



Medicaid On The Web

Training Guide

Revision History

Document Version Number	Revision Date	Revision Page Number(s)	Reason for Revision	Revisions Completed By
1.0	May 2003	All	New Manual	Publications
1.1	Nov. 2003	Various	Manual updates	Publications
1.2	Dec. 2003	Various	Procedure updates	Publications
1.3	May 2004	13-15	Added section on PA submission forms	Publications
1.4	Nov. 2004	1-14	Redaction	Publications
1.5	Sept. 2005	All	Web site update	Publications
1.6	March 2010	All	Manual Update	Publications

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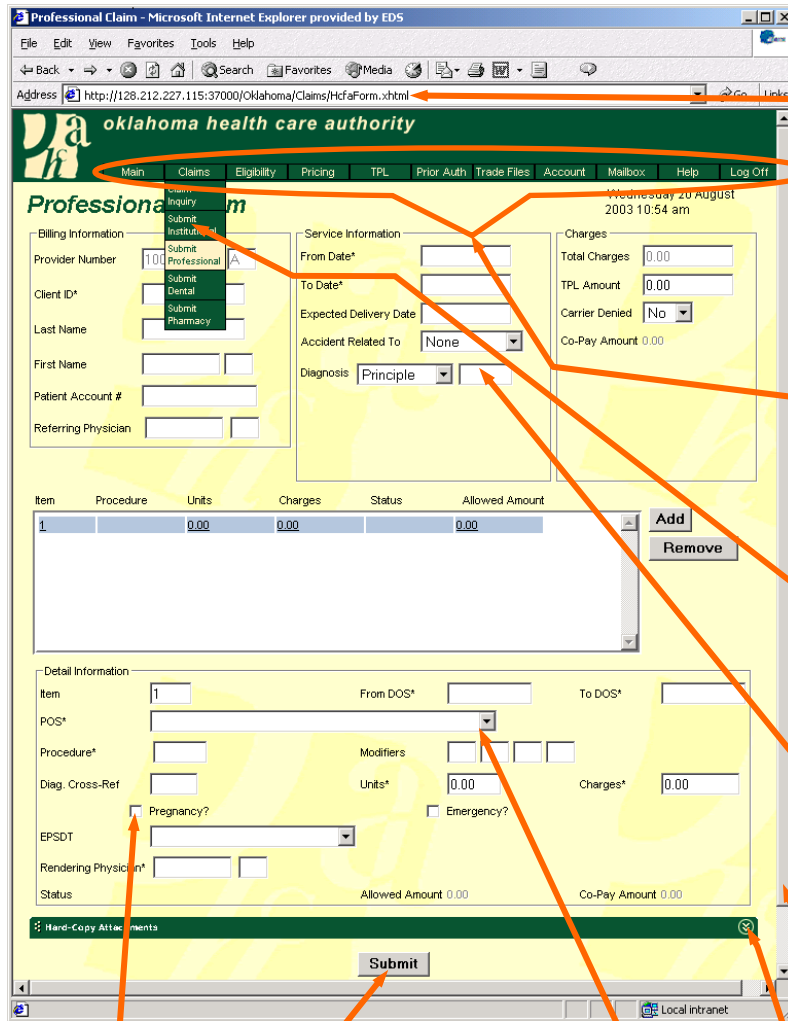
Web Basics

Fundamental instructions for Web page usage are listed below. Understanding basic usage of Web site elements will help users make the most of Medicaid on the Web. Use Windows Internet Explorer 6.0 or 7 (Currently will not support version 8).

Terms to Know:

Left click – The action of clicking the left button on the mouse to activate a function.

Cursor tool – This is the  icon, which mimics movement of the mouse to select page elements.



Address Field – Characters entered in this field make up an address specific to a Web page or screen, as it is also referred to. For example, entering www.okhca.org in this field and pressing the enter key will open the OHCA homepage.

Menu Bar – Links within each tab, when accessed, will open the related screen. To access a topic, place the Cursor tool on the desired Menu Bar option and left click on the selection. This opens the screen.

Drop-down menu – Some Menu Bar selections have a sub-section of menu choices. To open a screen, move the Cursor tool to the desired selection and left click.

Field – To enter information here, place the Cursor tool on the field and left click. Start typing when cursor appears in the field.

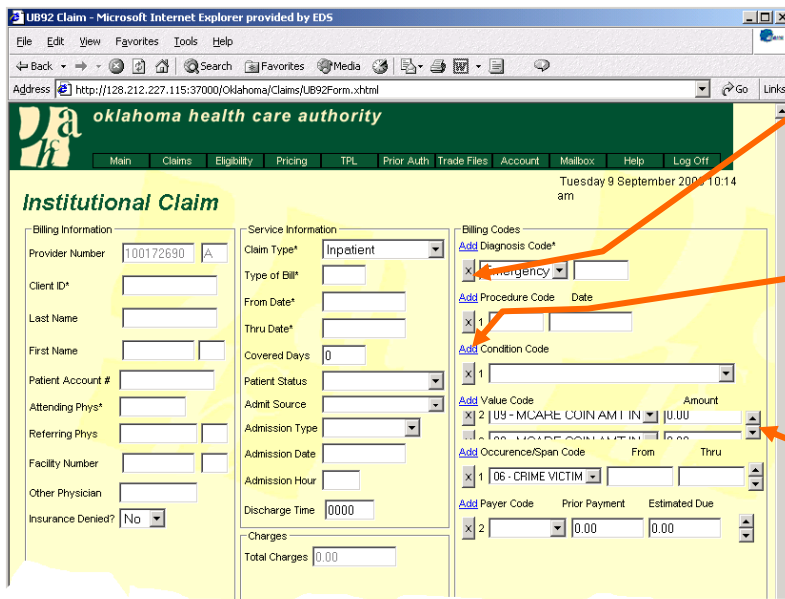
Scroll Bar – This allows the user to move the screen to view desired parts of the document. Place the Cursor tool on the bar, left click and hold the button, and move the mouse to scroll.

