first step to becoming an electronic claims submitter is to complete an EDI application form. The form is found on the OHCA website at www.okhca.org or by contacting the EDI Help Desk.
Providers may take advantage of the EDI process by using a billing agency, clearinghouse or VAN/third party vendor approved by the fiscal agent.

DXC promotes the use of electronic claims submissions through EDI. The EDI team is available to provide direction, answer questions and assist providers or billing agents with the submission of electronic transactions.

**EDI Resources**

OKMMIS-specific companion guides and National Council of Prescription Drug Programs (NCPDP) payer sheets are available on the OHCA public website at: [www.okhca.org](http://www.okhca.org).


The EDI Help Desk can be reached by phone at 800-522-0114 or 405-522-6205 Option 2, 2.

Email correspondence can be sent to okxixEDI@dxc.com.

Written correspondence for the EDI Help Desk can be sent to:

**DXC Technology – EDI Help Desk**

2401 NW 23rd Street, Suite 11
Oklahoma City, OK 73107

**Section A: Professional Claims (837 Professional)**

**837 Professional Transaction**

The ASC X12N 837 Professional transaction is the electronic equivalent for the 1500 paper claim form.

**Key Notes**

- No more than 50 service lines are allowed per claim.
- Typical Providers must use the 10-digit NPI as the billing/pay-to, referring and rendering provider ID.
- For atypical providers that are not eligible for an NPI, the REF segment (Bill-to Provider’s Secondary ID #) in Loop 2010AA must be included and must have the “EI” field qualifier and the provider’s Tax Identification #.
- The PAT segment, Loop 2000C and 2010CA is no longer needed. All SoonerCare subscribers have their own SoonerCare ID number. When the subscriber
and the patient are the same person, omit the PAT information in Loop 2000C and 2010CA.

- SoonerCare numbers sent on all claims:
  - Atypical Providers must use Identification
  - Typical Providers must use NPI# as primary Identification. (Please refer to the companion documents for further information regarding loops and segments).
  - Subscribers – 123456789 (nine digits)
- No more than 5,000 claims per transaction set are allowed.

**Section B: Institutional Claims (837 Institutional)**

**837 Institutional Transaction**

The ASC X12N 837 Institutional transaction is the electronic equivalent of the UB-92 paper claim form. All hospitals and institutional facilities must use the 837 Institutional transaction to bill electronically for services covered under the SoonerCare program.

**Key Notes:**

- The 837 Institutional transaction must be used for inpatient claims.
- Providers must use their 10-digit NPI number as the billing/pay-to provider ID. (See companion documents for loops and segments.)
- Limit each transaction set to 5,000 claims.
- Limit each claim to a maximum of 50 service lines.
- For attending, operating and other physicians, please use only the physician’s 10-digit NPI number as the primary identifier in the appropriate NM1 segment.
- The physician’s taxonomy code is not used for operating physicians or physicians classified as “other.”
- Do not use revenue code 001 as a total for all service lines included on the claim.
- Unit rate is required if revenue code is 100-219 (SV02-06).
Section C: Dental Claims (837 Dental)

837 Dental Transaction

The ASC X12 837 Dental transaction is the electronic equivalent of the ADA 2012 paper claim form.

Key Notes:

- No more than 50 service lines are allowed per claim.
- Providers must use the 10-digit NPI as the billing/pay-to, referral, and rendering provider ID.
- The PAT segment, Loop 2000C and 2010CA, is no longer needed unless billing a claim for a newborn. Every SoonerCare subscriber, except newborns, have their own SoonerCare ID number. When the subscriber and the patient are the same person, omit the PAT information in Loop 2000C and 2010CA.
- The SoonerCare numbers to be sent on claims should follow this format:
  - Providers – 100000000A (nine digits with one alpha character at the end for a total of 10 characters)
  - Subscribers – 123456789 (nine digits)
- The tooth quadrant in field SV30401 must be listed.
- The TOO segment must be populated indicating tooth number and surface code.
- No more than 5,000 claims per transaction.

Section D: Pharmacy Claims

Pharmacy Claims

All interactive electronic pharmacy claims should be submitted using the NCPDP version 5.1 standard. All pharmacy claims submitted electronically in batch must be in NCPDP version 1.1 standard.

Key Notes:

- To obtain NCPDP payer sheets, go to www.okhca.org and select the Provider link. Under Claims Tools, select the HIPAA Companion Documents for
Electronic Transaction link, then scroll down the page and select the NCPDP link.

- 3C version is no longer accepted.
- If a pharmacy is sending a compound claim, a 2 needs to be entered in field 406-D6 in the claim segment.
- If a 2 is entered in 406-D6, the compound details must be with the claim. Each NDC number must be listed.
- To send test files, the pharmacy must check with their van/switch and have them send the test to the DXC test port.

**Section E: Claim Inquiries/Responses**

**276 Claim Inquiry Transaction (Batch)**

The 276 Transaction Set is used to transmit health care claim status request/response inquiries from health care providers, clearinghouses and other health care claims adjudication processors. The 276 Transaction Set can be used to make an inquiry about a claim or claims for specific SoonerCare members. It is mandatory under HIPAA that the OKMMIS is able to accept this transaction set to create health care claim status responses.

**Key Notes:**

- The 276 should be limited to 5,000 inquiries per transaction set (ST-SE envelope).
- In order to return valid claim data on the 277, the data in the 276 must match the data on the claim.
- The hierarchy of the search criteria in the EDI system is:
  - NPI/Provider ID
  - Recipient ID
  - Recipient ID and Name must match
  - ICN
  - Amount Billed
  - Date of Service
277 Claim Inquiry Response Transaction (Batch)

The 277 Transaction Set is used to transmit health care claim status inquiry responses to any health care provider, clearinghouse or other health care claims adjudication processors that have submitted a 276 to the OKMMS.

Key Notes:
The 277 is used solely as a response to a 276 request. The 277-Unsolicited (version 3050) is not the same thing. Refer to Section H for more information on RAs and the 277-Unsolicited.

Section F: Eligibility Inquiries/Responses

270 Eligibility Inquiry Transaction (Batch)

The ASC X12N 270 Eligibility Inquiry Transaction set is used to transmit health care eligibility benefit inquiries from health care providers, clearinghouses and other health care adjudication processors.

Key Notes:
The 13-Month Rule – The only time to get 13 months of retrospective eligibility is at the beginning of a month. Checking at the end of the month allows you to review the past 12 months in addition to the upcoming month. Eligibility is updated toward the end of the month.

Inquiry Types:

- Type of insurance plan
- Type of service performed
- Where the service is performed
- Where the inquiry is initiated
- Where the inquiry is sent

When identifying a recipient/subscriber based on the information on a 270 request, the following combinations of data are valid:

- Recipient ID only
- SSN and DOB
- SSN and name
- DOB and name
- No more than 99 inquiries per ST-SE transaction set
Chapter 6: Electronic Data Interchange

271 Eligibility Inquiry Transaction

The ASC X12N 271 Eligibility Response Transaction set is used to respond to health care eligibility benefit inquiries as the appropriate mechanism.

Key Notes:

- The eligibility information returned is not a guarantee of claims payment.
- A value of 1 will be returned in the 271 response for a member with active coverage. This is indicated in loop 2110C-EB01.

Section G: Remittance Advice (RA)

835 Remittance Advice

The 835 Transaction Set will only be used to send an Explanation of Benefits (EOB) RA. For SoonerCare, payment is separate from the EOB RA and will therefore not be affected by changes to how the provider receives payment – via paper or electronically. The 835 transaction will be available to OHCA providers and contracted clearinghouses requesting electronic remittance advice (ERA).

The 835 Transaction does not accommodate notification of a claim status of pending/suspended/under review. SoonerCare provides a supplemental transaction that provides claim status information on pending claims. This transaction is the 277 Health Care Payer Unsolicited Claim Status (X12 version 3050) and is available to every OHCA provider and contracted clearinghouse requesting ERA.

Key Notes:

- Requests for changes in the delivery of an RA must be made in writing to the EDI team.
- ERAs may be combined and/or sent to a designated receiver via the provider’s secure Internet account.

Section H: Electronic Claims/PAs with Paper Attachments

An attachment cover sheet, form HCA-13, is available for every attachment to be submitted with electronic claims or electronic PA requests. HCA-13 allows claims or PA request submitters to continue billing their claims or PA requests electronically, even if an attachment needs to be sent with the claim or PA request.
To ensure proper handling of attachments:

- The Attachment Control Number (ACN) in the PWK segment in the electronic claim or the Control field of the direct data entry page on SoonerCare Provider Portal must be identical to the ACN field on HCA-13. (See Section F of the Claims Completion chapter in this manual.)

- The provider and recipient numbers on the claim must match the provider and recipient numbers on form HCA-13.

- Each submission of a claim must have a new ACN. If resubmission of a claim occurs, a counter after the original number is suggested.

- All ACNs must be unique.

- The number must be clear and legible on the HCA-13. Please do not mark out information on the form; use a new form if a mistake is made.

- When creating ACNs, avoid using:
  - Dashes, spaces or any other special characters
    - ICN (claim number)
    - Phone numbers
  - Patient’s date of birth
    - Patient’s SSN/FEIN

- Copies of the Attachment Cover Sheet can be obtained:
  - In the Forms Chapter of this manual.
  - By calling the DXC Call Center at 405-522-6205 or toll-free at 800-522-0114

**Section I: Electronic Media Types**

EDI transactions can be submitted to DXC via:

- OHCA SoonerCare Provider Portal
- Batch upload process
EDI Batched Electronic Transactions

Batch transactions/files sent to DXC via the OHCA SoonerCare Provider Portal or the RAs are immediately placed in the OKMMIS for processing.

Section J: HIPAA Transaction and Code Set Requirements

The Health Insurance Portability and Accountability Act (HIPAA) is a national effort driven by the Department of Health and Human Services (DHHS) and the Centers for Medicare and Medicaid Services (CMS) geared toward administrative simplification and electronic submission standardization. The HIPAA influences the way protected health information (PHI) is transferred and sets specific guidelines for protection of PHI used for treatment, payment and business operations.

On August 14, 2000, the DHHS issued a Final Rule for Standards for Electronic Transmissions as part of the Administrative Simplification portion of the HIPPA. Find the Final Rule at http://aspe.hhs.gov/admnsimp/final/txfin00.htm. In October 2002, DHHS issued an addendum to the Final Rule, which was accepted in December 2002 and published in February 2003. This is the most current HIPAA compliant formatting standard for the Transaction Code Set (TCS) rule.

The OKMMIS follows the HIPAA-mandated TCS standards as set forth by DHHS and CMS.
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Chapter 7: Claims Resolution Process

Introduction

This chapter is designed to outline the process a claim goes through from submission to completion. By understanding this process, providers should have a better idea of how to evaluate their denied claims and how to get those claims corrected.

Section A: Claim Creation

When paper claims are received, they are first sorted into groups related to the claim type (i.e., outpatient, inpatient, dental, physician).

Once the claims are sorted by claim type, they are scanned into the Oklahoma Medicaid Management Information System (OKMMIS). The scanners translate the information into the OKMMIS by optical character recognition (OCR). This reduces the amount of human error by allowing the system to read the claims directly.

When claims are scanned into the OKMMIS, they are assigned an Internal Control Number (ICN). This number has information regarding the claim and assists the providers and the OHCA when researching a claim. An example of the ICN coding orientation is found below, followed by the coding description.

Coding Orientation: R R Y Y J J J J J J

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>R R</td>
<td>These first two digits of the ICN refer to the region code assigned to a particular type of claim. Region codes are explained later in this chapter.</td>
</tr>
<tr>
<td>Y Y</td>
<td>These two digits of the ICN refer to the calendar year the claim was received. For example, all claims received in calendar year 2006 would have 06 in this field.</td>
</tr>
<tr>
<td>J J J</td>
<td>These 3 digits of the ICN refer to the Julian date the claim was received. Julian dates are shown on many calendars as days elapsed since January 1. There are 365 days in a year, 366 in a leap year, so a claim received on March 17, 2004, a leap year, would have a Julian date of 077, which indicates that March 17, 2004, is the 77th day.</td>
</tr>
<tr>
<td>J J J</td>
<td>The final six digits of the ICN refer to the claim number, which is assigned when the claim comes into the DXC mailroom.</td>
</tr>
</tbody>
</table>

Based on this information, an ICN number of 1006032123456 indicates that the claim was received on paper (region code 10), in the year 2006 (06), on February 1st (032). The remaining 6 digits
are assigned as a batch sequence number by the OKMMIS, and illustrate the order in which the claim was received.

Region codes indicate the claim submission method used. More frequently used region codes are:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>Paper claims without attachments</td>
</tr>
<tr>
<td>11</td>
<td>Paper claims with attachments</td>
</tr>
<tr>
<td>20</td>
<td>Electronic claims without attachments</td>
</tr>
<tr>
<td>21</td>
<td>Electronic claims with attachments</td>
</tr>
<tr>
<td>22</td>
<td>Internet claims without attachments</td>
</tr>
<tr>
<td>23</td>
<td>Internet claims with attachments</td>
</tr>
<tr>
<td>25</td>
<td>Point of service claims</td>
</tr>
<tr>
<td>26</td>
<td>Point of service claims with attachments</td>
</tr>
<tr>
<td>40</td>
<td>Claims converted from old OKMMIS</td>
</tr>
<tr>
<td>45</td>
<td>Adjustments converted from old OKMMIS</td>
</tr>
<tr>
<td>47</td>
<td>Converted history – only adjustments</td>
</tr>
<tr>
<td>49</td>
<td>Recipient linking claims</td>
</tr>
<tr>
<td>50</td>
<td>Adjustments – non-check related (recoupment/payout)</td>
</tr>
<tr>
<td>51</td>
<td>Adjustments – check related (refund)</td>
</tr>
<tr>
<td>52</td>
<td>Mass adjustments – non-check related</td>
</tr>
<tr>
<td>53</td>
<td>Mass adjustments – check related</td>
</tr>
<tr>
<td>54</td>
<td>Mass adjustments – void transaction</td>
</tr>
<tr>
<td>55</td>
<td>Mass adjustments – provider rates</td>
</tr>
<tr>
<td>56</td>
<td>Adjustments – void non-check related (recoupment)</td>
</tr>
<tr>
<td>57</td>
<td>Adjustments – void check related (refund)</td>
</tr>
<tr>
<td>58</td>
<td>Adjustments – processed by DXC SE</td>
</tr>
<tr>
<td>59</td>
<td>Provider reversals/voids</td>
</tr>
<tr>
<td>60</td>
<td>Adjustments – history only</td>
</tr>
<tr>
<td>61</td>
<td>Mass adjustments – history only</td>
</tr>
<tr>
<td>62</td>
<td>Mass adjustments – void non-check related</td>
</tr>
<tr>
<td>63</td>
<td>Mass adjustments – void check related</td>
</tr>
<tr>
<td>64</td>
<td>HMO Copay adjustments – non-check related (w/ refund)</td>
</tr>
<tr>
<td>65</td>
<td>HMO Copay adjustments – check related (w/out refund)</td>
</tr>
<tr>
<td>80</td>
<td>Claims reprocessed by DXC systems engineers</td>
</tr>
<tr>
<td>90</td>
<td>Special projects</td>
</tr>
<tr>
<td>91</td>
<td>Batches requiring manual review</td>
</tr>
<tr>
<td>92</td>
<td>HMO Copays – paper</td>
</tr>
<tr>
<td>94</td>
<td>Web HMO Copays – with attachment</td>
</tr>
<tr>
<td>99</td>
<td>Converted claim with duplicate ICN</td>
</tr>
</tbody>
</table>
Section B: Data Entry

Once claims are scanned into the OKMMIS and assigned an ICN, the OKMMIS sends the claim to the data entry department. There, the required fields are keyed manually to verify that the information necessary to process the claim is complete and accurate. Once the claim data are entered, the OKMMIS will attempt to automatically adjudicate the claim. The claim will run through two different types of edits. Please note that the following information regarding edits is very general and should not be considered a full and comprehensive list of all the edits used by the OKMMIS system.

MMIS Edits

OKMMIS edits are wide-ranging edits that review the claim and details from a very general perspective. OKMMIS edits will review the claims data for accuracy and compare the claim to the member’s file to check for eligibility and programs. The system will then compare the claim to the provider’s file for contract effective dates and check the provider’s file to ensure the provider type is eligible to receive payment for the type of services provided. Lastly, the system will check the service lines to ensure that the services being provided are covered under Oklahoma SoonerCare, as well as checking for any policy limitations regarding units allowed, prior authorizations or age restrictions.

ClaimCheck Edits

ClaimCheck edits evaluate claims for coding accuracy. ClaimCheck employs logic from three edits: Rebundling, Incidental and Mutually Exclusive. The Rebundling edit checks are for procedure unbundling. This occurs when two or more procedure codes are used to report a service when a single and more comprehensive procedure code exists. Incidental edits check for certain procedures performed at the same time as a more complex primary procedure and are clinically integral to the successful outcome of the primary procedure. Mutually Exclusive edits check for procedures that represent overlapping services, or different techniques or approaches that accomplish the same result.

Section C: Resolutions

Once a claim has adjudicated, it is assigned one of four statuses by the OKMMIS system. The claim is paid, denied, suspended or given a status of resubmit.
Paid Claims

Paid claims are claims that contain services which are covered by Oklahoma SoonerCare; however, they do not always result in a payment being issued. For example, if a claim is submitted which has a primary insurance payment of $100.00, and a SoonerCare allowable of $75.00, the claim will be marked paid since the charges are eligible for coverage. No payment would be made under this circumstance. Additionally, if any lines on the claim are covered, the claim will be marked paid, even though one or more of the service lines may have denied.

Once a claim is assigned a paid status, the payment will be issued on the following financial cycle (usually on Wednesdays) and will be listed on the Paid Claims page of the provider’s remittance advice (RA).