Check Box – Place Cursor tool on the box and left click so check mark populates the box.

Button – Place Cursor tool on the button and left click to activate the function.

Drop-down Field – Left click on the down arrow to display selections. Choose by moving Cursor tool on the desired selection and left click. The field will populate with that selection.

Down Arrow – Place Cursor tool on the arrow and left click to open the expanded document.



Delete button – This button is used to delete entered data. Place the Cursor tool on the delete button and left click to activate.

Add link – This allows the user to add entries into the adjacent field. With data entered, place the Cursor tool on the Add link and left click to activate.

Scroll buttons – These buttons appear when more than one selection has been made and are used to view those selections. Place the Cursor tool on either the up or down Scroll button, press and hold down the left button on the mouse. This will activate the scrolling action. Release the mouse button to stop scrolling.

Navigating Medicaid on the Web

The following tables contain detailed instructions for navigating Medicaid on the Web.

Global Notes:

- Required fields are marked with an * in this document and on the Web.
- All dates should be entered in MMDDYYYY format.
- Dollars and cents should be entered with a decimal point.
- Buttons are distinguished in this document by bold text.
- Fields are distinguished in this document by bold italic text.
- Links are distinguished in this document by bold underlined text.
- Pop-up blocker software must be turned off or set to allow pop-ups on this website to access the Agreement page and other important pop-up pages on this website.

Getting to the Web site
Type www.okhca.org into the <i>Address</i> field
Under the <i>Providers</i> Heading, click the OHCA Secure Sites link.
Click on the SoonerCare (Secure Site) link.

Initial login – Provider Level
Under ‘First Time Here’ enter the Provider ID number in the <i>Log on ID*</i> field (do not include the service location alphabet letter). (i.e. 123456789).
Enter the nine character PIN in the <i>PIN*</i> field. (Pin is case sensitive)
Click on the Log On button at the bottom of the screen.
An ‘Oklahoman Confidentiality Agreement’ page will appear. Read this data. At the bottom of the page are two buttons – I Agree and Reject . If you accept the agreement, click on the I Agree button and proceed. Otherwise, click on Reject and stop.
<i>Note: Pop-up blocker software must be turned off or set to ‘allow pop-ups’ on this Web</i>

Initial login – Provider Level
<i>site in order to access the Agreement page and other important pop-up pages on this Web site.</i>
You will be redirected to the Account Maintenance screen.
Enter a user name in the User Name* field. <i>(Must begin with a letter of the alphabet and consist of 6 to 12 characters.)</i> <i>Note: This field is case sensitive.</i>
Enter a password in the New Password* field. <i>(Must begin with a letter of the alphabet, consist 6 to 8 characters total and contain no fewer than two numeric characters.)</i> <i>Note: This field is case sensitive.</i>
Confirm the password by retyping it into the Confirm Password* field.
Enter your name in the Contact Name* field.
Enter an e-mail address in the E-Mail field.
Enter phone number in the Phone Number* field.
Click on the Submit button.
If all data is entered correctly, a pop-up notice will appear telling you that your data has been successfully saved. Click the OK button. <i>Note: This will take you to your mailbox. Click next for Main page with provider number and name.</i>

Note: After setting up your user name and password, future login attempts are done at 'Already a member?' by entering the user name in the User Name field and password in the password field.*

Creating a Clerk
Click on the <u>Account</u> tab from Provider main page and choose <u>Maintenance</u> .
Click the Create New Clerk button. A clerk creation screen will appear where the new clerk's information will be entered.
In the User Name* field create a <i>temporary</i> name (i.e. CLK12345). In the Contact Name* field enter the clerk's full name. In the Password* field enter a <i>temporary</i> password (i.e. CLK12345). <i>Note: The clerk will replace the generic user name and password with desired selections when they logon the first time.</i>
Select roles to be added to clerk's list from the menu field located right of the buttons. <i>Note: Hold down the Ctrl key to select multiple roles.</i>
Click on the Grant Role button when the desired roles are highlighted in the field. This selection will appear in the field at left.
Click on the Add All Roles button, if clerk needs access to all the roles on this list.
To delete a role from the list, highlight the role to remove and click the Cancel Role

Creating a Clerk
button.
Click on the Create Clerk button.
Click on the Save button once you're back on the Account page.
Select the Cancel button to exit the clerk creation process.

Note: Verify that the username and contact name are in the Provider Associations box.

Initial Logon for Clerk Level
Type www.okhca.org into the Address field.
Under the Provider header click the OHCA Secure Sites link, and then Click the SoonerCare Secure Sites link.
Under 'Already a member?' enter the <i>Temporary</i> user name in the User Name* field.
Enter the <i>Temporary</i> password in the Password* field.
Click on Log On under this area.
An 'Oklahoman Confidentiality Agreement' page will appear. Read this data. At the bottom of the page are two buttons – I Agree and Reject . If you accept the agreement, click on the I Agree button and proceed. Otherwise, click on Reject and stop.
The Account Maintenance screen will appear.
Enter a user name in the User Name * field. (Must begin with a letter and consist of six of 12 characters.)
<i>Note: This Field is case sensitive and must be different from Temporary User Name.</i>
Enter a password in the New Password* field. (The Password must have 6-8 characters total. The password must begin and end with an alpha character, and have two numerical characters. The numerical characters cannot be on the beginning or end of the password. Example: te23mp)
<i>Note: This Field is case sensitive and has to be different from Temporary Password.</i>
Confirm the password by retying it into the Confirm Password* field.
Enter an email address in the E-mail field
Enter phone number in the Phone Number* field
Fill in the two secret questions and answer fields.
<i>Note: Answers are Case Sensitive</i>
Click on the Submit button
If all data is entered correctly, a box will appear telling you that your data has been successfully saved. Click the OK button.
<i>Note: This will take you to a message page. Click next for the Main page with provider number and name.</i>

Editing Roles of an Existing Clerk
To change roles in an existing clerk's account, click the Account tab, choose Maintenance and highlight the desired clerk.
Click on the Edit Clerk Roles button. A small window will appear.

Use the same process as in creating the clerk to add and remove roles as desired.

Click on the **Update Clerk** button when selections are complete.

Click on the **Save** button once you're back on the Account page.

Granting Access to an Existing Clerk

Note: Clerk accounts only need to be created once.

If an existing clerk needs access to your provider accounts, you must log on and grant the clerk access. From the Provider Main page, click on **Account** and choose **Maintenance**.

Key the user name of the clerk you wish to grant access in the *User Name* field.

Note: This field is case sensitive

Click on the **Grant Access To** button.

Click on the **Edit Clerk Roles** button to add roles the clerk will have access to.

Click on the **Update Clerk** button when all selections are made.

Click the **Save** button when back on the Account page.

Note: This process must be followed for each provider account the clerk needs access to.

Revoking Access of a Clerk

If a clerk no longer needs access to your provider account, access needs to be disabled. Log in as the provider and click on the **Account** tab and choose **Maintenance**.

Highlight the user name in the Provider Associations box and click on the **Revoke Permissions** button.

Click the **Save** button once you're back on the Account page.

Allow third party to receive 835 Remittance Advice

If you need a third party (billing agent or other provider) to receive your 835 remittance advice report, log on and navigate to the account maintenance section by clicking on the **Account** tab at the top of the page.

Key the user name of the third party you wish to grant access in the *User Name* field.

Click the check box for **Designate User to Receive RA's**.

Click the **Grant Access To** button.

Click the **Save** button.

Note: If you authorize a third party to receive your electronic remittance advice (835), you will no longer receive a remittance advice (via paper or electronically) directly from OHCA. For more information on designating a thirty party to receive 835 files, call the EDI Help Desk at (405) 416-6801.

Global Messages

After logging in, any global messages you have will appear. After reading each message click on the **'Read'** check box. This will move the message to the mailbox for future reference until it is purged out when it expires.

After reading all messages click on the **Next** button.

Eligibility Inquiry
Click on the <u>Eligibility</u> tab.
Select the type of "lookup" desired from the drop-down box by executing a lookup by <u>MEMBER ID</u> , <u>SSN</u> and <u>DATE OF BIRTH</u> , <u>NAME</u> and <u>DATE OF BIRTH</u> , or by <u>CASE NUMBER</u> . Each option will require that you also enter a date-of-service (DOS) range of up to 13 months. The Calendar option to the right of each date field may be used for a fast selection of the date. For lookup by SSN or Name, the member's date of birth is also required.
Click on the Search button.
<i>Note: Status A indicates the electronic request for eligibility was accepted by OK Medicaid and is not the eligibility of the Member. The actual eligibility and benefit programs should appear below the status.</i>

Pricing
<i>The Pricing feature allows providers to look up detailed information on Procedure codes, Drug codes and DRG codes, such as the allowed amount, billing restrictions and prior authorization requirements.</i>
Click on Pricing Tab at the top. A disclaimer page will appear, if you agree to all terms of the agreement click on ' <i>I Accept</i> ' to go to the next page. If you do not agree, click ' <i>I do Not Accept</i> ' – if you do not accept you will be redirected to the Home page.
Click on the radio button in front of the Procedure, Drug or DRG code.
Click the Benefit Package dropdown button and select the benefit *
Enter the Date of Service in the MM/DD/YYYY format or use the calendar window option.
If applicable enter Modifiers and/or Age for more accurate results.
Click Search
Click on link provided to view pricing results. See pricing results example below:
Pricing Example
Procedure 90806: Title 19 Provider Type: Physician Provider Specialty: Family Practitioner Pricing and limitations for date of service 12/10/2009: <ul style="list-style-type: none"> • Allowed Amount: \$85.46 • No PA Required • Maximum Units: 1 • Age Restriction: 0 - 999 • Gender: Both • Attachment is Not Required • Not a Lifetime Procedure • Not restricted to any Diagnosis • Restricted to certain Specialty • Ambulatory Surgical Facility Fee: \$0.00 • Ambulatory Payment Classification Fee: \$0.00

- Discounted: NA

Note: Pricing results are based on the provider specialty, date of service selected, benefit package selected and/or modifier combination.

Claim Submission – Professional

From the Provider Main Page, click on the **Claim Submission** link to open the Claims screen and click on the **Professional** link here. Another option is to move the mouse pointer tool on the **Claims** tab to open the drop-down menu and select **Submit Professional**.