Denied Claims

Denied claims are claims that have been determined not covered by Oklahoma SoonerCare. These denials may be issued for various reasons including: non-covered services, inaccurate information submitted on the claim, member’s eligibility or the provider’s contract information.

Claims denied for non-covered service could be due to program restrictions or policy limitations. Providers can contact the OHCA call center for details on these denial types.

Claims denied for inaccurate information, including incorrect member’s SoonerCare identification number, can be corrected by the provider and resubmitted for consideration.

Claims may be denied based on the member coverage being inactive for claim date(s) of service. Eligibility is determined by the Oklahoma Department of Human Services (OKDHS). Eligibility disputes should be directed to the member’s local county OKDHS office.

In some instances, a claim may deny because of information listed on the provider’s contract. The provider’s contract period may have terminated or the provider’s contract type may not be eligible to bill for the service provided (for example: a family practitioner billing for dental services).

Suspended Claims

Suspended claims are claims that are currently still in process. Claims suspend when they cannot be automatically adjudicated or require additional review. Suspended claims are forwarded to a resolutions department for manual review. For example, if a claim
has a primary insurance payment, the claim and attached documentation are reviewed. Remember, suspended claims are still being processed and do not need to be resubmitted.

Resubmit Status

Once a suspended claim has been reviewed, the resolutions department will resubmit the claim so the OKMMIS can rerun the editing process. The claims system cycles every six hours. Subsequently, a claim in resubmit status will normally adjudicate in no more than six hours. It is important to note that claims in resubmit status require no action from the provider.

Working Denied Claims

Claims can be denied at either the header or detail levels. The header level contains information about the member and provider, but not about the services performed. This is where the OKMMIS will verify member’s eligibility and provider’s contract information. Denials at this level will cause the entire claim to be denied.

The detail level of the claim contains information specific to the services performed. The detail level verifies coverage of services, policy limitations or program restrictions. Denials at this level will deny specific service lines and not the entire claim.

Once a claim has been denied, providers have two ways to research their denials: via the SoonerCare Provider Portal or the RA.

RA Research

When researching using the RA, locate the denied claims section. Once you have found a denied claim, view the header information. Any edits applying to the header information will be listed as Header EOBs. These codes are the HIPAA Adjustment Codes and contain general information about the claim. For further description of these codes, see the EOB Code Descriptions page of the RA. You may find several edits listed. Please note that not every edit listed is a denial edit. If there are no header denials, look at each detail line for edits specific to that service. These edits will be listed at the end of each detail line as Detail EOBs.

If the denial reason is still unclear, providers may contact the OHCA call center for assistance or log onto the SoonerCare Provider Portal at www.okhca.org and do additional research.
SoonerCare Provider Portal Research

To research denied claims on the SoonerCare Provider Portal, go to the claim inquiry page. For information on how to get to this section, see the Web/RAs Usage chapter of this manual. On the claim inquiry screen, you may search by the denied ICN or the member ID and date of service. Once the claim has been accessed, scroll to the bottom of the claim to view the header and detail denials. The HIPAA Adjustment Code will be listed here along with a HIPAA Adjustment Remark Code, which provides more detailed information. If the denial reason is still unclear, you may select the HIPAA Adjustment Code number to view the MMIS EOB description. The MMIS EOB provides the most detailed information about the denial.

Once the reason for the denial has been determined, any inaccurate or incomplete information can be corrected and the claim can be resubmitted for processing. If all information is accurate and complete, the claim may have denied due to policy limitations or program restrictions.
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Chapter 8: Paid Claim Adjustment Procedures

Introduction

This section explains the business processes of how claim-specific adjustments and non-claim specific adjustments flow through the Oklahoma Medicaid Management Information System (OKMMIS). It is the responsibility of the adjustment department to process in a timely manner all claim-specific and non-claim-specific financial transactions. When a claim is adjusted, it is reprocessed as a new claim. When the adjustment claim processes, it may be affected by system changes made since the original claim was processed.

Section A: Adjustment Categories

Adjustments are classified in two categories – check-related (refund) or non-check related. Check-related adjustments are classified as either full or partial. An explanation of the claim adjustment types is provided below. Adjustments are made to paid detail lines only on paid claims.

Non-Check Related Adjustments

Underpayment Adjustments

The provider is seeking additional reimbursement for a paid claim. The net payment to the provider is the difference between the original claim amount and the adjusted claim amount, when the adjusted claim amount is more than the original claim amount.

Overpayment Full Offset

The provider or the OHCA has recognized that a full overpayment for a claim occurred, and the provider or the OHCA has requested that the overpayment amount be deducted from future claim payments to the provider. After the adjustment void processes, the claim is systematically adjusted to zero and an account receivable is established for the entire amount of the claim.

Overpayment Partial Offset

The provider or the OHCA has recognized that a partial overpayment for a specific claim occurred and the provider has requested that the overpayment amount be deducted from future...
claim payments. The historical data for the claim are adjusted and an account receivable is established for the overpayment amount.

Check-Related Adjustments

Full Claim Refund
The provider or the OHCA has recognized that a full overpayment for a claim occurred and the provider issues a refund check for the amount of the entire claim payment. During the claim adjustment process, the refund amount is applied to the claim and the original claim is systematically adjusted to zero.

Partial Claim Refund
The provider or the OHCA has recognized that a partial overpayment for a specific claim occurred and the provider issues a refund check for the amount of the overpayment. The refund amount is applied to the adjustment claim during processing and the historical data for the claim are adjusted.

Negative Adjustment Amounts (Overpayments)
If a claim is incorrectly adjudicated and the provider receives an overpayment, the provider is required to immediately take action with one (1) of the following options:

1) Mail a check in the amount of the overpayment along with a completed adjustment request form (HCA-14 for UB-04 and IP/OP Crossover, or HCA-15 for CMS 1500, Dental and Crossover Part B).

Please send check to:

**OHCA – Finance**  
P.O. Box 18299  
Oklahoma City, OK 73154; or

2) Void the claim on the SoonerCare Provider Portal to set up a recoupment; or

3) Complete an adjustment request form (HCA-14 or HCA-15) and submit it according to the instructions provided on the form.

In addition to completing one of the options listed above, include a copy of the paid remittance advice (RA) and a copy of the corrected claim, which applicable; a copy of the
Medicare EOMB; and/or a copy of the insurance EOB. Please send correspondence to:

**OHCA – Adjustment Unit**
4345 N. Lincoln Blvd.
Oklahoma City, OK 73154-0299

If the payment is not received, recoupment procedures will be initiated by the OHCA.

When a claim has resulted in a recoupment, the amount of the overpayment will appear on your remittance advice as NET OVERPAYMENT (AR) and the amount of the overpayment will be listed. This amount will be deducted from the current remittance net payment. If the AR amount is larger than the net payment, it will carry over to future remittances until satisfied. A summary of the recoupment activity is reported on the financial transactions page of the RA as well as the summary page.

**Positive Adjustments (Underpayments)**

If a claim is incorrectly adjudicated and the provider receives an underpayment, the OHCA will initiate procedures to generate a payment adjustment to the submitted claim.

If the provider identifies an underpayment error to a paid claim, the provider may request a payment adjustment by submitting:

1. A completed adjustment request form (HCA-14 for UB, Inpatient/Outpatient crossover, or HCA-15 for 1500, Dental or Crossover Part B) for each claim requested for adjustment.

2. A copy of the paid RA or detailed explanation of the paid information and a copy of the corrected claim. If applicable, a copy of the Medicare EOMB and/or copy of the insurance EOB.

3. Any additional documentation – including sterilization consent form, hysterectomy acknowledgment, abortion certification or patient certification for Medicaid funded abortion. These documents must be attached to the adjustment request in order to assist the OHCA in making proper determination.

All documentation is mailed to:

**OHCA – Adjustment Unit**
4345 N. Lincoln Blvd.
Oklahoma City, OK 73154-0299
OHCA Review

Each adjustment request is reviewed for proper documentation and OHCA policy and procedural compliance. Requests failing to meet these requirements will be returned to the provider for the missing information.

Section B: Adjustment Types and Workflow

Adjustments are typically initiated by the provider but may also be requested by the OHCA. The provider completes an adjustment request form and forwards it to the specified adjustment address on the form.

Non-Check Related Adjustments (regions 50 and 56)

Non-check-related adjustments are defined as provider requests for additional payment, which are referred to as:

- An underpayment adjustment, or
- Provider requests for an overpayment amount to be deducted from future claim payments (referred to as an offset adjustment).

Offset adjustments are further categorized as full-claim offsets or partial-claim offsets. Non-check-related adjustments are processed through the OKMMIS.

Check-Related Adjustments (regions 51 and 57)

Check-related adjustment requests are cash receipts received and dispositioned as claim-specific refunds to the OHCA. The refunded dollar amount is posted to the specific claim as the adjustment is processed in the OKMMIS. A reason code, indicating the source of the refund, is typed in the adjustment record. This allows the system to categorize the refunds into provider, SURS and TPL recoveries for cash management reporting. Check-related adjustments are processed through the OKMMIS.
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Chapter 9: Third Party Liability

Introduction

Private insurance coverage generally does not exclude an individual from receiving Oklahoma SoonerCare benefits. Many SoonerCare members have other insurance in addition to SoonerCare. Insurance may be a commercial group plan through the member’s employer, an individually purchased plan, Medicare, or insurance available as a result of an accident or injury. For most Oklahoma members, SoonerCare supplements other available coverages and is primarily responsible for paying the uncovered medical expenses.

To ensure that the OHCA does not pay expenses covered by other sources, federal regulation (42 CFR 433.139) established the OHCA as the payer of last resort. This means that if an OHCA member has any other resource available to help pay for the cost of his or her medical care, that resource must be used prior to the OHCA. Other resources include, but are not limited to

- Commercial health insurance policies, both group and individual
- Medicare
- TRICARE, formerly known as CHAMPUS
- Indemnity policies that pay a fixed per diem for hospital or nursing home services
- Auto insurance
- Homeowner’s insurance
- Worker’s compensation
- Other liability insurance

In Oklahoma, the Victim Compensation Act and Indian Health Services are the only resources that do not have to be used prior to the OHCA.
OHCA Third Party Liability Program

The OHCA Third Party Liability (TPL) program is charged with ensuring compliance with federal and state TPL regulations. The program has two primary responsibilities:

1. To identify OHCA members who have third party resources available.
2. To ensure that those resources pay prior to the OHCA.

The OHCA has full authority to fulfill these responsibilities. The OHCA member must sign an assignment of rights form, which allows the third party payment be made directly to the OHCA. This is one of the eligibility conditions to OHCA membership. Each member must further agree to cooperate with the OHCA to obtain payment from those resources, including authorization of providers and insurers to release necessary information to pursue third party payment. TPL requirements are the same, regardless of the type of third party resource. The TPL program fulfills its responsibilities based on whether the other resource falls under the general category of health insurance. These may include: commercial policies, Medicare, and liability insurance such as auto and homeowner.

The TPL program has four primary sources of information for identifying members who have other health insurance:
caseworkers, providers, data matches and discrepancy letters.

Caseworkers

When a member applies for SoonerCare, the caseworker asks if the member has other insurance coverage. If so, the caseworker obtains all available information about the other policy and updates the member's file, which will update the OKMMIS with that information.

Providers

During the OHCA member's medical appointment, providers must ask if the member has other insurance coverage. If so, the provider obtains information about the other policy and provides it to the OHCA by written notice, phone call or inclusion on a claim form. Providers should request that the OHCA member sign an assignment of benefits authorization form. This form should state that the member authorizes the insurance carrier to reimburse the provider directly.
Data Matches
The OHCA uses private vendors, Health Management Systems (HMS) and DXC Technology (DXC) to perform regular data matches between OHCA members and commercial insurance eligibility files. Data matches are performed with all major insurers, including Blue Cross and Blue Shield, Aetna, Cigna, HealthChoice and others.

Discrepancy Letter
The discrepancy letter is used to update the OHCA member’s file. This letter will be mailed to a provider when there is a TPL payment indicated on a paid claim, but no TPL is shown in the DXC system. The completed discrepancy letter can be faxed or mailed to the TPL unit. The unit verifies the information prior to updating the system. This form can be downloaded from the OHCA website. It is located in the Forms section under TPL forms. Regardless of the source, all TPL coverage information is stored in the DXC system and available to providers through the Eligibility Verification System (EVS).

Section A: Services Exempt from Third Party

Liability/Cost Avoidance Requirements
To increase overall savings to the OHCA, the Centers for Medicare and SoonerCare Services (CMS) encourage three types of medical services:
1. Pregnancy care
2. Prenatal care
3. Preventive pediatric care, including Early Periodic Screening Diagnosis and Testing (EPSDT)

To help ensure that providers are not deterred from providing these services, federal regulations exempt claims for these types of care from the cost-avoidance requirement. Providers that render any of these exempted services are still permitted, but are not required, to bill available third party resources. Claims for these services, identified by the diagnosis codes, bypass the normal cost-avoidance process.

Cost Avoidance
When a provider determines that a member has an available TPL resource, the provider is required to bill that resource prior to billing the OHCA. If the EVS indicates TPL resource information and the
provider submits a claim to the OHCA without documentation that the third party resource was billed, federal regulations (with a few exceptions as described in Section B of this chapter) require that the claim be denied. This process is known as cost avoidance. When a claim is cost avoided, the provider must bill the appropriate third party. If that resource denies payment or pays less than the OHCA would have paid, the provider can rebill the OHCA. Providers must be fully aware of and comply with the procedures outlined in this chapter to prevent claims from being erroneously cost avoided.

**Liability Insurance**

Unlike health insurance, liability insurance is generally available only under certain circumstances. For example, an auto insurance liability policy covers medical expenses only if expenses are the direct result of an auto crash and the policy's insured is liable. However, if there is medical payments coverage under the auto policy of the vehicle in which the member was injured, the member must only establish that the injuries are accident-related. He or she does not have to establish liability to pursue a medical payments' claim. Under homeowner’s and other property-based liability insurances, the at-fault party's liability generally must be established before an injured member is reimbursed for medical expenses related to the injury, unless there is a separate medical payments coverage available under the policy. In that case, to obtain medical payment benefits, the member would typically only have to establish they were injured on the property. Because of the circumstantial nature of this coverage, the OHCA does not cost avoid claims based on liability insurance.

If a provider is aware that a member has been in an accident, the provider can bill the OHCA or pursue payment from the liable party. If the OHCA is billed, the provider must note that claims are for accident-related services by marking the appropriate box in field 10 on form 1500, listing the appropriate occurrence code on form UB-04; or entering the appropriate Related Causes Code in data element 1362 on form 837 Professional (837P) or 837 Institutional (837I) electronic transaction. Providers that choose to initially pursue payment from the liable third party must remember that claims submitted to the OHCA after the one-year timely filing limit are denied.

When the OHCA pays claims for accident-related services, the TPL program performs post-payment research, based on trauma diagnosis codes, to identify cases with potential liable third parties. When third parties are identified, the OHCA presents all paid claims associated with the accident to the responsible third party for
reimbursement. Providers are not normally involved in this post-payment process, and are not usually aware that the OHCA has pursued recoveries. Providers may contact the TPL unit with questions about TPL case procedures and are encouraged to report all identified third party liability cases to the TPL unit. For example, if a provider receives a record’s request from an attorney regarding a third party liability case, providers are encouraged to notify the TPL unit of these requests.

Section B: TPL Claim Processing Requirements

This section outlines provider responsibilities for supporting cost containment through timely identification and billing of primary insurers. Providers are required to bill all other insurance carriers prior to billing the OHCA, except for programs that are secondary to the OHCA. The TPL Unit is available to assist with determining other insurance resources and maintaining the most current member TPL files.

Documentation Requirements

The OHCA must deny claims if there is evidence that TPL exists and documentation indicating that the third party was billed is not submitted with the claim. To prevent claims from being denied, providers must be aware of responsibilities concerning third parties and comply with the procedures described in this chapter.

Third Party Liability Identification

Prior to rendering a service, the provider must verify that the member is eligible. Use the EVS described in the Member Eligibility chapter of this manual to check eligibility status for all members. Additionally, the EVS should be used to verify TPL information so providers can determine if another insurer is liable for all or part of the bill. EVS has the member’s most current TPL information, including, the insurance carrier, benefit coverage and policy numbers. In some cases, it is not possible to determine by the EVS if a specific service is covered. If a specific service does not appear to be covered by the stated TPL resource, providers must still bill that resource to receive a possible denial or payment. For example, some insurance carriers cover optical and vision services under a medical or major medical plan. Medical services that are covered by a primary insurer must be billed first to the primary insurer. If there is no other insurer indicated on the EVS and the member reports no additional coverage, bill the service to the OHCA as the primary payer.

When the EVS shows a member is a qualified Medicare beneficiary (QMB) only or a specified low income Medicare beneficiary (SLMB)
only, the provider should contact Medicare to confirm medical coverage. Failure to confirm medical coverage with Medicare could result in claim denial because the Medicare benefits may have been discontinued or recently denied. The OHCA pays the Medicare premiums for SLMB only and QMB only members, but does not provide medical coverage. The coinsurance and deductible are covered for members with Medicare entitlement.

Prior Authorization

A service requiring OHCA’s prior authorization (PA) must be satisfied to receive payment from the OHCA, even if a third party paid a portion of the charge. The only exception is when the third party payer is Medicare Parts A or B and Medicare allows in whole or in part for the service.

Billing Procedures

When submitting all claims, the amount paid by a third party must be entered in the appropriate field on the claim form or electronic transaction.

If a third party payer made payment, an explanation of payment (EOP), explanation of benefits (EOB), or remittance advice (RA) is not required for electronically submitted claims.

When a member has other insurance and the primary insurer denies payment for any reason, a copy of the denial such as an EOP, EOB or RA must be attached to the OHCA claim or the claim will be denied.

If an EOP, EOB or RA cannot be obtained, attach to the claim a statement copy or correspondence from the third party carrier.

When billing the OHCA for the difference between the amount billed and the primary insurer’s payment, the OHCA pays the provider the difference, up to the OHCA allowable charge. If the primary insurer payment is equal to or greater than the allowable charge, no payment is made by the OHCA. In this instance, the provider is not required to send the claim to the OHCA for processing. Providers cannot bill members for any balance.

Non-Covered Services or Lifetime Maximum Exceeded

When a service that is repeatedly furnished to a member and repeatedly billed to the OHCA is not covered by the third party insurance policy, a provider can submit photocopies of the original denial for up to one year from the date of the original denial. The provider should write Non-Covered Service on the insurance denial when submitting copies for billing purposes. For example, if an
insurer denies a claim for skilled nursing care because the policy limits are exhausted for the calendar year, that same denial could be used for subsequent skilled nursing care related claims for the duration of that calendar year. The denial reason must relate to the specific services and timeframes of the new claim.

Subsequent Third Party Liability Payment

TPL payments received by providers for claims paid by the OHCA cannot be used to supplement the OHCA allowable charges. If the OHCA paid the provider for services rendered and the provider subsequently receives payment from any other source for the same services, the OHCA payment must be refunded within 30 days. The refund should not exceed the OHCA payment to the provider. Checks must be made payable to the OHCA and mailed to:

**OHCA Finance Unit**

P.O. Box 18299

Oklahoma City, OK 73154

Remittance Advice Information

If a claim denies for TPL reasons, Electronic RAs identify this information with the adjustment reason and adjustment remark codes. If the provider has information that corrects or updates the TPL information provided on the RA, follow the procedures for updating TPL information. For additional information, refer to the Member Third Party Liability Update Procedures section in this chapter.

Insurance Carrier Reimburses OHCA Member

Providers with proof that an OHCA member received reimbursement from an insurance carrier should follow these steps:

1. Contact the insurance carrier and advise them that payment was made to the member in error. Request that a correction and reimbursement be made to the provider.

2. If unsuccessful, the provider must bill the member for the services. In future visits with the OHCA member, the provider should request that the OHCA member sign an assignment of benefits authorization form. The form states the member authorizes the insurance carrier to reimburse the provider. This process might result in reimbursement to the provider.
Section C: Coordination with Commercial Plans

Specific guidelines must be followed to receive payment from the OHCA when submitting claims for a member enrolled in private preferred provider organization (PPO) or private health maintenance organization (HMO) plans.

HMO Billing OHCA

The OHCA reimburses providers for copayments and services not covered by commercial plans incurred by OHCA members under a capped arrangement.

Copayment Billing

In 2001, the OHCA implemented a procedure for providers to bill the OHCA for HMO copays on eligible SoonerCare recipients enrolled in private health plans and Medicare Replacement HMOs.

The appropriate claim form (UB-04 or 1500) should be used. At the top of the paper claim form, print in large letters: “HMO copay.” Use the appropriate procedure code. However, provide only the desired copay reimbursement amount due in box 24F and 29 on the 1500 claim form and box 47, the TOTALs box, and box 55B on the UB-04.

The paper claim forms should be mailed to:

DXC Technology
P.O. Box 18500
Oklahoma City, OK 73154

HMO copay claims can also be billed on the SoonerCare Provider Portal. When submitting a claim on the portal, select “yes” on the drop-down box labeled “HMO COPAY.” These claims must be billed with the desired copay reimbursement amount and an EOB must be attached. Do not bill total charges or the claim will be denied.

Claims will be subject to all other applicable regulations. If you have any questions, please call the OHCA at 405-522-6205 or 800-522-0114.

Covered and Non-covered Services Billing

When billing for services not covered under the member’s plan, the provider bills the OHCA and indicates carrier denied in the TPL amount on forms 1500 or 837P. The provider must attach a copy of the statement from the capped plan that indicates the service is not covered. The OHCA requires that a member follow the rules of his or her primary insurance carrier. Therefore, if the primary insurance carrier
carrier requires the member to be seen by in-network providers only or payment will be denied, the OHCA does not reimburse for claims denied by the primary carrier because the member received out-of-network services. However, if the primary carrier pays for out-of-network services at the same rate as in-network services or at a reduced rate, the provider may submit the bill to the OHCA. Also, if the primary insurance carrier pays for out-of-network services, but does not pay a particular bill in full due to a deductible or copayment, the provider may still submit the bill to the OHCA. If no payment or a partial payment was made by the primary carrier, this should be indicated on the claim form, and documentation from the carrier noting the deductible or copayment amount must be attached to the claim.

Section D: Medicare-OHCA Related Reimbursement

Many OHCA members are eligible for SoonerCare and Medicare. These individuals are called dually eligible. According to TPL regulations, Medicare is treated just as any other available resource. Thus, when an OHCA member is also enrolled in Medicare, providers must bill Medicare prior to submitting a claim to the OHCA for reimbursement. For an OHCA provider to receive reimbursement from Medicare, the provider must be enrolled in the Medicare program. Providers can be enrolled in Medicare as participating or nonparticipating. Medicare participating providers receive payment directly from Medicare. Medicare benefits for nonparticipating providers are paid directly to the OHCA member.

In either scenario, the OHCA pays the coinsurance and deductibles. If a provider is not enrolled in Medicare, either as participating or nonparticipating, the member should be referred to a Medicare/SoonerCare dually enrolled provider. OHCA reimbursement is not available to a non-Medicare enrolled OHCA provider who renders service to a Medicare/SoonerCare dually eligible member.

Medicare Enrolled Participating Provider Reimbursement Process

When a provider is enrolled with Medicare, the Medicare payment is made directly to the provider. The provider accepts Medicare’s allowable amount and the patient is not responsible for the disallowed amount. The OHCA is only responsible for the deductible and coinsurance. For example, the charge is $150, the allowable amount is $100, $50 is disallowed, the deductible is $25 and coinsurance is $15. Medicare pays $60; the provider absorbs $50. The OHCA pays $40. The member is not responsible for any charges.
Medicare Enrolled Non-participating Provider Reimbursement Process

When a nonparticipating provider is enrolled with Medicare, the Medicare payment is made to the member. The member is responsible for the complete charge, as the provider does not accept assignment. For example, the charge is $150, the allowable amount is $100, the disallowed amount is $50, the deductible is $25 and the coinsurance is $15. The patient is billed for $150. Medicare reimburses the patient $60 and the patient is responsible for paying the remaining $50.

The OHCA SoonerCare member must be referred to a Medicare/OHCA SoonerCare provider to receive the best benefit.

Crossover Claims

It is important to remember that providers must include the correct Medicare identification number for a claim to crossover automatically. The following information concerns crossover claims:

- If a provider does not receive the OHCA payment within 60 days of the Medicare payment, claims that did not crossover should be submitted electronically.

- If the member has a Medicare supplement policy, proof of filing with the Medicare supplement carrier as well as Medicare must be submitted with the OHCA claim or the claim will deny.

- If the member has a Medicare supplement policy, the claim is filed with Medicare and automatically crosses over to the Medicare supplement carrier rather than the OHCA for payment of coinsurance and deductible. After the provider receives all EOBs, the provider must submit the claim and EOBs to OHCA.

- **NOTE:** If the TPL benefit code has been entered incorrectly as a hospitalization (A) or medical (C) versus Medicare Supplemental Part A (O) or Medicare Supplemental Part B (P) for the supplemental policy, the claim crosses directly to the OHCA and may be paid without proof of filing with the Medicare supplement carrier. These situations generally result in OHCA overpayments that must be refunded immediately. To prevent overpayment, a provider that identifies enrollees with a Medicare supplemental policy conveyed as an A or B on EVS can request a TPL file update by sending a copy of the enrollee’s Medicare supplemental insurance card to the TPL Unit.
Providers whose claims are not crossing over automatically should contact Provider Enrollment to verify that OHCA has your Medicare provider number correctly in the system.

**Prior Authorization**

Prior authorization is not required for members with Medicare Part A and Part B coverage if the services are covered by Medicare and Medicare pays for the services in whole or in part. Services not covered by Medicare are subject to normal prior OHCA authorization requirement restrictions, referral and prior authorization requirements of SoonerCare.

**Medicare Non-Covered or Denied Services**

Claims for services not covered by Medicare will crossover to OHCA and be denied. The claim must be resubmitted to the OHCA’s P.O. Box 18506, Oklahoma City, OK 73154 address, with a copy of the Medicare RA and the HCA-17 form attached. These claims are treated as any other TPL claim. Certain services are excluded and never covered by Medicare; therefore, the OHCA can be billed first for these services, bypassing the requirement to bill Medicare first. This applies to Medicare supplements as well. Otherwise, OHCA benefits can only be paid to the provider of services after Medicare payment or denial of payment occurs.

**Other TPL Resources**

If the member has other insurance on file that covers those services not covered by Medicare, the other insurance resources must be billed before the OHCA.

**Section E: Member TPL Update Procedures**

Other insurance information is entered into the DHS system by the caseworker when a member is enrolled in the OHCA. The information is transmitted electronically via real-time transaction to the OHCA. The county office and the OHCA TPL Unit update TPL information. The TPL Unit is the primary entity for maintaining TPL information about the member. Providers who receive information about OHCA members from insurance carriers that is different from what is listed on EVS can forward the information to the TPL Unit. Information about additional insurance coverage or changes in insurance coverage must be relayed to the TPL Unit as soon as possible to keep member files current and to assist in accurate provider claim processing.
Automated Recovery, Resource Data Request Letters and Questionnaires

Automated discrepancy letters and questionnaires are sent to insurance carriers, members, and providers when recoveries are initiated or TPL resource data are requested. When the TPL data are verified, the system is updated accordingly. As a result, providers have access to the most current insurance billing information through the eligibility verification system (EVS) applications or the automated voice response (AVR) system. When a discrepancy letter is received, providers must thoroughly complete the form and return it to the TPL Unit via fax or mail. The address is indicated on the form.

Providers may access and use the discrepancy letter, and TPL Accident/Injury Questionnaire on the OHCA website. When a questionnaire is completed, the provider can fax or mail it to the DXC TPL Unit. The TPL Unit verifies and investigates the information prior to updating the system.

General Update Procedures

When forwarding update information to the TPL Unit, indicate the member identification (RID) number and any other pertinent member or carrier data on all correspondence. Copies of letters, RA, EOB or EOP information from other insurance carriers are important for maintaining member TPL file information. Carrier letters, RAs, EOPs or EOBs that document coverage must substantiate any requested changes. Mail the above information concerning other insurance coverage to:

TPL Unit
Third Party Liability Update
4345 N Lincoln Blvd.
Oklahoma City, OK 73105

The TPL discrepancy letter can be downloaded from the OHCA website. When completed, providers should fax or mail it to the address indicated on the letter.

The TPL Unit can be reached by phone at 800-522-0114 and selecting option 3 then 2.

The TPL Unit reviews and verifies the OHCA member insurance information, coordinates with the carrier, if required, and makes necessary changes to the TPL file in the OHCA system to accurately reflect member TPL coverage. Providers can confirm the update with EVS or by calling the TPL Unit. Allow 10 business days from the date of receipt for the OHCA member’s file to be updated.
Telephone Inquiry Procedures

To discuss other insurance issues, providers should contact the TPL Unit using the telephone numbers below from 8 a.m. to 5 p.m. Monday through Friday, excluding holidays:

**Third Party Liability Unit**
800-522-0114 Option 3, 2
Fax: 405-530-3478

When calling the TPL Unit, have the member's identification number available. This telephone inquiry function is limited to TPL issues. Direct general provider inquiries to the OHCA Call Center.

**NOTE:** OHCA cannot provide information about benefits covered under each coverage type. Providers should contact the insurance carrier for this information.

Written Inquiry Procedures

Documentation must substantiate each change made to a member’s TPL file. If changes to member files are necessary, providers must forward copies of information from other insurers that document the member’s TPL information to be updated.

When forwarding update information to the TPL Unit, indicate the member’s name; RID number; copy of EOB, RA, member’s third party insurance card, letter from carrier and any other correspondence that will help maintain the member’s TPL file. The TPL Unit verifies all TPL information submitted with the respective insurance carrier. Mail information about other insurance coverage to:

**OHCA TPL Unit**
Third Party Liability Update
4345 N Lincoln Blvd.
Oklahoma City, OK 73105

Summary

The following is a summary of the steps used to revise member TPL:

- When a policy is terminated, a patient was never covered, or the insurance carrier has a different billing address than on the TPL resource file, the provider sends the updated TPL information to the TPL Unit.

- If the provider sends documentation from the insurance carrier, the member’s TPL file is updated with the corrected information within 10 business days from the date of receipt by the OHCA.
• If the provider sends in documentation that is not from the insurance carrier (discrepancy letter, copy of insurance card, handwritten note, etc.), the TPL unit will contact the insurance carrier to verify the other insurance information and if appropriate, update the system within 10 business days of receipt.

• The provider does not need to delay filing a claim; however, notifying the TPL Unit of updated TPL data will make subsequent billing easier.

• The provider can download the TPL questionnaire and discrepancy letter form from the OHCA website.

• Do not send TPL-related claims to the TPL unit for processing.
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Chapter 10: Prior Authorization

Introduction

Under the Oklahoma SoonerCare program, there are services that require prior authorization (PA) by the Oklahoma Health Care Authority (OHCA). To obtain additional information on PAs and a list of services that require PA, go to the OHCA website at www.okhca.org.

All services requiring PA will be authorized on the basis of the service procedure code. The OHCA authorization file will reflect the service codes authorized. A PA number will be assigned and a notice generated to the medical provider. The notice of authorization will contain the PA number, the service/procedure code authorized and the number of units or dollar amount allotted. Notices will be provided online for providers using Web services or by email for all other providers.

Section A: Prior Authorization Requests

Medical and DME Requests

Method of PA Submission for medical supplies or procedures to Medical Authorization Unit (MAU)

Provider Portal: (required, effective 11/01/2016)

- Keyed by provider with all documents uploaded
- Keyed by provider with all documents faxed to DXC at the fax number located on HCA-13A form
  - Faxed documentation accepted through 06/30/2017

eviCore (previously CareCore and MedSolutions)

High Tech Imaging Requests

Imaging (CT, MRA, MRI, PET) prior authorization requests (PAR) are processed by eviCore.

To submit an Imaging prior authorization request, select the Imaging option on the Create Authorization page on the SoonerCare Provider Portal. Selecting Imaging will provide a tab for Imaging Information, including a link to the eviCore website to initiate PARs for imaging services.
Imaging PAR Information

- Once PA documentation has been reviewed by eviCore, a PA decision notice will be provided by eviCore and transferred to the SoonerCare Provider Portal within three (3) business days.
- Contact eviCore for Therapy amendment requests:
  Email: ClientServices@evicore.com
  Phone: 800-575-4517

Therapy – Occupational Therapy (OT), Physical Therapy (PT), and Speech Therapy (ST) Requests for Children

Prior authorization requests for Occupational, Physical and Speech Therapy for children (0-20) are processed by eviCore.

To submit a Therapy prior authorization request, select the Therapy option on the Create Authorization page on the SoonerCare Provider Portal. Selecting Therapy will provide a tab for Therapy Information, including a link to the eviCore website to initiate PARs for therapy services.

Therapy PAR Information

- Once PA documentation has been reviewed by eviCore, a PA decision notice will be provided by eviCore and transferred to the SoonerCare Provider Portal within three (3) business days.
- Retro authorizations are not allowed for Therapy services.
- Contact eviCore for Therapy amendment requests:
  Email: ClientServices@evicore.com
  Phone: 800-575-4517

Dental Requests

Dental prior authorization requests (PAR) may be submitted electronically through the SoonerCare Provider Portal or by mail.

Provider Portal PA Submission:
How to submit dental PAs on the Provider Portal (tutorial).

Mail/Paper Dental PA Submission:
Submit paper/mailed requests for dental prior authorization requests (PAR) to:
All prior authorization requests must demonstrate medical necessity. Providers have seven (7) days to submit additional information for any PAR that was placed in a pending status for additional documentation requirements. After seven (7) days, the PAR will "system cancel" and the provider must submit a new PAR with all necessary documentation.

Dental PAR Requirements:

**Minimum required records** to be submitted include *all* of the following:

- Comprehensive treatment plan
- Right and left identified bitewing X-rays or panoramic X-ray
- Periapical film(s) of tooth/teeth involved or the edentulous areas (if not visible in bitewings), tooth number identified and dated; all images must be of diagnostic quality
- Requests for **scaling and root planning** must include periodontal charting, in addition to the records listed above

**Comprehensive orthodontic requests** must include the following:

- Caries Risk Assessment
- Completed HLLD form
- Referral letter from the member’s general dentist
- Cephalometric X-ray with tracing
- Panoramic X-ray
- 3-D model images or study models (images preferred)
- Detailed description of any oral maxillofacial anomaly; if diagnosed as a surgical case, submit an oral surgeon’s written opinion that orthognathic surgery is indicated and the surgeon is willing to provide this service
- Estimated length of treatment
- Intraoral photographs showing teeth in centric occlusion and/or photographs of trimmed anatomically occluded diagnostic casts; a lingual view of casts may be included to verify impinging overbites

**NOTE**—RECORDS WILL NOT BE RETURNED. We are unable to accept faxed PAR submissions.
Pharmacy Requests

Requests for PA for prescription medication should be submitted on the appropriate pharmacy PA forms. These forms are available on the OHCA website at www.okhca.org. The University of Oklahoma’s College of Pharmacy, Medication Coverage Authorization Unit (MCAU), approves or disapproves each medication authorization request on behalf of the OHCA.