Billing Information Section

Your billing information, including NPI should be auto-populated for you. Confirm that it is correct. If it is not, you may need to log out and access the correct provider.

Enter the Member ID number in the **Member ID*** field.

Member Count – If applicable enter the member count. (DMHSAS providers only, based on Member ID).

Patient account number will be captured and appear on the remittance advice if entered into the **Patient Account #** field. (Optional field).

If claim being billed requires a referral from the PCP, enter the PCP’s NPI in the **Referring NPI** field.

Service Information Section

The Claim Type drop down field is automatically set to Professional. (*for information on submitting a Professional Crossover see page 8*)

The **From Date*** field is auto-populated from the detail section, please ignore.

The **To Date*** field is auto-populated from the detail section, please ignore.

If applicable, enter date into the **Expected Delivery Date** field (for pregnancy related services).

If claim is related to an accident, select accident type in the **Accident Related To** drop down menu (‘None,’ ‘Employment,’ ‘Auto,’ or ‘Other’).

Select appropriate diagnosis type in the **Diagnosis** field by clicking on the down arrow, highlighting the appropriate type and clicking on it. Then enter the diagnosis code(s). (without decimals)

Charges Section

The **Total Charges** field will be automatically populated from the detail section. *Do not enter charges here.*

If applicable, enter the third party liability paid amount in the **TPL Amount** field.

If the third party liability carrier denied coverage, click on the down arrow in the **Carrier Denied** field, highlight ‘Yes’ and click on it.

If claim is related to laboratory services (non-CLIA waved), enter the facility CLIA number in the **CLIA Number** field.

Claim Submission – Professional
Detail Information Section
The number the <i>Item</i> (line number) field is automated and not a manual data entry.
Enter the date(s) of service in the <i>From DOS</i> and <i>To DOS</i> fields.
Select the place of service code by clicking on the down arrow in the <i>POS*</i> field, highlighting the appropriate code, and clicking on it.
Enter the procedure code in the <i>Procedure*</i> field.
If applicable, enter modifiers codes in the <i>Modifiers</i> fields.
If applicable, enter the diagnosis cross-reference in the <i>Diag. Cross-Ref</i> field. <i>Note: If the claim has diagnosis codes, enter the numeric codes 1, 2, 3 or 4, (Do not use commas or dashes.) in order of importance corresponding with the diagnosis code(s) entered.</i>
Enter number of units billed in the <i>Units*</i> field.
Enter the dollar amount of charges in the <i>charges*</i> field. This action will automatically populate the <i>Total Charges</i> field.
If applicable, enter an NDC code in the <i>NDC*</i> field. (The National Drug Code [NDC] is an 11 digit number that must be in the format 00000-0000-00)
If, applicable, enter the Quantity in the <i>NDC Quantity*</i> field. <i>Note: When changing from liters to ml and mg to grams it must be rounded to the nearest 10th.</i>
If applicable, enter the UOM (unit of measure) in the <i>UOM*</i> field.
If claim is related to a pregnancy, click the checkbox for <i>Pregnancy?</i>
If claim is related to an emergency, click the checkbox for <i>Emergency?</i>
If claim is related to an EPSDT, enter the code in the <i>EPSDT</i> field by clicking on the drop-down field, highlighting the appropriate code and clicking on it.
If applicable, enter a contract source code in the <i>DMH Contract Source</i> field.
Enter the Rendering physician’s NPI number in the <i>Rendering NPI*</i> field. This is the person or entity that actually rendered the service and is not necessarily a physician.
If more items are to be billed on this submission, click the Add button next to the line item window and repeat process.
When finished, click on the Submit button.

Claim Submission – Professional Crossover
<i>Note: Please allow ample time for Medicare to crossover claims directly to Medicaid before filing crossovers on this website. The Medicare information that is needed for this claim type should be taken directly from the Medicare EOMB.</i>
From the Provider Main Page, click on the <u>Claim Submission</u> link to open the Claims screen and click on <u>Professional</u> . Alternatively, hover the mouse pointer over the Claims tab and from the drop-down menu and select <u>Submit Professional</u> .

Claim Submission – Professional Crossover	
<p>Under the Service Information Heading click on the Claim Type drop down menu and choose Crossover - Professional. (The Crossover Details section should now be visible)</p>	<p>Service Information</p> <p>Claim Type <input type="text" value="Crossover - Professional"/></p> <p>From Date <input type="text" value="Professional"/> <input type="text" value="Crossover - Professional"/></p> <p>To Date <input type="text"/></p> <p>Expected Delivery Date <input type="text"/></p> <p>Accident Related To <input type="text"/></p> <p>Diagnosis <input type="text" value="Principle"/> <input type="text"/></p>
<p>Under the Crossover Details Heading enter the Medicare Allowed Amount in the Allowed Medicare Amount*Field.</p>	<p>Crossover Details</p> <p>Allowed Medicare Amount <input type="text" value="0.00"/></p> <p>Deductible <input type="text" value="0.00"/></p> <p>Co-Insurance Amount <input type="text" value="0.00"/></p> <p>Psychiatric Services Amount <input type="text" value="0.00"/></p> <p>Medicare Payment Amount <input type="text" value="0.00"/></p> <p>Medicare Payment Date <input type="text"/></p>
<p>If applicable, enter the Deductible in the Deductible* Field.</p>	
<p>If applicable, enter the Co-Insurance Amount in the Co-Insurance Amount* field</p>	
<p>If applicable enter the Psychiatric Services Amount in the Psychiatric Services Amount* Field.</p>	
<p>Enter the Medicare Payment Amount in the Medicare Payment Amount* Field.</p>	
<p>Enter the Medicare Payment Date in the Medicare Payment Date*Field.</p>	
<p><i>Note: The remainder of the claim must still be completed as a Professional claim.</i></p>	