Fax Pharmacy Prior Authorization Request Forms to:
Toll Free: 800-224-4014  
Metro Area: 405-271-4014

OHCA Pharmacy Help Desk:
Toll Free: 800-522-0114, option 4  
Metro Area: 405-522-6205, option 4

Pharmacy PA Forms:  
www.okhca.org/rx-forms

Pharmacy PA Criteria:  
www.okhca.org/providers/rx/PA

Outpatient Rehabilitative Behavioral Health, Licensed Behavioral Health Professionals and Psychologist Services

Public and private outpatient behavioral health agencies, and private independent licensed practitioners must complete the Customer Data Core (CDC) Form and submit to the OHCA designated behavioral health utilization management and quality improvement organization. Currently this information must be submitted via the PI Client Information System found at https://ww4.odmhsas.org/cdc/. The information provided for pre-admission is brief and is primarily used to track the utilization of various services.

Preadmission services do not require clinical review and will be approved unless the member has exhausted the benefit or another provider has requested prior authorization for additional services.

Inpatient Behavioral Health, Detoxification, Group Home and Therapeutic Foster Care Services

Inpatient psychiatric services for SoonerCare members under the age of 21 must be prior authorized before the service is provided. Telephonic initial and concurrent reviews to determine Medical Necessity Criteria are required for the following services:

- Acute Inpatient Care
- Psychiatric Residential Treatment Facility (PRTF) Services
• Residential Behavior Management Services in Therapeutic Foster Care (TFC) Settings
• Residential Crisis Stabilization

Please contact the OHCA Inpatient Review Request Line for telephonic review contact (800) 522-0114. Please have your Provider ID number ready. Select:

• Option 1 for Provider
• Option 6 for Prior Authorizations
• Option 2 for Behavioral Health

Requests for Services to Illegal/Ineligible Aliens/Sooner To Be Sooners

Illegal aliens are only eligible for emergency medical services. Requests for alien services should be submitted to the local county OKDHS office with a notification of needed medical services form, along with the history/physical and discharge summary. The county OKDHS office staff will complete the appropriate paperwork and forward all information to the OHCA Level of Care Evaluation Unit (LOCEU). LOCEU will create a new case in MEDATS and forward the documents to medical Professional Services where an Administrative Assistant (AA) checks the time between the date of service and application date for needed medical services (the time span must not exceed 20 days. The AA forwards the documents to a Medical Director who reviews the case, notes their decision on the cover sheet and returns it to the AA. The AA records the decision in MEDATS, prints the screen and a cover sheet to send to DXC for scanning. The scanned copies are returned to the AA who securely trashes the documents. MEDATS will notify the county OKDHS office of the decision(s) (the approval or denial) of the requested services. The OKDHS county office staff members are responsible for notifying the applicant and the provider of the decision.

Section B: Prior Authorization Process

The OHCA staff will issue a determination for each requested medical/dental service requiring a PA. A computer-generated PA request decision form showing OHCA determination of the service is mailed to the member. The request decision form is not a confirmation of the individual's eligibility for SoonerCare, and the approved clinical period for services may extend beyond the actual period of the member’s eligibility. The request decision form serves as notification of the status of a request for PA or a notice of change for the listed services.

Prior authorization represents a clinical decision regarding medical necessity, but is not a guarantee of member eligibility or
Chapter 10: Prior Authorization

SoonerCare payment. It is the responsibility of the provider to verify not only SoonerCare eligibility, but also to verify program eligibility and benefit plan (example: TXIX, Insure Oklahoma) at the time of service. Factors that affect payment are correct claim completion, appropriate referral (if required), provider contract, timely filing and member eligibility.

Retroactive Authorization

Medical Authorization should be requested prior to providing a service. If this is not possible due to urgent or emergency situations, the provider must request authorization within 30 days of the initial date of service. Requests received after 30 days of initial date of service will not be processed. The following conditions must be met for a retroactive medical authorization request to be approved:

1. The services rendered must be covered under the SoonerCare program.
2. The services must be verifiable and meet OHCA medical necessity criteria.

See the Forms chapter of this manual for an example of the Medical and Dental Prior Authorization request forms.

Note: Retro authorizations do not apply to all services, such as requests processed by eviCore. It is the provider’s responsibility to confirm retro limitations prior to providing services.

Section C: Reconsideration and Appeal Procedures

Level 1—Reconsideration

All denial reconsiderations for medical/DME and Behavioral Health must be submitted as a new authorization request (see Section A). The same 30-day retroactive authorization limit applies to all reconsideration requests (i.e. the resubmitted request must be received within 30 days of the initial date of service).

The MAU will accept reconsiderations submitted via the SoonerCare Provider Portal.

Mail or fax the new authorization request to the appropriate address below:
Medical:

DXC Medical Authorizations
2401 NW 23rd Street, Suite 11
Oklahoma City, OK, 73107
Fax: Local 405-702-9080 or statewide toll free 866-574-4991

Pharmacy:

University of Oklahoma College of Pharmacy
Pharmacy Management Consultants
Medication Coverage Authorization Unit
P.O. Box 26901
ORI W-4403
Oklahoma City, OK 73190
Fax: 800-224-4014 or 405-271-4014

Level 2—Appeal

Dissatisfaction with the results of a review may be disputed by the member only through a formal appeal by returning a completed OHCA LD-2 Form to the OHCA Legal Division within 20 days of Notice of Prior Authorization receipt. Individuals may represent themselves, have another party represent them or have an attorney represent them. An LD-2 form may be obtained from the OHCA website at www.okhca.org, by contacting the Legal Division of the OHCA at 405-522-7217 or by sending a request to:

OHCA Legal Division Docket Clerk
P.O. Box 18497
Oklahoma City, OK, 73154-0497

In the appeal explain what's being appealed and the reason(s) for the appeal.
Section D: Home & Community-Based Services (HCBS) §1915(c) WAIVER Prior Authorizations

Medicaid State Plan services are provided to waiver members. Services that are covered as an integral part of the specific waivers must be prior authorized by the entity or agency that administers the particular waiver under which the member receives services.

**ADvantage Waiver**
823 S Detroit Ave, 4th Floor
Tulsa, OK 74120

or

P.O. Box 50550
Tulsa, OK 74150
918-933-4900

www.okdhs.org/divisionsoffices/visd/asd/advadm

Community Waiver, In-Home Supports Waiver for Adults, In-Home Supports Waiver for Children and the Homeward Bound Waiver:

**OKDHS/Developmental Disabilities Services Division (DDSD)**
405-521-6267
www.okdhs.org/programsandservices/dd

**Personal Care Services:**
OKDHS – Personal care services are prior authorized by the OKDHS. Inquiries should be directed to:

**OKDHS**
Claims Unit
P. O. Box 50550
Tulsa, OK 74150
918-933-4900
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Chapter 11: Financial Services

Introduction

Financial Services ensure that all funds are appropriately disbursed for claim payments and all post-payment transactions are applied correctly. The financial processing function includes generation of payments to providers and production of a remittance advice (RA) for providers that claims were adjudicated and/or financial transactions were processed. Payments are issued via electronic funds transfer (EFT). The only exceptions are: personal care, individual rehab, aides, respite care and foster care.

The Financial Processing function maintains the following information:

- Payment information (checks and EFTs)
- RA reporting
- 1099 and W-2 IRS reporting
- Void, stop payments, re-issuance of payments

Section A: Payment Information

Payments

The provider has two (2) primary methods of receiving payment from SoonerCare: system-generated checks and electronic funds transfer (EFT). These payments, along with the remittance advice, are produced during the financial cycle. The remittance advice, which details each provider’s claims and financial transaction activity during the period, is made available to the billing provider through an electronic format to allow verification of billing and payments.

Checks or EFT notices are printed and sent/mailed separately from the electronic remittance advice.
Electronic Funds Transfers (EFT)
Providers use the EFT payment option to expedite funds directly to their designated bank account. EFTs will be the default payment disbursement option for all providers unless it is proven that a provider cannot receive an EFT transaction. Those who cannot receive an EFT will receive their payment by paper check.

Manual Payments
A less common method for provider payment receipt is the paper warrant issuance (check).

State Agency Funds Transfers
For all state agencies participating in the Oklahoma Medicaid program, payments will be disbursed via state agency funds transfers. Since the Oklahoma Medicaid program is operated by a state agency, the funds are transferred to the corresponding state agency participating in the Oklahoma Medicaid program.

Section B: Remittance Advice (RA)
OHCA providers receive a weekly remittance advice (RA) for any claims submitted the previous week. The RA identifies claims that are paid, denied, in process or adjusted. The RA includes the client ID number, the provider number, the Internal Control Number (ICN) of the claim processed, the date(s) of service and paid amount. The RA also details any reductions to the paid amount, for reasons such as TPL and/or client copayment. Each claim detail might have an explanation of benefit (EOB) code explaining the reason for payment, denial, adjustment or in-process statuses. RAs are tailored to individual claim form types—1500, UB-04, Dental and Pharmacy. When applicable, RAs include additional information, including procedure codes, revenue codes or admission and discharge dates for providers billing on the UB-04 claim form.

The RA has several document types in this order:

1. Check or EFT advice (if applicable)
2. Address page
3. Banner messages (if applicable)
4. Claims activity/status reports (if applicable)
   a. Ordered by claim type (Physician, Institutional, Dental, Pharmacy)
b Ordered by claim status (paid, denied, in process, adjusted)

5 Financial transactions
   a Expenditures (system generated only)
   b Cash receipts
   c Accounts receivable

6 TPL information (if applicable)

7 EOB descriptions (if applicable)

8 Summary report

The RA is generated in each claims payment cycle. A provider will receive an RA if the provider has activity during the claim cycle or outstanding accounts receivable.

Remittance Advice Section Descriptions

The RA contains the following information:

Medicare Crossover Paid
Claims with a paid status are shown in this RA series, including claims paid at zero.

Medicare Crossover Denied
These claims have been denied payment.

Medicare Crossover in Process
Claims in the processing cycle not finalized are listed in this RA series. Claims found here include

- with attachments;
- past the filing limit;
- suspended;
- requiring manual pricing; and
• with adjustments that have not been finalized.

**These claims have not been denied.** Claims reflected as In Process are ultimately shown as paid, denied or adjusted on subsequent RAs. Claims in process must be monitored to final resolution.

**Claims Paid**
Claims with a paid status are shown in this RA series, including claims paid at zero.

**Claims Denied**
These claims have been denied payment.

**Claims in Process**
Claims in the processing cycle that have not been finalized are listed in this RA series. Claims found here include

• with attachments;
• past the filing limit;
• suspended;
• requiring manual pricing; and
• with adjustments that have not been finalized.

These claims have not been denied. Claims reflected as In Process are ultimately shown as paid, denied, or adjusted on subsequent RAs. Claims in process must be monitored to final resolution.

**NOTE:** Each claim in process lists the EOB message that corresponds to the reason it has been suspended.

**Claims Adjustments**
Adjusted claims are listed in this RA series. Two header lines are shown for each adjusted claim. The first header line is for the original or *mother* claim, while the second header line is for the adjusted or *daughter* claim.
Financial Transactions
Non-claim-specific payouts, refunds, and accounts receivable (A/R) transactions are listed in this series of the RA. A transaction number is used to uniquely identify each financial transaction. If a financial transaction is associated to a cash receipt, the cash control number (CCN) is also displayed for informational purposes. Examples of miscellaneous financial transactions tabulated in this RA section include:

1. non claims specific payouts to a provider;
2. refunds made to the OHCA by a provider not associated with a single claim; and
3. amounts scheduled for recoupment, which the A/R section tracks repayment of to determine amount to be recouped.

EOB Code Descriptions
Explanation of Benefits (EOB) codes applied to submitted claims are listed along with the respective code narrative. These codes and corresponding narratives describe the reasons submitted claims were suspended, denied or not paid in full.

Summary
Data from the entire RA series are reflected on this page. This section summarizes all claim and financial activity for each weekly cycle and reports year-to-date totals.

Remittance Advice Sorting Sequence
Claims are shown on the RA by type and according to the following priority sequence:

1500

1. Alphabetically by member name
2. Alphanumerically by patient number assigned by the provider
3. Numerically by ICN
Chapter 11: Financial Services

UB-04
1. Alphabetically by member name
2. Alphanumerically by patient number assigned by the provider
3. Numerically by ICN

Drug
1. Alphanumerically by prescription number
2. Alphabetically by member name
3. Numerically by ICN

Dental
1. Alphabetically by member name
2. Numerically by ICN

EOB Codes
EOB codes are provided with each RA. These codes and the corresponding details describe the reason submitted claims were suspended, denied, or not paid in full. Because the claim can have edits and audits at both the header and detail levels, EOB codes are listed for both header and detail information. A maximum of 20 EOBs are listed for the header, and a maximum of 20 EOBs are listed for each detail line. Exceptions are suspended claims, which have a maximum of two EOBs per header and detail. **These are not denial codes, but rather the reason the claim is being reviewed.** EOB data are listed immediately following the claim header and detail information beside the caption of the EOB. EOB 00 lists header codes, EOB 01 lists line one of the claim's codes, and EOB 02 lists line two of the claim's codes. If there are no EOBs posted for a particular EOB XX line, the line is not printed. Explanation of benefits and denial information are provided in HIPAA compliant formats.

For more detailed EOB and denial information, providers are encouraged to use the OHCA SoonerCare Provider Portal available at [www.okhca.org](http://www.okhca.org). Once there, use the claim inquiry option. An additional resource for this information can be found by calling 800-522-0114 and selecting option 1, for claim status.

For more information about HIPAA, please visit: [www.cms.hhs.gov](http://www.cms.hhs.gov)
For a detailed listing of these new HIPAA codes, visit:
www.wpc-edi.com/ClaimAdjustment_40.asp

Remittance Advice Examples
The following pages display examples of the OHCA RA and detailed information regarding the statements. The illustrative samples give examples of where the data are found on the RA document. Examples that follow the illustrative samples include claims adjudication pages for each claim type. The examples are a representative sample of what a provider might see on an RA. This is not a comprehensive listing for each claim type.

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
<th>Field Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Additional Payment</td>
<td>Provides the additional payment amount when the adjustment results in a positive paid amount.</td>
<td>Number 9</td>
</tr>
<tr>
<td>Address</td>
<td>Payee’s address.</td>
<td>Character 31</td>
</tr>
<tr>
<td>Admit Date</td>
<td>The date member was admitted to hospital.</td>
<td>Character 6</td>
</tr>
<tr>
<td>Allowed (Compound Drug ADJ)</td>
<td>Computed detail-level dollar amount allowable for dispensed drug under the medical assistance program being billed.</td>
<td>Number 9</td>
</tr>
<tr>
<td>Allowed Amount (Compound Drug)</td>
<td>The computed detail level allowed amount for dispensed drug under the Medical assistance program being billed.</td>
<td>Number 9</td>
</tr>
<tr>
<td>Allowed Amount (Home Health)</td>
<td>The computed detail level amount allowable for the services rendered under the Medical assistance program being billed. Adding all the allowable amounts for all the services described on the detail lines arrives at this amount.</td>
<td>Number 9</td>
</tr>
<tr>
<td>Allowed Amount (Dental)</td>
<td>The computed dollar amount allowable for services rendered on each detail line under the Medical Assistance Program being billed. May occur 12 times depending on the number of detail lines billed.</td>
<td>Number 9</td>
</tr>
<tr>
<td>Allowed Amount (Compound Drug)</td>
<td>The computed dollar amount for the dispensed drug under the Medical Assistance Program being billed. This amount is determined by totaling prices of all ingredients used to formulate the compound.</td>
<td>Number 9</td>
</tr>
<tr>
<td>Allowed Amount (LTC ADJ)</td>
<td>This is the computed allowable amount for the services billed. The data displayed pertain to the adjusted claim.</td>
<td>Number 9</td>
</tr>
<tr>
<td>Allowed Amount (CMS-1500 ADJ)</td>
<td>The computed dollar amount allowable for the services rendered under the Medical Assistance Program being billed. Adding all the allowable amounts on all the detail lines arrives at this. The first amount (credit) displayed is for the original claim. The amount for the adjusted claim is displayed under the amount for the original claim. These numbers may vary.</td>
<td>Number 9</td>
</tr>
<tr>
<td>Attending Prov</td>
<td>Number used to identify provider performing the service.</td>
<td>Number 10</td>
</tr>
<tr>
<td>Billed Amount</td>
<td>Dollar amount billed by provider for the claim.</td>
<td>Number 9</td>
</tr>
<tr>
<td>Billed Amount (LTC Denied)</td>
<td>Dollar amount requested by the provider for the service billed on each detail line. May occur 23 times depending on number of detail lines billed.</td>
<td>Number 9</td>
</tr>
<tr>
<td>Field</td>
<td>Description</td>
<td>Field Type</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>------------</td>
</tr>
<tr>
<td>Billed Amount (Dental)</td>
<td>Dollar amount requested by the provider for the service billed on each detail line. May occur 12 times depending on number of detail lines billed.</td>
<td>Number 9</td>
</tr>
<tr>
<td>Billed Amount (CMS-1500 ADJ)</td>
<td>The total dollar amount requested by the provider for the services billed on all the detail lines. Adding all the billed amounts on all the detailed lines will arrive at this amount. The first amount (credit) displayed is for the original claim. The amount for the adjusted claim is displayed under the amount for the original claim. These numbers may vary.</td>
<td>Number 9</td>
</tr>
<tr>
<td>Billed Amount (LTC ADJ)</td>
<td>Dollar amount requested by the provider for the service billed on each detail line. May occur 23 times depending on number of detail lines billed. The data displayed pertain to the adjusted claim.</td>
<td>Number 9</td>
</tr>
<tr>
<td>Billed Amount (CMS-1500 Denied)</td>
<td>The total dollar amount requested by the provider for the services billed on all the detail lines. Adding all the billed amounts on all the detailed lines will arrive at this amount.</td>
<td>Number 9</td>
</tr>
<tr>
<td>Billed Amount (Compound Drug)</td>
<td>Dollar amount requested by the provider for dispensed drug.</td>
<td>Number 9</td>
</tr>
<tr>
<td>Blood Deductible (MCR)</td>
<td>Amount of money paid toward the blood deductible on a Medicare claim.</td>
<td>Number 8</td>
</tr>
<tr>
<td>City</td>
<td>City in which payee resides.</td>
<td>Character 15</td>
</tr>
<tr>
<td>Client Number</td>
<td>Client’s Medicaid identification number.</td>
<td>Character 12</td>
</tr>
<tr>
<td>Client Number (Inpatient In-Process)</td>
<td>Client's Medicaid identification number. Unique identifier of the client.</td>
<td>Character 12</td>
</tr>
<tr>
<td>Client Name</td>
<td>Client's name.</td>
<td>Character 29</td>
</tr>
<tr>
<td>Copay AMT (MCR)</td>
<td>The dollar amount of member liability on a claim that is to be collected by the provider at the time the service is rendered. It is the patient's liability for a medical bill.</td>
<td>Number 8</td>
</tr>
<tr>
<td>Copay Amount</td>
<td>The dollar amount member should pay and is deducted from the allowed amount to arrive at paid amount.</td>
<td>Number 8</td>
</tr>
<tr>
<td>Copay Amount (CMS-1500 ADJ)</td>
<td>The dollar amount member should pay and is deducted from the allowed amount to arrive at paid amount. The first amount (credit) displayed is for the original claim. The amount for the adjusted claim is displayed under the amount for the original claim. These numbers may vary.</td>
<td>Number 8</td>
</tr>
<tr>
<td>Copay Amount (Compound Drug)</td>
<td>The dollar amount member should pay and is deducted from the allowed amount to arrive at paid amount. The copay amount that is deducted depends on the type of drug dispensed.</td>
<td>Number 8</td>
</tr>
<tr>
<td>Copay Amount (MCR Part B ADJ)</td>
<td>The dollar amount of member liability on a claim that is to be collected by the provider at the time the service is rendered. It is the patient's liability for a medical bill.</td>
<td>Number 8</td>
</tr>
<tr>
<td>Copay (MCR Part A ADJ)</td>
<td>The dollar amount of member liability on a claim that is to be collected by the provider at the time the service is rendered. It is the patient's liability for a medical bill. For example, some pharmacy programs require that the patient pay a specific amount toward each prescription filled. The fee will not be charged for the following members: individuals under 21, or members in nursing facilities and intermediate care facilities for the mentally retarded.</td>
<td>Number 8</td>
</tr>
<tr>
<td>Date SVC PERF (Dental)</td>
<td>Date service was actually performed. May occur 12 times depending on number of detail lines billed.</td>
<td>Character 6</td>
</tr>
<tr>
<td>Days</td>
<td>Total days member was in hospital/nursing home</td>
<td>Number 3</td>
</tr>
<tr>
<td>EOBS/Detail EOBs</td>
<td>These are the detail EOBS that apply to the detail on the claim form. There could be a maximum of 20 EOBS codes per claim detail. See HIPAA Reason Code for detailed information on EOBS.</td>
<td>Number 4</td>
</tr>
<tr>
<td>Field</td>
<td>Description</td>
<td>Field Type</td>
</tr>
<tr>
<td>----------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>------------</td>
</tr>
<tr>
<td>Dispense Date (Compound Drug)</td>
<td>The date drug was dispensed to member. This serves as the service date for drug claims.</td>
<td>Character 6</td>
</tr>
<tr>
<td>EOB Codes</td>
<td>The detail EOB codes that apply to the detail on the compound drug claim form. There can be a maximum of 20 EOB codes per detail. See HIPAA reason code for detailed information on EOBs.</td>
<td>Number 4</td>
</tr>
<tr>
<td>EOB Sequence Code/Number</td>
<td>This is the sequential line number of the EOB code line.</td>
<td>Number 2</td>
</tr>
<tr>
<td>HCPCS/Rate</td>
<td>These are the HCPCS procedure codes that correspond to the revenue codes on each of the detail lines being billed. These codes are used to compute the allowable amount for the services rendered. This might occur 23 times depending on the number of detail lines billed.</td>
<td>Character 8</td>
</tr>
<tr>
<td>Header EOBS</td>
<td>The EOB codes that apply to the header on the claim form. There can be a maximum of 20 EOB codes per claim. See HIPAA Reason Code for detailed information on EOBs.</td>
<td>Number 4</td>
</tr>
<tr>
<td>Header EOBS (CMS-1500 Denied)</td>
<td>The EOB codes that apply to the header on the claim form. These codes are used to explain how the claim was processed or priced. There can be a maximum of 20 EOB codes per claim. See HIPAA Reason Code for detailed information on EOBs.</td>
<td>Number 4</td>
</tr>
<tr>
<td>ICN</td>
<td>This is a unique number used to identify and track a claim processed through the system.</td>
<td>Character 13</td>
</tr>
<tr>
<td>ICN (ADJ)</td>
<td>This is a unique number used to identify and track a claim processed through the system. The first number displayed is the ICN of the original claim. The ICN of the adjusted claim is displayed under the ICN of the original claim.</td>
<td>Character 13</td>
</tr>
<tr>
<td>Issue Date</td>
<td>Date check/payment was issued.</td>
<td>Character 10</td>
</tr>
<tr>
<td>LVL Care</td>
<td>This field indicates the level of care rendered for patient.</td>
<td>Character 3</td>
</tr>
<tr>
<td>Medicaid Billed Amount</td>
<td>This is the dollar amount billed by the provider.</td>
<td>Number 9</td>
</tr>
<tr>
<td>Medicaid Paid Amount</td>
<td>This is the dollar amount that is payable.</td>
<td>Number 9</td>
</tr>
<tr>
<td>Medicaid Reimbursement Amount</td>
<td>The full amount payable on claim prior to deducting state share. The paid amount is the amount after state share is deducted from reimbursement amount.</td>
<td>Number 9</td>
</tr>
<tr>
<td>Medicaid TPL Amount</td>
<td>Indicates the payments made by sources outside of the state medical assistance programs. This amount is deducted from the allowed amount to arrive at the paid amount.</td>
<td>Number 9</td>
</tr>
<tr>
<td>Medicare Coinsurance Amount</td>
<td>This is the dollar amount that the member should pay and is deducted from the allowed amount to arrive at the Medicare paid amount.</td>
<td>Number 8</td>
</tr>
<tr>
<td>Medicare Deductible Amount</td>
<td>Indicates the dollar amount that the member is responsible for paying. The Medicare deductible amount includes the Medicare deductible and blood deductible dollar amounts. This dollar amount will crossover and be paid by Medicaid.</td>
<td>Number 8</td>
</tr>
<tr>
<td>Modifiers</td>
<td>This column shows the modifiers used to further describe the service rendered. Up to four modifiers may be entered on each detail line.</td>
<td>Character 2</td>
</tr>
<tr>
<td>NDC</td>
<td>National Drug Codes correspond to the ingredients used. A maximum of 15 ingredients can be entered on one claim.</td>
<td>Character 11</td>
</tr>
<tr>
<td>Net Overpayment/(AR)</td>
<td>Provides the Net Overpayment amount when the adjustment results in a negative paid amount and an accounts receivable (setup) transaction is established</td>
<td>Number 9</td>
</tr>
<tr>
<td>Field</td>
<td>Description</td>
<td>Field Type</td>
</tr>
<tr>
<td>------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
<td>------------</td>
</tr>
<tr>
<td>Paid Amount</td>
<td>The dollar amount that is payable for the claim.</td>
<td>Number 9</td>
</tr>
<tr>
<td>Paid Amount (Dental)</td>
<td>The dollar amount that is payable for the claim. Computing allowable amount for the services and deducting the TPL amount determine this.</td>
<td>Number 9</td>
</tr>
<tr>
<td>Paid Amount (Home Health)</td>
<td>The dollar amount that is payable for the claim/services rendered. This represents the allowable amount plus the overhead amount, minus the TPL and deductible amounts.</td>
<td>Number 9</td>
</tr>
<tr>
<td>Paid Amount (CMS-1500 ADJ)</td>
<td>This is the dollar amount paid for the services rendered. This is arrived at by computing the allowable amount for the services and deducting the TPL amount. The first amount (credit) displayed is for the original claim. The amount for the adjusted claim is displayed under the amount for the original claim. These numbers may vary.</td>
<td>Number 9</td>
</tr>
<tr>
<td>Paid Amount (Compound Drug)</td>
<td>Dollar amount paid for drug. This is determined by computing allowable amount for drug and deducting TPL, and/or copay amounts.</td>
<td>Number 9</td>
</tr>
<tr>
<td>Patient Account Number/PAT NO</td>
<td>This is a unique number assigned by the provider. This is usually used for filing or tracking purposes</td>
<td>Character 30</td>
</tr>
<tr>
<td>Patient Number (ADJ)</td>
<td>This is a unique number assigned by the provider. This is usually used for filing or tracking purposes. This is the same for both the original and adjusted claims.</td>
<td>Number 30</td>
</tr>
<tr>
<td>Patient Liability</td>
<td>This is the patient liability amount the member is responsible for paying. This amount is subtracted from the allowed amount to arrive at the paid amount.</td>
<td>Number 9</td>
</tr>
<tr>
<td>Payee Number</td>
<td>Provider number for provider receiving payment and RA.</td>
<td>Number 9</td>
</tr>
<tr>
<td>Payment Number</td>
<td>Check number corresponding to a check or the control number of an EFT transaction</td>
<td>Number 9</td>
</tr>
<tr>
<td>PL SERV (Dental)</td>
<td>This column shows the place of service code(s) indicating where the services were actually rendered. May occur 12 times depending on the number of detail lines billed.</td>
<td>Character 2</td>
</tr>
<tr>
<td>PL SERV (CMS-1500)</td>
<td>This column shows the place of service code(s) indicating where the services were actually rendered. May occur 6 times depending on the number of detail lines billed.</td>
<td>Character 2</td>
</tr>
<tr>
<td>PROC CD (Dental)</td>
<td>This column shows the American Dental Association (ADA) procedure code used to indicate what services were actually rendered to the member by the provider. May occur 12 times depending on the number of detail lines billed.</td>
<td>Character 5</td>
</tr>
<tr>
<td>PROC CD (CMS-1500)</td>
<td>This column shows the HCPCS procedure code used to indicate what services were actually rendered to the member by the provider. May occur 6 times depending on the number of detail lines billed.</td>
<td>Character 5</td>
</tr>
<tr>
<td>Provider Name</td>
<td>Payee’s name.</td>
<td>Character 50</td>
</tr>
<tr>
<td>RX NO.</td>
<td>Prescription number on the prescription used to dispense the drug.</td>
<td>Character 7</td>
</tr>
<tr>
<td>Refund Amount Applied</td>
<td>Provides the Refund Amount Applied when the adjustment results in a negative paid amount and cash is applied in the payment cycle.</td>
<td>Number 9</td>
</tr>
<tr>
<td>Reimbursement Amount</td>
<td>The full amount payable on claim prior to deducting state share. The paid amount is the amount after state share is deducted from reimbursement amount.</td>
<td>Number 9</td>
</tr>
<tr>
<td>Rendering Provider Number</td>
<td>Number used to identify provider performing the service.</td>
<td>Number 9</td>
</tr>
<tr>
<td>REV CD</td>
<td>Revenue code pertaining to the service billed on the detail line. This might occur 23 times depending on the number of detail lines billed.</td>
<td>Number 3</td>
</tr>
<tr>
<td>Field</td>
<td>Description</td>
<td>Field Type</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>------------</td>
</tr>
<tr>
<td>Service Dates From</td>
<td>Earliest date of service on detail lines.</td>
<td>Character 6</td>
</tr>
<tr>
<td>Service Dates Thru</td>
<td>Latest date of service or discharge date on the detail lines.</td>
<td>Character 6</td>
</tr>
<tr>
<td>Service Dates From (ADJ)</td>
<td>Earliest date of service on detail lines. The dates pertaining to the original claim are displayed first. The dates pertaining to the adjusted claim are displayed under the dates for the original claim.</td>
<td>Character 6</td>
</tr>
<tr>
<td>Service Dates Thru (ADJ)</td>
<td>Latest date of service on the detail lines. The dates pertaining to the original claim are displayed first. The dates pertaining to the adjusted claim are displayed under the dates for the original claim.</td>
<td>Character 6</td>
</tr>
<tr>
<td>Service Location Code</td>
<td>One-byte alphabetic code used to indicate billing provider location.</td>
<td>Character 1</td>
</tr>
<tr>
<td>Spenddown Amount</td>
<td>This field is not currently being used for Oklahoma Medicaid billing.</td>
<td>Number 8</td>
</tr>
<tr>
<td>SRV Date</td>
<td>These are the dates the services were actually rendered. Each detail line will have a date on which the service billed on that line was rendered to the member. These might occur 23 times depending on the number of detail lines billed.</td>
<td>Character 6</td>
</tr>
<tr>
<td>SRV Date (LTC Denied)</td>
<td>If other services or supplies are billed aside from the patient stay (accommodation code), then the service date is entered and displayed. The occurrence of this field depends on the number of detail lines used to bill other than accommodation codes.</td>
<td>Character 6</td>
</tr>
<tr>
<td>SRV Date (LTC ADJ)</td>
<td>If other services or supplies are billed aside from the patient stay (accommodation code), then the service date is entered and displayed. The occurrence of this field depends on the number of detail lines used to bill other than accommodation codes.</td>
<td>Character 6</td>
</tr>
<tr>
<td>State</td>
<td>State where payee resides.</td>
<td>Character 2</td>
</tr>
<tr>
<td>Surface (Dental)</td>
<td>This column shows the surface code pertaining to the part of the tooth that was worked on. May occur 12 times depending on the number of detail lines billed.</td>
<td>Number 5</td>
</tr>
<tr>
<td>Tooth (Dental)</td>
<td>This column shows the tooth number of the tooth or the tooth quadrant that was worked on.</td>
<td>Number 2</td>
</tr>
<tr>
<td>TPL Amount</td>
<td>Dollar amount paid by any source outside of the state medical assistance program that is being billed. If present, this amount is subtracted from allowed amount to arrive at the paid amount.</td>
<td>Number 9</td>
</tr>
<tr>
<td>TPL Amount (ADJ)</td>
<td>Payments made by sources outside of the state medical assistance programs. This amount is deducted from the allowed amount to arrive at the paid amount. The first amount (credit) displayed is for the original claim. The amount for the adjusted claim is displayed under the amount for the original claim. These numbers may vary.</td>
<td>Number 9</td>
</tr>
<tr>
<td>Total Claims Paid - Allowed Amt</td>
<td>Total amount allowed for payee claims.</td>
<td>Number 10</td>
</tr>
<tr>
<td>Total Claims Paid - Billed</td>
<td>Total billed amount for payee’s claims</td>
<td>Number 10</td>
</tr>
<tr>
<td>Total Claims Paid - Blood Deductible Amt</td>
<td>This amount reflects the total of all blood deductible amounts for the claims.</td>
<td>Number 9</td>
</tr>
<tr>
<td>Total Claims Paid - Coinsurance Amt</td>
<td>This amount reflects the total of all coinsurance amounts for the claims.</td>
<td>Number 9</td>
</tr>
<tr>
<td>Total Claims Paid - Copay</td>
<td>Total amount of copay for payee’s claims.</td>
<td>Number 9</td>
</tr>
<tr>
<td>Total Claims Paid - Deductible Amt</td>
<td>This amount reflects the total of all deductible amounts for the claims.</td>
<td>Number 9</td>
</tr>
<tr>
<td>Field</td>
<td>Description</td>
<td>Field Type</td>
</tr>
<tr>
<td>-----------------------</td>
<td>-----------------------------------------------------------------------------</td>
<td>------------</td>
</tr>
<tr>
<td>Total Claims Paid - Paid</td>
<td>Total amount paid for payee’s claims.</td>
<td>Number 10</td>
</tr>
<tr>
<td>Total Claims - Patient Liability</td>
<td>The total of Patient Liability amounts for all the claims.</td>
<td>Number 9</td>
</tr>
<tr>
<td>Total Claims Paid - Reimbursement</td>
<td>This amount reflects the total of all reimbursement amounts for the claims.</td>
<td>Number 10</td>
</tr>
<tr>
<td>Total Claims Paid - Spenddown</td>
<td>This field is not currently being used for Oklahoma Medicaid billing.</td>
<td>Number 9</td>
</tr>
<tr>
<td>Total Claims Paid - TPL</td>
<td>This amount reflects the total of all TPL amounts for the claims.</td>
<td>Number 10</td>
</tr>
<tr>
<td>Total No. Adj</td>
<td>This is the total number of all claims adjusted for the current financial cycle.</td>
<td>Number 6</td>
</tr>
<tr>
<td>Units (CMS-1500)</td>
<td>This shows the units of service being billed on each detail line. May occur six times depending on the number of detail lines billed. On adjusted claims, the data displayed pertain to the adjusted claim.</td>
<td>Number 6</td>
</tr>
<tr>
<td>Units (LTC)</td>
<td>This is the number of units of service.</td>
<td>Number 8</td>
</tr>
<tr>
<td>Units (Compound Drug)</td>
<td>Quantity of ingredient(s) used.</td>
<td>Number 6</td>
</tr>
<tr>
<td>Units (Inpatient/Outpatient)</td>
<td>This shows the units of service rendered. This might occur 23 times depending on the number of detail lines billed.</td>
<td>Decimal 8</td>
</tr>
<tr>
<td>Zip Code</td>
<td>Payee’s zip code. It may contain zip code plus four-digit geographic indicator.</td>
<td>Character 10</td>
</tr>
</tbody>
</table>

**Section C: Electronic Remittance Advice**

An electronic RA is available by using the X12 835 transaction as mandated under HIPAA. The 835 transaction is available to all OHCA providers and contracted trading partners that have requested electronic RAs. The 835 is a financial transaction that functions as an electronic means of posting accounts receivable. The 835 Transaction is available from the Web or Remote Access Server (RAS) in a downloadable file. The 835 Transaction does not accommodate notification of a claim status of pending/suspended/under review. Oklahoma Medicaid will be providing a supplemental transaction that will provide claim status information on pended claims. This transaction is the 277pc Health Care Payer Unsolicited Claim Status.