Claim Submission – Institutional
From the Provider Main Page, click on the <u>Claim Submission</u> link to open the Claims screen and click on the <u>Institutional</u> link here. Alternatively, hover the mouse pointer over the Claims tab and from the drop-down menu and select <u>Submit Institutional</u> .
Billing Information Section
Your Provider NPI should be auto-populated for you. Confirm that it is correct. If it is not, you may need to log out and access the correct provider.
Enter the Member ID number in the <i>Member ID*</i> field.
Patient account number will be captured if entered into the <i>Patient Account #</i> field. (optional field)
Enter the attending physician in the <i>Attending Physician NPI</i> field.
If the service was for a SoonerCare Choice member, enter the referring provider’s NPI into the <i>Referring Physician NPI</i> field.
If applicable, enter the <i>Facility NPI</i> number.
If applicable, enter any other physician <i>NPI</i> number in the <i>Other Physician NPI</i> field.
Select yes or no in the <i>Insurance Denied</i> drop-down field.
Select the appropriate type of claim in the <i>Claim Type*</i> drop-down field.
Service Information Section
Enter the three-digit Bill Code number in the <i>Type of Bill*</i> field. <ul style="list-style-type: none"> • First digit identifies Type of Facility. • Second digit identifies Level of Care. • Third digit identifies Frequency. See UB92 Uniform Codes www.nubc.org .
Enter the beginning date of service in the <i>From Date*</i> field.
Enter the end date of service in the <i>Thru Date*</i> field.
Enter the number of eligible days in the <i>Covered Days</i> field. This field is also applicable to Long Term Care. This is required on all Inpatient and Nursing Facility claims.
Select the patient’s current status in the <i>Patient Status</i> drop-down field.
Select the type of admission in the <i>Admission Type</i> drop-down field.
Enter the date of admission in the <i>Admission Date</i> field.
Use military time conversion in the <i>Admission Hour</i> field.
Enter discharge time using military time convention in the <i>Discharge Time</i> field.
Charges Section
The <i>Total Charges</i> field is automatically populated and manual input is not required.

Claim Submission – Institutional
Billing Codes Section
Select appropriate diagnosis type in the Diagnosis Code* drop-down field. Enter the diagnosis code(s). <i>Note: Do not use a decimal when entering the diagnosis code.</i>
If applicable, when submitting an inpatient claim select the Point of Admission (POA) code for each diagnosis code entered. (drop down menu)
Enter the appropriate four-digit ICD-9-CM procedure code and date in Procedure Code . Enter date in the Date field. <i>Note: See the volume 3 ICD-9-CM manual.</i>
If applicable, click on the drop-down arrow, highlighting the appropriate condition code in the Condition Code field.
If applicable, click the drop-down arrow, highlighting the appropriate value code affecting this claim in the Value Code field; enter a dollar amount (including decimal point).
If applicable, select the appropriate occurrence code in the Occurrence/Span Code drop-down field. Enter the dates in the From and Thru fields.
If applicable, select the appropriate payer code in the Payer Code drop-down field
If applicable, enter the dollar amount (including decimal point) in the Prior Payment field (the amount that has been received from a previous third party payer).
If applicable, enter the dollar amount due (including decimal point) in the Estimated Due field (the amount still due from Medicaid).
Detail Information Section
The number of the detail on the claim in the Item field is automated and not a manual data entry.
Enter the date in which the service performed started and ended in the From DOS* and To DOS* fields, respectively. <i>Note: This is automated but might need to be changed for this item.</i>
Enter the three-digit revenue code in the Revenue Code* field.
Enter the five-digit HCPCS code in the HCPCS/Rates field, if applicable.
If applicable enter the modifiers in the Modifiers field.
If applicable, enter an NDC code in the NDC Code* field. (The National Drug Code [NDC] is an 11 digit number that must be in the format 00000-0000-00)
If, applicable, enter the Quantity in the NDC Quantity* field. <i>Note: When changing from liters to ml and mg to grams it must be rounded to the nearest 10th.</i>
If applicable, enter the NDC UOM (unit of measure) in the UOM* field.
Enter the number of units billed at the detail level in Units* field.
Enter the amount billed in the Charges field.

Claim Submission – Institutional
Enter the co-pay amount in the <i>Co-pay</i> field (including decimal), if applicable.
The <i>Allowed Amount</i> field is automated and not a manual data entry.
The <i>Units Allowed</i> field is automated and not a manual data entry.
The amount of funds paid to an entity in the <i>Paid Amount</i> field is automated and not a manual data entry.
If additional items are to be billed on this submission, click the <i>Add</i> button (next to the line item window) and repeat the entry process in the Detail Information Section. Click the Delete button to delete a line entry.
Click the <i>Submit</i> button when finished.

Claim Submission – Crossover Institutional
<i>Note: Please allow ample time for Medicare to crossover claims directly to Medicaid before filing crossovers on this website. The Medicare information that is needed for this claim type should be taken directly from the Medicare EOMB.</i>
From the Provider Main Page, click on the <u>Claim Submission</u> link to open the Claims screen and click on the Institutional link. Another option is to move the mouse pointer tool on the Claims tab to open the drop-down menu and select <u>Submit Institutional</u> .
Under the Service Information Heading click on the <i>Claim Type</i> drop-down menu and choose the Crossover claim type. (The Crossover Details section should now be visible).