**Section D: 1099 & W-2s**

Annual earnings, based on the unique Tax Identification Number (TIN), are reported on IRS Form 1099 and submitted to each provider and the Internal Revenue Service. All money earned by TIN is reported on the Form 1099, based on an untaxed basis. It is then the responsibility of the provider to file and pay the appropriate taxes. These taxes can be owed to federal, state and local governments.
Additionally, an IRS Form W-2 is generated to report earnings and FICA contributions to the OCHA’s Individual Personal Care Services providers. All money earned and FICA withholdings for each of these providers is reported on the Form W-2. It is then the responsibility of the provider to file and pay the appropriate taxes. These taxes can be owed to federal, state and local governments.

**Section E: Stop Payments, Voids, Re-issuance**

**Stop Payments**

Stop Payments occur when a provider indicates a check was not received. If the provider has not received a check, a stop payment request is necessary so that a replacement check can be issued. If a check is incorrectly issued, the stop payment request is necessary to prevent the funds from being disbursed in error.

A provider may call to request that a stop payment be placed on a check that was not received. In order for a payment to be reissued, the original check must first be stopped in the OKMMIS, and the OHCA manually reissues the provider a system-generated replacement check. The check can be resubmitted anytime and will be printed in the next manual check print run.

**Check Void**

There are two types of voids that can occur within the OKMMIS: regular check voids and check void/reissue.

**Regular Check Voids**

The first type, a regular void, occurs for any of the following reasons:

- The individual receiving treatment, listed on the RA, is not a patient of the provider who received the check.
- A payment was received by the wrong provider, and the check is returned to the OHCA with “void” or “not ours” written on the face of the check.
- A check was paid to a provider who does not belong to the group or has left the group.
- The payment was inappropriately made payable to the wrong location or provider identification number.
- The check is cancelled by statute and the OHCA directs that a void can be completed.
In the above situations, the checks would be voided within the OKMMIS and all claims associated with the dollars identified to this check will become denied claims. In order to receive payment for any of the now voided claims, it will be necessary for the provider to resubmit the claims.

**Check Void/Reissue**

The second type of voided check is a Void/Reissue. Void/Reissue items are a result of a check being mutilated or destroyed and a subsequent reissued check being manually prepared.

**Section F: Electronic Care Coordination Payments**

The 820 Transaction Set is the HIPAA compliant financial transaction used to transmit care coordination payments. The 820 Transaction Set is generated by the Oklahoma OKMMIS and is distributed to primary care providers/case managers (PCP/CMs) who request electronic capitation reports and participate in the SoonerCare Choice program.

The 820 Care Coordination Payment is combined with the last financial cycle of the month. This transaction is used for the Premium Payment Remittance Information (PPRI). Total payment amount noted in the BPR02 segment of the 820 Transaction may or may not equal the actual payment amount. This is due to the integration of the premium payment with fee-for-service claims payment in the same weekly financial cycle.

The 820 Transaction is only available by download via the Web or RAS. The PCP/CMs must contact DXC to make other arrangements if other media is required.

**Appendices**

- Banner Page
- CMS-1500 Claims Paid Page
- CMS-1500 Claims Denied Page
- CMS-1500 Claims In Process Page
- CMS-1500 Claim Adjustments Page
- Provider Remittance Advice Summary
- Explanation of Benefit Codes
Provider Remittance Advice Banner Messages Example

THIS IS A TEST OF RA BANNER MAINTENANCE BY CLAIM TYPE.
TEXT REGARDING PROVIDER SPECIFIC INFORMATION COULD BE FOUND IN THIS AREA.

Provider Remittance Advice CMS-1500 Claims Paid Example
# Provider Remittance Advice CMS-1500 Claims Denied Example

```plaintext
REPORT: OCA-114-W  STATE OF OKLAHOMA  DATE: MM/DD/YY
PROCESS: FIN/CD  MEDICAID MANAGEMENT INFORMATION SYSTEM  PAGE: 1
LOCATION: FIN/421  PROVIDER REMITTANCE ADVICE  CMS-1500 CLAIMS DENIED

<table>
<thead>
<tr>
<th>PAYEE NUMBER</th>
<th>PAYMENT NUMBER</th>
<th>ISSUE DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>00000000</td>
<td>0000000</td>
<td>MM/DD/YY</td>
</tr>
</tbody>
</table>

---

**CLIENT NAME** XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

**CLIENT NO.** XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

**PPVYJ/DDDD** MM/DD/YY MM/DD/YY 0,000,000.00 0,000,000.00 0,000.00

---

**HEADER EB05** 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999

**SERVICE DATES RENDERING** 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999

**SERVICE DATES BILLED** 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999

**PL SERV PROC CD MODIFIERS UNITS** 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999

**TOTAL CMS-1500 CLAIMS DENIED** 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999 9999
```

**Library Reference:** OKPBPM

**Revision Date:** November 2017

**Version:** 6.1
Provider Remittance Advice CMS-1500 Claims In Process

---

REPORT: CRA-0116-W
STATE OF OKLAHOMA
LOCATION: PHNW201

PAYEE NUMBER: X
PAYMENT NUMBER: X
ISSUE DATE: X

CLIENT NAME: X
CLIENT NO.: X

HEADER EOB: X

TOTAL CMS-1500 CLAIMS IN PROCESS: X

---

Library Reference: OKPBPM
Revision Date: November 2017
Version 6.1
# Provider Remittance Advice CMS-1500 Claims Adjustments

<table>
<thead>
<tr>
<th>Service Dates</th>
<th>Billed</th>
<th>Allowed</th>
<th>Edits</th>
<th>Amount</th>
<th>Details</th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Additional Payment

- Total: $0,000.00
- Applied: ($9,399.99)

---

**Provider Remittance Advice CMS-1500 Claims Adjustments**
## Provider Remittance Advice Summary

<table>
<thead>
<tr>
<th>Claim Data</th>
<th>Current Amount</th>
<th>Current Year-to-Date</th>
<th>Year-to-Date Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claims Paid</td>
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<td>0,000,000</td>
<td>0,000,000</td>
</tr>
<tr>
<td>Claim Adjustments</td>
<td>999,999</td>
<td>999,999,999</td>
<td>999,999,999</td>
</tr>
<tr>
<td>Total Claims Payments</td>
<td>999,999</td>
<td>999,999,999</td>
<td>999,999,999</td>
</tr>
<tr>
<td>Claims Denied</td>
<td>0,000</td>
<td>0,000</td>
<td>0,000</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Earnings Data</th>
<th>Current Amount</th>
<th>Current Year-to-Date</th>
<th>Year-to-Date Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payments</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reimbursement Amount</td>
<td>0,000,000</td>
<td>0,000,000</td>
<td>0,000,000</td>
</tr>
<tr>
<td>State Share Amount</td>
<td>(999,999,999)</td>
<td>(999,999,999)</td>
<td>(999,999,999)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Capitation Payments</th>
<th>Current Cycle</th>
<th>Previous Cycle</th>
<th>Non-Claim Specific</th>
</tr>
</thead>
<tbody>
<tr>
<td>System Payouts (Non-Claim Specific)</td>
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** Net Payment amount has been reduced. Lien payments have been made to the following lien holders:

† Capitation payment for the month of MM/DD: YY. Please refer to your capitation payment listings for additional detail.
### Explanation of Benefits Code Example

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Note: The code example is a placeholder and the actual codes and descriptions may vary.
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Chapter 12: SoonerCare Choice

Introduction
SoonerCare Choice is a managed care model in which each member is linked to a Primary Care Provider/Case Manager (PCP/CM) who serves as the “medical home”. PCP/CMs manage the basic health care needs, including after-hours care and specialty referral of the members on their panel. The level of medical home determines the care coordination payment the PCP receives. All other services are paid based on the OHCA current FFS payment methodology. PCPs may also qualify for SoonerExcel incentive payments based on individual performance. Physicians (M.D./D.O.), nurse practitioners and physician assistants in primary care specialties can contract as PCP/CMs.

Quality Assurance
The OHCA is committed to ensuring that high quality health care is always available to its members. SoonerCare Choice providers agree to cooperate with external review organizations, internal reviews and other quality assurance efforts.

CAHPS Report Card
Annual telephone and mail surveys of SoonerCare Choice members are conducted by an external review organization, which measures health care satisfaction, including care provided by their PCP/CM.

After-hours Surveys
Telephone surveys are conducted by the OHCA or one of its agents to ensure that PCP/CMs provide information concerning after-hours access to medical information or a medical professional.

Member Reports
Member calls to the SoonerCare Helpline for issues regarding quality of care or access to care needs are documented and forwarded to the OHCA for research and/or resolution.

On-site Audits
On-site audits are conducted by OHCA Quality Assurance/Quality Improvement staff.
Encounter Data Reviews
Data reflecting medical care use rates, preventive care services and referral patterns are reviewed and analyzed. This information is used in determining use patterns, referral patterns, rate setting and other reporting purposes.

Emergency Room Utilization Profiling
OHCA Quality Assurance/Quality Improvement staff perform quarterly analysis of PCP/CM office encounter claims submission versus emergency room claim submission. The results of these reports are forwarded to the PCP/CMs as well as SoonerCare Provider Services. The goal of this project is to reduce inappropriate use of emergency rooms.

Covered Members
OHCA determines eligibility for most SoonerCare members using MySoonerCare.org. This system is a secure web-based application process that provides real-time eligibility for members who have internet access. The Oklahoma Department of Human Services (OKDHS) continues to determine eligibility for some SoonerCare programs. Members must meet financial, residency, disability status and other requirements before they can become eligible for SoonerCare.

SoonerCare Choice covers members who qualify for medical services through the Temporary Aid to Needy Families (TANF) program or those who qualify due to age or disability. Members may also include women who have been diagnosed with breast or cervical cancer under Oklahoma Cares or children with disabilities who qualify under the Tax Equity and Fiscal Responsibility Act (TEFRA).

Native Americans
Native Americans who are eligible for SoonerCare Choice must enroll with a Primary Care/Case Manager. They may choose a traditional SoonerCare Choice provider or enroll with an Indian Health Service, Tribal, or Urban Indian (I/T/U) clinic provider that participates in the program. All Native American members have the option to self-refer to any I/T/U facility for services that can be provided at these facilities.

SoonerCare Choice Exempt
Most members who are eligible for SoonerCare benefits will be enrolled in the SoonerCare Choice program. Individuals exempt from this mandate are:

- Eligible for Medicare and SoonerCare Traditional
• Enrolled in a waiver program (ADvantage waiver, Home/Community waiver, etc.)
• Residing in a long-term care center or institution
• Individuals with other forms of credible health insurance coverage
• Subsidized adoption
• State or Tribal custody

Access to Care

**SoonerCare Choice** PCP/CMs are required to maintain access to primary and preventive care services in accordance to the contract. The following standards apply:

1. PCP/CMs must maintain 24 hour, seven day per week telephone coverage, which will either page an on-call medical professional or provide alternative information to members concerning whom they can contact to obtain medical advice.
2. PCP/CMs must offer hours of operation that are no fewer than the hours of operation offered to commercial patients or SoonerCare Traditional members.
3. PCP/CMs must provide medical evaluation and treatment within 24 hours for urgent medical conditions. Generally, urgent care is for sudden illnesses or injuries where there is no immediate danger of death or permanent disability.
4. PCP/CMs can charge the appropriate copayment to Choice members ages 21 and over. PCP/CMs may not deny services based on the member’s inability to pay the appropriate copayment.

Emergency Care

PCP/CMs are not required to provide emergency care either in office or in an emergency room. PCP/CMs that do provide emergency care in the emergency room will be reimbursed based on current OHCA policy.

PCP/CMs should not refer members to an emergency room for non-emergency services. Providers should interact with their assigned members to discourage inappropriate emergency room use. PCP/CMs should manage follow-up care from the emergency room, as needed.
Member Enrollment/Disenrollment

SoonerCare Choice Enrollment

SoonerCare member benefits start when eligibility for SoonerCare is determined.

The effective date of SoonerCare Choice member benefits depend on the certification date. Always check the Eligibility Verification System (EVS) either by calling the toll-free EVS line, through the swipe machine or on the SoonerCare Provider Portal.

**NOTE:** Medical care during the time a member is eligible for SoonerCare Traditional, but not yet effective in SoonerCare Choice, will be covered under the SoonerCare Traditional fee-for-service program.

Continuing eligibility for SoonerCare benefits must be recertified periodically. The recertification intervals vary according to the type of assistance members receive. SoonerCare members are notified in writing by DHS prior to expiration of benefits.

Breaks in eligibility may result in a disruption in the continuity of care. If the PCP/CM’s capacity is limited in comparison to demand, the member may not be able to regain his or her place on that PCP/CM’s panel.

Members may re-enroll with a PCP/CM by calling the SoonerCare Helpline if they have a break in eligibility and are being recertified. Members who lose and regain eligibility within 365 days are assigned to their most recent PCP/CM, if the PCP/CM has available capacity and if the member’s age is within the PCP/CM’s scope of practice.

Choosing a PCP/CM

OHCA offers all members the opportunity to choose a PCP/CM from the provider directory. If a member does not choose a PCP/CM, OHCA will contact the member to assist them in choosing a medical home. If a member seeks care prior to choosing a medical home the provider seeing the member will become the medical home.

Families with more than one eligible member are allowed to choose a different PCP/CM for each eligible member.

Enrollment with a PCP/CM takes effect on the day the selection is made. Prior to the first day of each month, the OHCA provides the PCP/CM with a SoonerCare Choice eligibility listing of new enrollees and continuing members.
Capacity (Number of Members requested per PCP/CM)

The PCP/CM specifies the maximum number of members he or she is willing to accept. The maximum number is 2,500 members for each physician PCP/CM. The maximum capacity for physician assistants and nurse practitioners serving as PCP/CMs is 1,250. The PCP/CM must agree to a minimum panel of 50 members. The OHCA cannot guarantee the number of members a PCP/CM receives.

A PCP/CM may request a change in its capacity by submitting a written request to the Provider Enrollment division of OHCA or by utilizing the Update Provider File link through the provider portal. If approved, OHCA will implement the change on the first day of the month with sufficient notice.

If a PCP/CM requests a lower capacity – within program standards and approved by the OHCA – the reduction in members will come through members changing PCP/CMs or losing eligibility. Members will not be disenrolled to achieve a lower capacity.

Changing PCP/CMs

The OHCA or the SoonerCare Helpline may change a member from one PCP/CM to another PCP/CM for the following reasons:

- Member can request change without cause
- When a PCP/CM terminates his or her participation in the SoonerCare Choice program

Disenrollment at the Request of the PCP/CM

The OHCA may also change a member from the assigned PCP/CM to another PCP/CM for good cause and upon written request of the assigned PCP/CM. If the request is a good cause change, the OHCA will act upon the request within 30 days of receipt from the OHCA SoonerCare Choice division.

Good cause is defined as:

- Non-compliance with PCP/CM's direction
- Abuse of PCP/CM and/or staff (includes disruptive behavior)
- Deterioration of PCP/CM-member relationship
- Excessive no-show appointments above the PCP/CM office policy limit

The dismissal request and supporting documentation should be forwarded for processing to SoonerCare at 405-530-3228. Members may not be
notified by the PCP/CM until approval for disenrollment is granted by the OHCA.

Either party has the right to appeal the decision to the administrative law judge, pursuant to OAC 317:2-1-2 (Authority's Grievance Procedure).

**Electronic Referrals**

**SoonerCare Choice** electronic referrals:

- Are made on the basis of medical necessity as determined by the PCP.
- Are required prior to receiving the referred service, except for retrospective referrals as deemed appropriate by the PCP/CM.
- Must have the correct provider referral number to ensure payment to the referred to provider (provider/referral numbers are site specific).

Electronic referrals must be created by the PCP/CM or a designee within the PCP/CM’s office who is authorized to create referrals for the provider. Some services may also require prior authorization. It is up to the referred to provider, or provider ordering services, to obtain prior authorization as needed. Prior authorization for services is obtained through the Medical Authorization Unit (MAU) at OHCA or one of its agents.

**SoonerCare Choice** electronic referrals must be made if the member requests a second opinion when surgery is recommended. Following the second opinion, any treatment received by the member is to be rendered by the PCP or through a referral made by the PCP/CM.

**SoonerCare Choice** electronic referrals may be made to another PCP/CM for services equal to those of a specialist. Examples of this include: a family practitioner referring to another family practitioner who performs a surgical procedure or a general practitioner referring to an internist who manages complicated diabetic patients.

SoonerCare Choice referrals may be made to a provider for ongoing treatment for time specified by the PCP/CM, but limited to 12 months. For the duration of the referral, the referred-to provider will not be required to receive further referrals to provide treatment for the specific illness indicated on the referral.

**SoonerCare Choice** electronic referrals are not required for:

- Child physical/sexual abuse exams
- Services provided by a PCP/CM for members enrolled or assigned to the PCP/CM
- Emergency room care
- Obstetrical care
- Vision screenings for members younger than 21 years
- Basic dental for members younger than 21 years (benefit is limited to emergency extractions for members older than 21 years)
- Behavioral/mental health
- Family planning
- Inpatient hospital services
- Routine laboratory and X-ray
- Services provided to Native Americans in a tribal, IHS or Urban Indian Clinic facility

Payment for Referred Services

Payment for referred services is subject to coverage limitations under the current SoonerCare reimbursement policies. Payment for referred services is limited to four specialty visits per month for adults older than 20 years of age. Visits to the PCP/CM are excluded from this limitation. To ensure payment, PCP/CMs must refer only to SoonerCare providers who have an active SoonerCare Traditional contract.

Documenting the Medical File

Documentation in the medical record should include a copy of each referral to another health care provider and any additional referrals made by the referred-to provider when this information is known. An example might be ancillary services.

Documentation in the medical record should include a medical report from the referred-to provider. The referred-to provider should report their findings to the referring PCP/CM within two weeks of the member’s appointment. In the event a medical report is not received within a reasonable time, the PCP/CM should contact the referred-to health care provider to obtain this information.

Early and Periodic Screening Diagnosis and Treatment (EPSDT)

Early and Periodic Screening Diagnosis and Treatment (EPSDT) is a federally mandated program and is one of the highest priorities of the SoonerCare Choice program. EPSDT is designed to provide a comprehensive program of preventive screening examinations, dental, vision, hearing and immunization services to SoonerCare Choice members age 20 or younger.
Schedule of EPSDT Services

As a minimum, the following schedule for EPSDT screening is required:

- Six visits during the first year of life
- Two visits in the second year of life
- One visit yearly for ages 2 through 5
- One visit every other year for ages 6 through 20
- Metabolic lead screen at ages 1 and 2; or at 6 years old if not done by age 2. *This is mandatory.*

Additional Requirements

The OHCA requires contractors to:

- Conduct and document follow-up appointments with all members younger than 21 years who miss appointments.
- Administer outreach, including telephone calls or printed notification mailed to a member when a health care screen is indicated or missed. This ensures that all members age 20 or younger are current.
- Educate families of members age 20 or younger about the importance of early periodic screening, diagnosis and treatment.

EPSDT Bonus Payment

The OHCA offers bonuses to be paid to PCP/CMs who demonstrate a specified screening rate.

To qualify for the EPSDT bonus, verifiable encounter claim data must be submitted in a timely manner as set forth in the SoonerCare Choice contract and for any following contract addendums.

The OHCA may conduct on-site chart audits.

See the Reimbursement section below for further bonus payment details.

Reporting Requirements

Data, information and reports collected or prepared by PCP/CMs in the course of performing duties and obligations as a PCP/CM are owned by the state of Oklahoma. The OHCA and other appropriate entities reserve the right to examine this information upon request. This information includes medical and financial records, accounting practices, and other items relevant to the provider’s contract.
The PCP/CM is required to report to the OHCA in writing and within a timely manner any changes to its SoonerCare Choice contract. The report must include demographic, financial and group composition information as reported in their contract.

Claims submitted by the PCP/CM should be submitted in the same manner and on the same claim forms used to submit claims for SoonerCare Traditional members. Encounter Claims must be submitted within 60 days from the date of services. Denied claims must be corrected and resubmitted within 60 days of adjudication.

Reimbursement

Care Coordination

SoonerCare Choice PCP/CMs are paid a Care Coordination payment for each member enrolled with them on a monthly basis.

Care Coordination payments vary according to the type of members the PCP services and their level of medical home status.

Care Coordination payments are made by the 10th working day of each month for all eligible members enrolled with the PCP/CM on the first day of each month. A single monthly payment is generated and accompanies the Care Coordination Listing or is deposited directly.

Claims

PCP/CMs are required to file a claim with the OHCA each time a service is provided to a member. Claims filed will be paid subject to the current SoonerCare Traditional fee schedule and reimbursement policies.

Claims are to be submitted on the appropriate claim form within 60 days of the date of services.

Immunization Incentive Payment

Immunization Incentive Payments are available when the PCP/CM provides written notice that it has administered the fourth dose of DPT/DTAP to a member prior to the member's second birthday.
Care Management

The Care Management Department is comprised of registered nurses and licensed practical nurses. These medical professionals assist in facilitating medical services for SoonerCare members with complex medical conditions.

Population Care Management Services

- Help members access care and services
- Assist providers with coordination of discharge planning
- Resolve issues and concerns with providers as related to medical care
- Help obtain approvals for medicines and medical services
- Provide patient education to identified groups
- Assist with coordinating community support and social service systems
- Offer out-of-state referrals if no comparable in-state services are offered or in cases of urgent care needs
- Complex medical conditions include:
  - High-risk OB cases
  - Transplant cases
  - Catastrophic illness or injury
  - Women enrolled in the Breast and Cervical Cancer (BCC) program
  - Children who receive in-home Private Duty Nursing services (includes periodic home visits to evaluate and certify medically necessary services)

Provide support to SoonerCare providers for issues with:

- Care Management Referral forms
- High service utilization
- Medical regimen noncompliance
- Inappropriate ER visits
- Multiple providers/pharmacies
- Scheduled medication requests
• Refusing alternative treatments/prescriptions
• Refusing pain management referrals
• Drug-seeking behaviors
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Chapter 13: Insure Oklahoma

Introduction

Insure Oklahoma was founded in 2005 in an effort to help provide health coverage to uninsured, working Oklahomans.

Insure Oklahoma is a program under the SoonerCare umbrella and administered by the OHCA. This program consists of two benefits branches.

Insure Oklahoma consists of two (2) benefit branches:

1) Insure Oklahoma Employer Sponsored Insurance (ESI):
   - Geared to small businesses.
   - Offers premium subsidy assistance for qualified group health care plans for eligible employees.

2) Insure Oklahoma Individual Plan (IP):
   - Designed as an option for people who cannot access Insure Oklahoma through their employer.

Member eligibility for both programs requires candidates to:

- Have valid Oklahoma residency.
- Be a U.S. citizen or a legal alien not currently receiving Medicaid or Medicare services.
- Be between 19 and 64 years old.

The ESI program requires candidates to have a household income not exceeding 200 percent of the federal poverty level (FPL). The IP program requires that candidates have a household income not exceeding 100 percent of the FPL.

Section A: What is the Insure Oklahoma Individual Plan?

Members of the Insure Oklahoma Individual Plan must choose an Insure Oklahoma Primary Care provider for themselves, and if eligible, their spouse and/or dependents.

This plan provides coverage to eligible:

- Self-employed individuals
- Workers unable to access Insure Oklahoma through their employer
- Workers who have a disability with a ticket to work
• Unemployed individuals currently eligible for Oklahoma unemployment

Questions about this plan or benefits should be directed to the Insure Oklahoma Helpline at 888-365-3752 or TDD at 405-416-6848, Monday through Friday, 8 am to 5 pm.

Persons Ineligible for the Insure Oklahoma Individual Plan

Certain persons are ineligible for Insure Oklahoma even though they may be eligible under other portions of the SoonerCare program.

These Exempt persons will not be enrolled in Insure Oklahoma if they are: a dependent, 18 years old or younger or eligible for Medicare or Medicaid, including SoonerCare Choice.

Coverage for Children

Children are eligible for Insure Oklahoma if household income is between 186-200 percent (%) of the federal poverty level (FPL). If the household income is less than 185 percent (%) of the FPL, children may qualify for health care coverage through SoonerCare Choice. For additional information, contact 405-521-3646.

Medical ID Card

Insure Oklahoma medical ID cards may look the same or different than SoonerCare cards. Both card versions may be valid.

See examples below:

Old versions:
Section B: Insure Oklahoma Individual Plan Billing Procedures

Billing procedures for the Insure Oklahoma IP are the same as SoonerCare billing procedures. Please refer to the Claim Completion chapter of this manual for details. The Insure Oklahoma IP uses the same mailing addresses as SoonerCare.

Claims are subject to a copayment. The provider reimbursement will be based on the Medicaid allowable plus the copayment. Providers who choose to be primary care physicians will be eligible to be chosen by members. Primary care referrals will follow the same guidelines as SoonerCare.

PCP Payments

Insure Oklahoma PCPs will receive a $3 monthly case management fee per recipient.
Changes to Primary Care Physician Panels

If the provider’s panel is closed, yet there is a patient the provider is willing to add to its panel, the Provider Action form (SC-13) should be completed and faxed to 405-917-7374.

Eligibility

Checking eligibility for IP will follow the same process as SoonerCare. A magnetic strip on the back of the card is used by the swipe machines to read member information. Eligibility is also accessible on the Web or through the Automated Voice Response (AVR) system. When viewing eligibility for those enrolled in the Insure Oklahoma IP, the system will reflect the program for Public Product (PUB).

Prior Authorization

The OHCA will handle the IP Prior Authorization (PA) process.

Adjustments

Insure Oklahoma IP adjustments follow the same guidelines as SoonerCare.
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Chapter 14: Pharmacy

Introduction

The purpose of the pharmacy division is to manage the Medicaid Pharmacy program in the most efficient and comprehensive manner possible by researching, designing and implementing mechanisms to ensure appropriate, cost-effective and quality therapy.

Pharmacy Policy (Rules)

Listed below is a brief overview of Pharmacy rules*:

- Dispensing limitation: 34-day supply or up to 100 units if on maintenance list.
- Covered Drugs: Must have a Federal Drug Rebate Agreement.
- Excluded Categories: Fertility, cosmetic, weight loss/gain, nutritional supplements.
- Beginning January 2017, OHCA will use Actual Acquisition Cost (AAC) to price brand and generic drugs:
  - The AAC will be set using the lower of Wholesale Acquisition Cost (WAC), National Average Drug Acquisition Cost (NADAC), or State Maximum Allowable Cost (SMAC).
- Professional Dispensing Fee: $10.55
- Indian Health Services/Tribal/Urban Indian Clinic pharmacies will be reimbursed at the federal OMB encounter rate. The OMB rate will be paid based on a per-member/per-facility/per-day payment.
- Copays:
  - There will be a $4.00 copay for most SoonerCare members.
  - For SoonerCare members in home and community-based waiver programs, copays are as follows:
    - Zero ($0) on preferred generics
    - $0.65 for $0.01 to $10.00
    - $1.20 for $10.01 to $25.00
    - $2.40 for $25.01 to $50.00
    - $3.50 for $50.01 and greater
  - Copayment is not required of:
    - members younger than 21 years old
    - members in nursing facilities and intermediate care facilities for the developmentally disabled
      - pregnant women
  - Copayment is not required for family planning services, Including all contraceptives and services rendered.
*Pharmacy program rules change frequently. For the most up-to-date SoonerCare Pharmacy program rules, visit the OHCA website at www.okhca.org/rx.

Prescription Drug Benefit

- Adults: Six (6) prescriptions per month with two (2) brand name drug limit.
- Prescriptions that don’t count toward prescription limit are HIV antiretrovirals, chemotherapy, contraceptives, hemophilia factor, and smoking cessation agents.
- Residents of long-term care facilities: no limit.
- Members younger than 21 years old: no limit.
- Waiver Advantage members.
  One (1) additional brand name prescription
  Seven (7) additional generic prescriptions
  Therapy Management, if additional prescriptions are needed

Product Based Prior Authorization (PBPA)

There are multiple Prior Authorization types used to manage the pharmacy benefit.

Product Based Prior Authorization (PBPA)

This program divides certain therapeutic categories of drugs into two or more levels called Tiers. Tier 1 medications are preferred as the first step for treating a member’s health condition. They are cost effective and are available without prior authorization (PA) from the OHCA in most cases. Members who do not achieve clinical success with Tier 1 medications may obtain a Tier 2 or higher medication. Providers with members having clinical exceptions may request a PA to skip the step therapy process and immediately receive a medication from a higher tier. For additional information, please review the OHCA website at www.okhca.org/pa.

Scope and Utilization-Based Prior Authorization

Many drugs are included under the scope or utilization-based prior authorization program. That means the drugs are restricted for certain diagnoses and/or should only be used at a specific dose or for a specific time period. See the link provided above for additional information.
Pharmacy Lock-In Program

When it is decided that a member meets specific criteria and should be placed in the Pharmacy Lock-in Program, a pharmacy and prescriber are assigned to that member and their eligibility file is updated to only pay claims for controlled substance medications at that pharmacy and from that prescriber. Referrals are made to the Lock-In unit by several sources, including physicians, pharmacies, caseworkers and OHCA staff. Referrals can be made by phone, online or in writing.

Lock-In Decision Process

Once a member is referred to the Lock-in program, the following information is verified and reviewed for each case:

1. Eligibility (members not eligible are not reviewed)
2. Medicare eligibility (not reviewed if eligible)
3. Paid pharmacy claims for past year
4. Hospital claims for past year
5. History of diagnostic information
6. Number of prescribers and their specialties

The lock-in process is started if the review shows that the member meets the required criteria based on this information.

Cases that look questionable but do not fully meet the criteria generally result in monitoring of those members or a warning letter sent to the member. Warning letters are sent to members explaining they are being monitored due to a high number of visits to different pharmacies. Cases that receive warnings are reviewed again in six months. If there is no improvement, the members are entered into the Lock-in program. If the behavior improves, the cases are closed. If a decision is made to monitor without a warning, the case is reviewed again in three months and a new decision is made based on behavior pattern.

Safety Concerns Criteria List:

- Number of ER visits (3)
- Number of different pharmacies (3)
- Number of different prescribers/physicians (5) (combined)
- Number of days’ supply of controlled substances
- Diagnosis of drug dependency/other diagnosis.
- Number of hospital discharges (3)
- Other information from past reviews

Who to Call:

OHCA Main number: 800-522-0114 or 405-522-6205
Pharmacy Help Desk, option 4:
   - Monday-Friday (8:30 am-7:00 pm)
   - Saturday (9:00 am-5:00 pm)
   - Sunday (11:00 am-5:00 pm)

Durable Medical Equipment (DME)

The general guidelines concerning the documentation necessary to obtain a prior authorization for DME supplies is located at [www.okhca.org/providers/dme/paguidelines](http://www.okhca.org/providers/dme/paguidelines). Please be sure you use your DME provider number, not your pharmacy provider number, when billing DME claims. With the exception of diabetic supplies, DME claims will not process through the pharmacy point-of-sale system. For a list of DME billing providers, go to [www.okhca.org/providers/dme/dmeproviders](http://www.okhca.org/providers/dme/dmeproviders).

Diabetic Supplies

Pharmacies should submit claims for diabetic testing supplies through their regular pharmacy point-of-sale system. Covered brands include OneTouch, FreeStyle, and Precision test strips and meters; any other brands of strips and/or meters are not covered. Lancets, syringes, pen needles and control solutions will also be covered in the pharmacy claims system. Supplies for insulin pumps will remain DME claims. For a list of covered products, please visit [www.okhca.org/rx](http://www.okhca.org/rx). Diabetic supplies are zero copay and do not count against the monthly prescription limit.
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Chapter 15: LTC Nursing Facilities

Introduction

SoonerCare provides members with coverage for Long-Term Care (LTC) Nursing Facilities and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID). SoonerCare reimburses providers with a set lump-sum payment for each member under their care. Items covered by the reimbursement include: dietary needs, room and board, personal hygiene items and most over-the-counter drugs.

Section A: LTC Nursing Facility Provider Eligibility

Long-Term Care (LTC) Nursing Facilities may receive payment for the provision of nursing care under the SoonerCare Title XIX program only when they are properly licensed and certified by the Oklahoma Department of Health, meet state and federal requirements, and hold a valid written agreement with the OHCA.

To obtain additional information, go to www.okhca.org, select the Provider link, select OHCA Rules from the Policies & Rules link on the left side of the page when it appears and select Chapter 30.

Section B: PASRR

Preadmission Screening and Resident Review (PASRR) is a federal requirement to help ensure individuals are not inappropriately placed in nursing home for long-term care. PASRR requires all members entering SoonerCare-certified nursing facilities be screened for possible mental illness, intellectual disabilities or related conditions prior to admission.

Nursing facilities are required to complete form LTC-300R for all members entering the facility, regardless of pay source. Providers may also submit the LTC-300R electronically using the OHCA SoonerCare Provider Portal.

For additional information, go to www.okhca.org, select the Provider link, select OHCA Rules from the Policies & Rules link on the left side of the page when it appears and select Chapter 30.

Section C: ICF/IID Process

Pre-approval and final approval for medical eligibility of SoonerCare-certified members entering public and private ICF/IID are made by the Level of Care Evaluation Unit at OHCA. ICF/IID facilities are required to complete form LTC-300, as well as provide evidence of an intellectual disability or related condition and additional documentation of active treatment needs.
For additional information, go to www.okhca.org, select the Provider link, select OHCA Rules from the Policies & Rules link on the left side of the page when it appears and select Chapter 30.

Section D: Member Level of Care Appeals Process

By law, any member who feels adversely affected by any Preadmission Screening and Resident Review (PASRR) determination made by the OHCA regarding a preadmission screening or an annual resident review may request a fair hearing within 30 days from the date of notice of the PASRR result. The member or authorized agent may contact the county DHS office to request a fair hearing Form H-1 to initiate the appeals process.

Providers or physicians who would like to appeal a level-of-care decision may request the OHCA form LD-2 by contacting the OHCA Grievance Docket Clerk Legal Division at 405-522-7217.

For additional information on documentation standards, go to www.okhca.org, select the Provider link, select the OHCA Rules from the Policies & Rules link on the left side of the page when it appears and select Chapter 30.

Section E: Billing Considerations

Individuals requesting billing information regarding nursing facilities should refer to the Electronic Data Interchange and Billing Instructions chapters of this manual. Nursing facilities will use the UB-92 paper form, 837-I for electronic batch submission and/or Direct Data Entry through the OHCA SoonerCare Provider Portal for claim submission.

Verifying member eligibility and program eligibility is very important. Members in nursing facilities are excluded from enrollment in SoonerCare Choice. If a member is enrolled in SoonerCare Choice, they must be disenrolled from managed care after admission to a nursing facility or ICF-IID.
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Chapter 16: Indian Health Services

Introduction

In Oklahoma there are three (3) types of Indian Health facilities: Indian Health Service (IHS), Tribes and Urban Indian clinics. IHS is the federal agency responsible for providing health services to most American Indians and Alaska natives. Unlike SoonerCare, IHS is not an entitlement program. Instead, this provision of health care to American Indians and Alaska natives falls under the federal trust responsibility that recognizes the debt owed to Indian tribal governments. Eligibility for care at IHS, Urban Indian and Tribal facilities is usually determined under federal statute and regulation and depends largely (but not exclusively) on membership in a federally-recognized tribe.