Service Information

Claim Type: Crossover - Professional

From Date: Professional

To Date: Crossover - Professional

Expected Delivery Date: [Text Box]

Accident Related To: [Text Box]

Diagnosis: Principle [Text Box]

Under the **Crossover Details** Heading enter the Deductible in the **Deductible*** field, if applicable.

Crossover Details

Allowed Medicare Amount: 0.00

Deductible: 0.00

Co-Insurance Amount: 0.00

Psychiatric Services Amount: 0.00

Medicare Payment Amount: 0.00

Medicare Payment Date: [Text Box]

Enter the co-insurance in the Co-Insurance* field, if applicable.
Enter the Blood deductible in the Blood Deductible* field, if applicable.
Enter the Medicare Payment Date in the field Medicare Payment Date*
To enter the Medicare payment information choose Medicare from the Add Payer Code field in the Billing Codes Section. Enter the dollar amount using two decimal points for cents in the Prior Payment field (the amount that has been received prior to this payment from the payer.) Enter the dollar amount due using two decimal points for cents in the Estimated Due field (the amount still due from Medicaid)
<i>Note: The remainder of the claim must still be filled out completely. To see screenshots of required fields for the Crossover Professional claim see Appendix A.</i>

Claim Submission – Dental
Click on the Claim button in the toolbar and then select Dental, OR hover the mouse pointer over the Claims tab, highlight the appropriate claim type (in this case ‘Submit Dental’) and click on it.
Billing Information Section
Your Provider NPI should be auto-populated for you. Confirm that it is correct. If it is not, you may need to log out and access the correct provider.
Enter the Member ID number in the Member ID* field. (The Patient’s name will automatically populate if the Member ID entered is found in the system).
The Patient Account #* field is optional and will be captured and passed back to you on the remittance advice if you enter it here.
The Insurance Denied? field refers to a primary insurance or other coverage. Was it denied? Yes or No.
Service Information Section
Specify whether the claim was an emergency by selecting Yes or No in the Emergency field.
The Accident field asks for selection of applicable type from the drop-down list.
The Place of Service* field requires selection of applicable type from drop-down list.
Populate the Rendering Provider NPI* field with the correct rendering provider NPI. <i>Please note, if the rendering provider has one NPI that is linked to more than one SoonerCare ID number then a 9 character zip code may be required</i>
The SC Rendering Provider field is for non-medical providers only.
Claim Charges Section
The Total Charges is auto-populated from the charges entered at the detail level. Do not type in this field.
TPL Amount: Enter total amount that has been paid by private insurance.
Detail Information Section
The number of the detail on the claim in the Item field is automated and not a manual

Claim Submission – Dental
data entry.
Enter the date of service into the <i>DOS</i> * field.
Enter the procedure code in the <i>Procedure</i> * field.
Enter tooth number in the <i>Tooth Number</i> field if the procedure is tooth specific.
Enter surface in the <i>Surface</i> field if the procedure is surface specific.
Choose the Quadrant, if applicable, from the options available in the <i>Prosthesis</i> field.
If applicable, enter modifiers codes in the <i>Cavity Code</i> fields.
Enter number of units billed in the <i>Units</i> * field.
Enter the total dollar amount of charges in the <i>Charges</i> * field for all units for this line of service.
If more items are to be billed on this submission, click the Add button next to the line item window and repeat process.
When finished, click on the Submit button.

Dental History Inquiry
From the Provider Main Page, click on the Dental Inquiry Link or hover over Claims and choose Dental Inquiry and click, you will be directed to the Treatment History page.
Enter the member’s SoonerCare number in the <i>Member ID</i> field.
The Date of Service field is auto populated with Past 1 year as the search criteria; you may choose a different span date by clicking the drop down button. (<i>Other options include Past 2 years, Past 3 years and Past 5 years</i>).
If applicable choose a tooth number.
If applicable enter a Procedure Code in the Procedure Code field.

Claim Submission – Pharmacy (Including Compounds)
Click on the <u>Claim Submission</u> link, OR hover the mouse pointer over the Claims tab, highlight the appropriate claim type, in this case ‘Pharmacy’ and click on it.
Billing Information Section
Your Provider NPI should be auto-populated for you. Confirm that it is correct. If it is not, you may need to log out and access the correct provider.
Enter the Member ID number in the <i>Member ID</i> * field. (The Patient’s Last Name and First Name will automatically populate if the Member ID entered is found in the system).
The <i>Prescriber NPI</i> field must be populated for claim to process.
The <i>Prescriber Name</i> field that correlates to the Prescriber ID above must be populated.
If applicable, (if the member was/is pregnant at the time the script was dispensed) change