Section A: SoonerCare Eligibility

As a matter of law, American Indians who meet SoonerCare eligibility standards are entitled to SoonerCare coverage. This applies to American Indians as it does to other American citizens. SoonerCare reimburses Indian Health providers for covered services provided to American Indian SoonerCare members. Indian Health is always the payer of last resort when an American Indian SoonerCare member is eligible for services through multiple payers such as Medicare, Medicaid and Indian Health.

Section B: Contract Health Services

Most IHS, Tribal and Urban Indian facilities provide basic health care services. When specialty services are needed, an Indian Health facility may authorize payment for contract health services. Contract health services are defined by IHS as “services not available directly from IHS or tribes that are purchased under contract from community hospitals and practitioners.” It is important to note that contract health services are usually purchased through a prior authorization arrangement. Since Indian Health is not an insurance company, it is not obligated to pay for health care services unauthorized by the facility.
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Chapter 17: Utilization Review

Utilization review activities required by the OHCA are accomplished through a series of monitoring systems developed to ensure that services are reasonable, medically necessary and of optimum quality and quantity. Members and providers are subject to utilization review. Utilization control procedures safeguard against

- Unnecessary care and services
- Inappropriate services and quality of care
- Inappropriate payment

Utilization Review Focus

Utilization review activities ensure the efficient and cost-effective administration of the OHCA by monitoring:

- Billing and coding practices
- Medical necessity
- Level of care validations
- Quality of care
- Documentation
- Misuse
- Overuse
- Reasonableness of prior authorization (PA)
- Other administrative findings

Federal Regulations

Title XIX of the Social Security Act, Sections 1902 and 1903, and regulations found in 42 CFR 456 mandate that utilization review of the OHCA services provide methods and procedures to safeguard against unnecessary use of care and services.

These federal regulations also require that the OHCA be able to identify and, if warranted, refer cases of suspected fraud or abuse to the Medicaid Fraud Control Unit of the Office of the Oklahoma Attorney General for investigation and prosecution. Utilization review guards against unnecessary medical care and services, and ensures that payments are appropriate according to the coverage policies established by the OHCA.
Utilization Review Monitoring

DXC Program Integrity System

The Program Integrity Subsystem of the Oklahoma interChange (iCE) MMIS provides the OHCA Program Integrity Unit with a comprehensive solution for identifying and tracking fraud and abuse within the Medicaid program.

J-SURS

The Truven Health Analytics, Surveillance and Utilization Review System (J-SURS) is used to help identify patterns of inappropriate care and services. Use of this system enables the OHCA to develop a comprehensive profile of any unusual pattern of practice and reveals suspected instances of fraud or abuse in the SoonerCare (Medicaid) program. The Utilization Review program is a useful tool in detecting the existence of any potential defects in the level of care or services provided under the SoonerCare program.

PI Case Tracker

The PI Case Tracker provides the ability to document and monitor all OHCA audits. This component allows the user to create multiple types of cases, create and track documentation throughout the review process, from initial audit to appeal, and finally financial recoupment of any outstanding monies owed back to the state.

Section A: Provider Utilization Review

Fraud Defined

Fraud is an intentional deception or misrepresentation made by the provider or member, which could result in an unauthorized benefit such as an improper payment to a SoonerCare provider. Some examples of fraud are:

- Altering a member’s medical records to generate fraudulent payments
- Billing for services or supplies not rendered or provided
- Soliciting, offering or receiving a kickback, bribe or rebate
- Submitting claim forms inappropriately altered to obtain higher reimbursement
Abuse Defined

The term abuse describes incidents or practices of the OHCA providers that, although not usually considered fraudulent, are inconsistent with accepted sound medical, business or fiscal practices. These practices can result in unnecessary costs to the OHCA, improper payment, or payment for services that fail to meet recognized standards of care or are medically unnecessary. Some examples of abuse are:

- Billing and receiving payment from an OHCA member for the difference between the provider charge and the OHCA reimbursement for the service
- Submitting claims for services not medically necessary in relation to a member’s diagnosis
- Excessive charges for services or supplies
- Violation of any of the provisions of the provider agreement

Record Retention

For more information on record retention, go to www.okhca.org, select the More Options link from the Providers section (see screen sample below), and then select the OHCA Rules link under Policies & Rules at left. Select the Chapter 30 link once the page opens, and then scroll down to Sections 317:30-3-4.1 and 317:30-3-15. Specific provider policy sections may be referenced for any additional requests.
Section B: Member Utilization Review

When member utilization review identifies a member who might be using SoonerCare services more extensively than his/her peers, the member can be placed on a Lock-In/Restricted Services Program. Visit www.okhca.org, select the More Options link in the Providers section, and then select the OHCA Rules link under Policies & Rules at left. Select the Chapter 30 link once the page opens, and then scroll down to Section 317:30-3-14 to obtain more information on member lock-in.

Identification of Lock-In Members

Restricted data are available from the following areas:

- Eligibility Verification System (EVS)/Automated Voice Response (AVR) at 800-767-3949 or 405-840-0650
- Swipe card device
- The SoonerCare Provider Portal

If the member is restricted, the EVS/AVR, SoonerCare Provider Portal or swipe-card device will list those restrictions. In addition to the restricted program guidelines, all other OHCA guidelines, such as prior authorization (PA) requirements, must be followed.

For questions about the Lock-In program, please contact the pharmacy help desk at 800 522-0114, option 4. The PHARM-16 (Pharmacy Lock-In Referral form) is located on the Pharmacy Forms page at www.okhca.org/provider/types/pharmacy/pharmacy_forms.asp
Section C: Utilization Review Trends

Fraud and abuse of the SoonerCare system costs taxpayers millions of dollars each year. Responsible Oklahomans need to work together to prevent fraud and abuse, and to ensure that the SoonerCare funds available are directed to those who truly deserve them.

The state relies on the health care provider community to be active participants in detecting, and deterring SoonerCare abuse and fraud. If abusive or fraudulent activities are suspected, providers are encouraged to contact one of the following offices:

Member Fraud

Department of Health and Human Services
The Office of Inspector General
Oklahoma City HOTLINE 800-784-5887
Tulsa HOTLINE 800-797-1780

Office of Inspector General (OIG) National Hotline

1-800-HHS-TIPS (800-447-8477)

Office of Inspector General

Department of Health and Human Services
Medicaid Fraud Control Unit
Attn: HOTLINE
330 Independence Ave., SW
Washington, DC 20201

Provider Fraud

Office of Attorney General
2300 North Lincoln Blvd., Suite 112
Oklahoma City, OK 73105
Phone: 405-521-4274
Tulsa Office: 918-581-2885

Program Integrity & Accountability

Oklahoma Health Care Authority
4345 North Lincoln Blvd.
Oklahoma City, OK 73154-0299
Phone: 405-522-7421
FAX: 405-530-3246
Section D: Administration Review and Appeal Process

Criminal Penalties
Section 1909 of the Social Security Act provides criminal penalties for providers or members who make false statements or representations or intentionally conceal facts in order to receive payments or benefits. These penalties apply to kickbacks, bribes and rebates to refer or induce purchase of SoonerCare compensable services. The penalties also apply to individuals who knowingly and willfully charge members the difference between billed amounts and the amount allowed by SoonerCare.

Basis for Sanctions
The OHCA may sanction a medical provider who has an agreement with the OHCA. To obtain more information on sanctions, go to www.okhca.org, select the More Options link under the Providers section, and then scroll down and select the OHCA Rules link under Policies & Rules at left. Select the Chapter 30 link once the page opens, and then scroll down to sections 317:30-3-18, and 317:30-3-19.

Appeals Procedures (excluding nursing homes and hospitals)
To obtain more information on appeals, go to www.okhca.org, select the More Options link in the Providers section, and then scroll down and select the OHCA Rules link under Policies & Rules at left. Select the Chapter 30 link once the page opens, and then scroll down to Section 317:30-3-20; 317:2-1-2.2 (Members appeals); 317:2-1-2.3 (other grievances).

Appeals Procedures for Long-Term Care Nursing Facilities
To obtain more information on long term care facility appeals, go to www.okhca.org, select the More Options link in the Providers section, and then scroll down and the OHCA Rules link under Policies and Rules at left. Select the Chapter 30 link once the page opens, and then scroll down to Section 317:30-3-21.
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Chapter 18: Quality Assurance and Improvement

Introduction

The Quality Assurance and Improvement Department of the Oklahoma Health Care Authority (OHCA) coordinates the quality assurance evaluation and improvement processes for all OHCA medical programs. These functions are accomplished through ongoing monitoring and evaluation of SoonerCare services and implementation of improvement initiatives to help ensure that SoonerCare beneficiaries receive appropriate and quality health care. This unit also coordinates the activities of the agency Quality Assurance Committee and provides technical support in developing and reporting federally required quality assurance/improvement activities of the agency.

The Quality Assurance and Improvement requirements of OHCA are completed through a variety of monitoring and evaluation activities to ensure the health care services provided to SoonerCare members meet quality standards as well as program requirements.

Quality Assurance and Improvement activities include:

- monitoring of utilization for the various SoonerCare programs;
- on-site provider audits for the evaluation of contract compliance;
- investigation of member and provider complaints; and development and monitoring of quality improvement studies

Section A: Provider Utilization Review

State Medicaid agencies are required by federal regulations to provide methods and procedures to safeguard against unnecessary utilization of care and services, and to assure efficiency, economy and quality of care. To meet the requirements of the federal regulations, the OHCA contracts with a Quality Improvement Organization (QIO) to conduct medical and utilization reviews. Telligen serves as the contracted QIO for the OHCA. The Quality Assurance and Improvement department provides oversight of the QIO contract and works with the contracted QIO.

Federal regulations and OHCA rules state that some Medicaid services are subject to utilization review by an external organization under contract with the OHCA. The QIO conducts a medical hospital random sample review on services provided to SoonerCare beneficiaries in the SoonerCare Traditional fee-for-service program. The purpose of the
The inpatient hospital utilization review program is to safeguard against unnecessary and inappropriate medical care rendered to SoonerCare beneficiaries. Federal regulations require medical services and/or records to be reviewed for medical necessity, quality of care, appropriateness of place of service and length of stay by the contracted organization. In addition to inpatient review, the QIO conducts a random sample review of hospital outpatient observation services to ensure the services meet specified guidelines.

OHCA rules state that the QIO conducts the administrative process for the providers it reviews. The process conducted by the QIO is the only administrative remedy available to providers and the decision issued by the QIO is considered by OHCA to be a final administrative decision. The final determination is not appealable to OHCA for any further administrative review. Following the final determination on a utilization review, OHCA will recoup the monies paid to the provider(s) associated with the review.

All inpatient and outpatient observation services are subject to QIO post-payment utilization review. These reviews are based on illness severity and treatment intensity. Hospitals and providers have the opportunity to present any and all documentation available to support the medical necessity of the provided services. If a denial determination is made by the QIO, a notice is issued to the facility and attending physician advising them of the decision and the time frame for submitting a reconsideration request. Additional information submitted with the reconsideration request will be reviewed by the QIO and a final decision on the reconsideration will be made by the QIO within the specified time frame. The provider(s) will be notified of that decision. Once the process is finalized, the QIO notifies OHCA of the decision. If the initial decision is upheld, the claim is processed for recoupment. If the review is denied and a refund from the hospital and physician is required, the SoonerCare member may not be billed for the denied services.

**Section B: On-Site Provider Audits**

The OHCA Quality Assurance and Improvement department conducts on-site provider audits on a routine basis for all SoonerCare Choice primary care providers. The purpose of these reviews is to assess contract compliance and provide education to providers on the SoonerCare program, contract requirements, EPSDT requirements, chart documentation and other topics. The unit staff provides information related to current performance improvement initiatives of the organization and referral assistance to other departments within the agency. It is the role of the Compliance Review Nurse to monitor the contract requirements. Prior to the review, a departmental staff member notifies the office staff and provider of the upcoming review. Once a review date is scheduled, the QA/QI staff sends a copy of the audit tool to the provider, including
information about the documents requested for the review. The randomly-
selected medical records list is sent in part to the provider prior to the on-
site audit; the remaining records list is provided at the time of arrival to the
on-site audit. Following the on-site review, the provider receives a written
audit report detailing the findings and any required follow-up action. If a
non-compliant area is identified, the QA/QI compliance team will work in
partnership with the contracted provider and additional OHCA staff to
establish an effective process to meet contract requirements.

Section C: Member or Provider Complaints

Quality Assurance and Improvement staff members conduct reviews and
follow-ups for potential quality of care issues. These cases are identified
by OHCA staff and are referred to the Quality Assurance and
Improvement department for review. When a referral is received, it is often
necessary to request records from the provider(s) identified in the referral
or through an analysis of claims related to the complaint.

Cases may also be identified by the contracted QIO through completion of
activities associated with contract requirements. Medical records and/or
additional information from the identified provider are requested to
complete the review of potential issues. OHCA staff may also refer
potential quality-of-care cases to the QIO for review and follow-up.

Section D: Quality Improvement Studies/Projects

OHCA conducts ongoing Quality Improvement studies. Some of these
studies are ad hoc in nature and developed in response to an identified
area of focus for improvement.

The completion of some studies requires review of the medical records
associated with the SoonerCare members selected in the sample. For
those studies, a request for a copy of each medical record needed for
review will be made by staff from the contracted QIO and/or by OHCA
staff. Providers are required to send requested records within the specified
time frame of the request. The Quality Assurance and Improvement
Department encourages any questions concerning the medical record
requests.

The Quality Assurance and Improvement Department participates as
support staff in various initiatives, such as prescription drug related deaths
of SoonerCare members.

The department has updated the medical home compliance review
scoring guide to improve preventive service measures and behavioral
health screening and treatment for the child and adult population.
Chapter 19: Forms

Updated versions of OHCA forms are located under the **Forms** subheading of the **Providers** section on the OHCA website ([www.okhca.org](http://www.okhca.org)) or at [www.okhca.org/providers.aspx?id=120](http://www.okhca.org/providers.aspx?id=120).
# Revision History

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<tr>
<td>6.0</td>
<td>2/14/2017</td>
<td>• Full manual update</td>
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<td>Publications</td>
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| 5.6     | 3/09/2015     | • Updates made to reflect new form (ADA 2012)  
• Chp.1 updated to reflect changes to  
  Quick Reference Guide. |        | Publications             |
| 5.5     | 01/09/2014    | • Global (Changed all screen shots  
  with “Care Management” on main the  
  menu to “Prior Authorizations”)  
• 5-42 (Account Initialization)  
• 5-46 (Performing a Claim Inquiry)  
• 5-49 (Prior Authorizations Page—  
  was Care Management Page)  
• 5-50 (Prior Authorization Inquiry)  
• 5-51 (Prior Authorization Summary  
  and Prior Authorization Notices)  
• 5-55 (Add Registered Clerk)  
• 6-73 (Direct Data Entry (DDE) Claim  
  Submission – Professional)  
• 6-77 (Removed DMH Contact  
  Source)  
• 6-113 (Direct Data Entry (DDE)  
  Claim Submission – Pharmacy (Including Compounds))  
• 6-115 -6-117 (Deleted Prior Auth#  
  Submitted, Dosage Form Description  
  Code, and Dispensing Unit Form  
  Indicator, Usual & Customary  
  Charge, Ingredient Drug Cost,  
  Diagnosis Code Type, Diagnosis  
  Code; changed DAW Code to  
  Dispense/Written and Dispensing  
  Fee to Total Chargers; changed  
  Rendering Provider NPI and  
  Rendering Provider Number  
  descriptions to display only)  
• 6-117 (Helpful Tips) | Changes made to  
  reflect user  
  acceptance testing  
  (UAT) changes. | Provider Portal Team |
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<td>5.4</td>
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<td>• Global (Updated misspellings and formatting)</td>
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<td>• Various – Added information about using the My Profile-Role Qualifiers from the billing agent user account, when the agent code is unknown.</td>
<td>Additional updates for the new SoonerCare Provider Portal DDI Enhancement</td>
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<td>• Various – Changed “ICD-9” to “ICD” and “ICD-9-CM” to “ICD-CM.”</td>
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| 5.1 | April 2013/February 2013 | Updated the following pages (sections):
| | |  | Updated for the new SoonerCare Provider Portal DDI Enhancement | Adrian Barron |
| 5.1 | April 2013/February 2013 | Updated the following pages (sections):
| | | • 2-15 (Medicaid on the Web/Secure Site) |
| | | • 4-34 (Secure Site Eligibility Verification) |
| | | • 4-38 (Accessing the Secure Website) |
| | | • 4-39 (Getting to the Secure Website) |
| | | • 4-43 (Broadcast Messages; was Global Messages) |
| | | • 4-43 (Main Page) |
| | | • 4-44 (Performing a Claim Inquiry) |
| | | • 4-45 (Resubmit Claim-Denied Claims Only and Void Claim-Paid Claims Only) |
| | | • 5-46 (Eligibility Page) |
| | | • 5-47 (Pricing Page, Prior Authorization Page, and Prior Authorization Submission) |
| | | • 5-48 (Prior Authorization Inquiry and Prior Authorization Summary) |
| | | • 5-49 (Prior Authorization Notices and Additional Tidbits for Successful Use) |
| | | • 5-51 (Trade Files Page) |
| | | • 5-55 (Mailbox Page) |
| | | • 5-56 (Help Page and Logout Page) |
| | | • 6-70 (Direct Data Entry (DDE) Claim Submission – Professional) |
| | | • 6-84 (Direct Data Entry (DDE) Claim Submission – Institutional) |
| | | • 6-97 (Direct Data Entry (DDE) Claim Submission – Dental) |
| | | • 6-107 (Direct Data Entry (DDE) Claim Submission – Pharmacy (Including Compounds)) |
| | | • Changed “ICN link” to “Claim ID” throughout. |
| 5.0 | February 2013 | N/A | Initial document based on previous Provider Billing and Procedures Manual | Publications Team |
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