Claim Submission – Pharmacy (Including Compounds)
the <i>Pregnancy Indicator</i> from No to Yes in this drop down menu.
If applicable, (if the script was written due to an emergency condition) change the <i>Emergency Indicator</i> field from No to Yes in this drop down menu.
If applicable, (if the member was/is at a nursing facility at the time the script was dispensed) change the <i>Nursing Facility Indicator</i> field from No to Yes in this drop down menu.
If applicable, (if another insurance carrier denied the current prescription) change the <i>Insurance Denied Indicator</i> from No to Yes in this drop down menu.
The <i>Rendering Provider</i> NPI is auto-populated and should be the same as the information in the Billing Information Section.
Prescription Information
Indicate in the <i>Claim Type</i> field (drop down menu - pharmacy claim or a compound).
Enter the prescription number in the <i>Prescription #</i> field
Enter the prescription date in the <i>Date Dispensed</i> field (date the prescription was dispensed by the pharmacy).
Enter the date prescribed in the <i>Date Prescribed</i> field (the date the prescription was prescribed by the physician).
If applicable, enter the number of refills in the <i>New/Refill</i> field. If there are no refills, or it is a new script, populate with 00.
Select the appropriate dispensing order by clicking <i>Dispense/Written</i> drop down menu and choosing the appropriate option. (Indicate if the script was dispensed as prescribed or other orders).
Enter the <i>Prior Auth #</i> field with applicable Prior Auth or Super PA for script. If no PA was obtained, leave this field blank.
Charges Section
Enter the <i>Total Charges</i> field with total amount being billed for all scripts in this submission.
Enter the <i>TPL Amount</i> field with amount paid on this claim by another insurance carrier before Medicaid. If no other insurance is involved or has paid on this claim, leave this field at 0.00.
DUR Overrides Section
If applicable, select the appropriate intervention used in the dispensing of the prescription using the <i>Intervention</i> drop down menu.
If applicable, select the appropriate intervention outcome using the <i>Outcome</i> drop down menu.
If applicable, select the conflict code that is to be overridden using the <i>Conflict Code</i> drop down menu.
Detail Information Section

Claim Submission – Pharmacy (Including Compounds)

Enter the applicable NDC for the prescription being billed in the *NDC Code* field.

Enter the quantity that is being dispensed in the *Quantity* field.

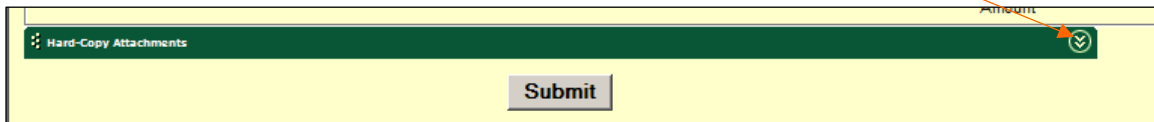
When finished, click on the **Submit** button.

Note: The Add and Remove buttons (enable the provider to add additional NDC codes on the same claim) are only viewable if the claim type is set to Compound Drug.

Hardcopy Attachment

Note: A hardcopy attachment cannot be added to a denied claim.

Providers can indicate that they are sending a claim attachment by using the Hard Copy Attachment window. From the claim submission screen, click on the down arrow on the Hard-Copy Attachments bar. (green bar located directly above the Submit button)



Enter the attachment control number in the *Attachment Control Number* field.

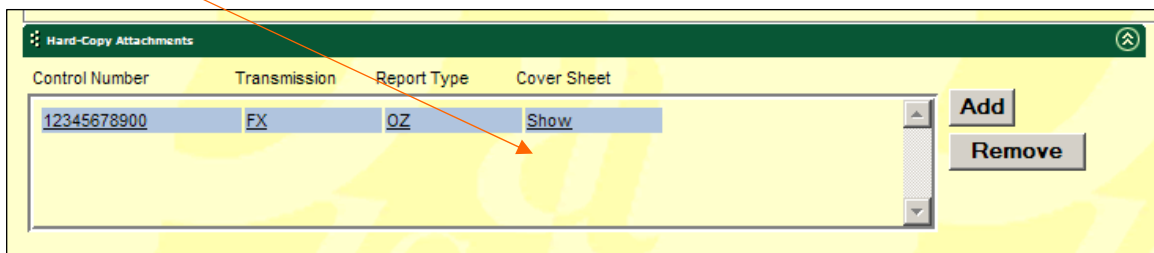
Note: ACN is a unique number that the provider creates for the attachment. It should be more the 6 characters in length.

Select the transmission code in the *Transmission Code* drop-down menu.

Select the *Report Type* code in the Report Type dropdown menu.

Free form text can be entered into the *Description* field (brief description of the attachment being sent).

Once all information is entered, a link entitled “Show” will be visible in the selection list box. Click on Show to view and print an Attachment Cover Sheet.



Click the **Submit** button when finished. *Note: A claim submitted successfully with an attachment will have a status of “Suspended” and will have an ICN number beginning with 23. (example: 2310678145603)*

Claim Inquiry

Click on the **Claim Inquiry** link or hover the mouse pointer over the **Claims** tab, highlight ‘Claim Inquiry’ and click on it.

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

To narrow search results, the **Claim Status** field can be set to ‘Any Status,’ ‘Denied,’ ‘Paid,’ ‘Suspended’ or ‘Resubmit’.

If the patient account number is known, it can be entered into the **Patient Acct. #** field.

Date type can be selected from the **Date Type** radio buttons  by single clicking inside of them; either ‘Date of Service’ or ‘Warrant Date’ can be selected.

If known, the internal control number can be entered in the **ICN** field (*if the ICN is known, all other fields can be left blank*).

The from date of service can be entered into the **From Date** field, and the through date of service can be entered into the **Thru Date** field.

Click on the **Search** button.

Resubmit Claim-Denied Claims Only

From the **Claim Inquiry** window (*see Claim Inquiry Section*) enter search criteria to locate the denied claim.

Click on the **ICN** link of the claim that needs correction.

When the claim window opens, change the information in the field containing the incorrect data, scroll down and click on the **Re-Submit** button.

Note: A hardcopy attachment can not be added to a denied claim.

Void Claim-Paid Claims Only

From the **Claim Inquiry** window (*see Claim Inquiry Section*) enter search criteria to locate the paid claim.

Click on the **ICN** link of the claim that needs to be voided.

When the claim window opens scroll down and click on the **Void** button. This will create an account receivable for the amount previously paid and this will be deducted from a future warrant. (*The only claims that may be voided are ones on which a warrant has been issued.*)

Copy Claim-Paid Claims Only and Resubmit

From the **Claim Inquiry** window (*see Claim Inquiry Section*) enter search criteria to locate the paid claim.

Click on the **ICN** link of the claim that needs to be Resubmitted.

When the claim window opens, click on **Copy Claim**. Make any changes to Member ID number, procedure codes, date of service etc., then click **Resubmit**.

PA Submission Form Entry Procedures

Submitting a prior authorization request on the secure website allows for the automatic generation of a prior authorization tracking number. (The HCA-12A and HCA13A are still required for consideration of PA requests) This generated PA# should be added to the HCA-13A coversheet.

Prior Authorization (PA) Submission

The following fields are to be populated by the Medical Authorization Unit or the system

PA Number - This will be populated automatically once the provider clicks the Submit button.

Requesting Provider - This field is automatically populated with the provider ID # that is logged on. (This can be a group #)

Media Type - This will always be Web.

Date Received - The date the PA is submitted.

Update Received - The date of any updates the PA Unit receives.

Date Mailed - The date the letter of PA status is mailed to provider.

Analyst - Person in the PA Unit that analyzes the PA.

Review Clerk - Clerk that reviews the PA information.

Entry Clerk - Clerk that entered PA information into the system.

Fund - Fund Code that is associated with PA.

Managed Care - PA Unit will choose No since Managed Care is no longer an option.

Header Section

(To be populated by the provider)

Member ID - Once the provider enters the member's Medicaid ID number and hits the "tab" key, the Date of Birth, Last Name, First Name and Middle Initial will automatically populate.

Servicing Provider – For medical providers, an NPI number is required (if applicable the 9 character zip code, contract code, and taxonomy code must exactly match what is entered on the HCA-12A) For non-medical providers the SC Servicing Provider field should be populated with the Oklahoma Medicaid ID.

Diagnosis - Enter the appropriate diagnosis code for the requested service (without decimals).

Assignment Code - Click on the drop down menu to select the provider type (the provider type of the servicing provider).

Line Item Details
Status – The PA will be in Evaluation status until the Medical Authorization Unit has conducted its review. After the review the status will change to Approved or Denied.
Service Type Code - Provider can choose to submit a PA with a procedure code, revenue code or NDC drug code. Click on the drop down menu to select an option.
Procedure/Revenue/NDC - Enter the appropriate procedure, revenue or NDC code.
Procedure Thru - Consecutive procedure codes may be requested on a PA. For example, to enter codes 99213, 99214 and 99215, enter the first consecutive procedure code in the Procedure field and the last consecutive procedure code in the Procedure Thru field.
Modifiers - Enter any modifiers for the requested code here.
Requested Effective Date and End Date - The requested begin and end date (or date span) for the prior authorization.
Units - The requested number of units.
Dollars - The dollar amount that is requested for services. <i>Note: this field may be left blank; the MAU will populate the Authorized Dollar amount.</i>
Tooth and Tooth Quad - Populated by Dentists. Fill out tooth number and tooth quadrant.
To add another procedure/revenue/NDC code, click on ‘Add’ button and complete the detail section for the new code.

Note: The Medical Authorization Unit will enter the authorized Effective and End Dates, Authorized Units and Dollars once the PA has been processed.

Prior Authorization Inquiry
From the Provider Main Page, click on the <u>Prior Authorization</u> link. Then click on the <u>Status Inquiry</u> tab or move the mouse pointer on the Prior Authorization tab to open the drop-down menu and click on Inquiry .
If you have the PA number, enter it in the <i>PA Number*</i> field.
If you do not have the PA number, you may search for the PA by entering the Member ID number in the <i>Member ID*</i> field. You may also wish to select the assignment code (optional) from the <i>Assignment Code*</i> drop-down to narrow the search results.
If a start date is known, a search can also be done by entering a date in the <i>Start Date</i> field or by choosing a date from the calendar function.
Click on the Search button.

Prior Authorization Notice
From the <u>Prior Authorization</u> drop-down menu choose and click <u>Notice</u> .
Enter one of the following search criteria:
<ul style="list-style-type: none"> • Member ID - to access recent PA notices submitted for a particular member.

- **Last Name, First Name** - to access recent PA notices submitted for a particular member.
- **PA Number** – to search for the notice related to a particular PA number.
- **Service Type** – (drop down menu) choose Procedure Code, NDC, Revenue Code or Procedure Code Group.
- **Search** – Click the search button after criteria have been entered to view search results. Alternatively, clicking the Search button with no other criteria will allow you to view all available PA notices under your provider number.

From Date, Through Date - the date fields are auto-populated with a 60-day date span.
Note: the website holds a 60-day rolling PA Notice history. For example, if the PA request was entered into the system on 01/01/10, the notice will not be available for online viewing after 03/02/10.

Notice Image (Search Results) – Click the PA number link to view and print the PA Notice.