



Medicaid Information
Technology System

Provider Medicaid Portal User Manual

Volume 7

Claims Submission

Version R5.0

September 23, 2011

This page intentionally left blank.

TABLE OF CONTENTS

1	Claims Submission	1
1.1	Additional Information about Common Codes.....	1
	Diagnosis – Codes.....	1
	Procedure Codes.....	1
	Place of Service Codes – Professional Claims.....	2
	DRG Codes	2
	NDC Codes.....	2
1.2	Submitting a Professional Claim	2
	Professional Claim Submission – Primary Panel.....	5
	Resolving Errors on a Professional Claim	9
	Submitting Professional Claim Attachments – Attachment Upload.....	10
	Submitting Professional Claim Attachments – Attachment Cover – Claim.....	11
	Suspended Professional Claim – EOB Panel.....	14
	Denied Professional Claim.....	16
1.3	Submitting an Institutional Claim	18
	Institutional Claim Submission – Primary Panel	20
	Resolving Errors on an Institutional Claim.....	26
	Submitting Institutional Claim Attachments – Attachment Upload	28
	Submitting Institutional Claim Attachments – Attachment Cover – Claim	29
	Suspended Institutional Claim – EOB Panel	32
	Denied Institutional Claim	32
1.4	Submitting Dental Claims	33
	Dental Claim Entry – Primary Panel.....	35
	Resolving Errors on a Dental Claim	38
	Submitting Dental Claim Attachments – Attachment Upload	40
	Submitting Dental Claim Attachments – Attachment Cover – Claim.....	41
	Suspended Dental Claim – EOB Panel.....	44
	Denied Dental Claim	44
2	Locating A Previously Submitted Claim.....	46
2.1	Claim Search Based on Provider ID.....	46
	Claim Search – Search	46
	Search Results – Claim Search	49
2.2	Detailed Claim Search	50
	Claim Search Detail – Search	50
	Search Results – Claim Search Detail	52
3	Working with Previously Submitted Claims	54
3.1	Resubmitting a Claim	54
3.2	Adjusting a Claim	54
3.3	Voiding a Claim	55
3.4	Copying a Detail Line on a Claim	56
3.5	Viewing a Pharmacy Claim	56
4	Trading Files With ODJFS	62

4.1 Attachment Uploads..... 62
4.2 Attachment Cover – Claim 63

1 CLAIMS SUBMISSION

When all necessary information has been entered in an electronic claim form, it is ready to be submitted for processing and reimbursement. As part of the submission process, the following tasks must be performed:

- Ensure all required information has been entered.
- Correct errors that the system may present.
- Submit attachments to the claim.

Note: Pharmacy providers who are enrolled with ODJFS to provide Medicaid services can only view their claims in this online application. To submit Medicaid claims, pharmacy providers should contact ODJFS at:

1-800-686-1516

Monday through Friday, 8:00 a.m. to 4:30 p.m.

1.1 Additional Information about Common Codes

Some Medicaid Information Technology System (MITS) subsystems use various reference codes as part of their data processing tasks. This section defines the most common reference codes and will provide links, where available, to comprehensive listings of these codes. These links connect to external Web sites on the public Internet, and may not work correctly if the owner of the Web site has changed the link.

Diagnosis – Codes

[ICD-9](#) (International Classification of Diseases, v. 9) code set includes diagnosis codes that describe the principal diagnosis or primary condition, and are maintained by the Centers for Medicare and Medicaid Services (CMS).

[ICD-9-CM](#) (Clinical Modification) diagnosis codes correspond to additional conditions that coexist at the time of diagnosis, or develop subsequently, and which have an effect on the treatment received or the length of stay.

Procedure Codes

[HCPCS](#) (Healthcare Common Procedure Coding System) are numeric codes that identify medical services and procedures. HCPCS is divided into three classifications:

Level I:

Level I HCPCS codes are comprised of the [CPT-4](#) (Current Procedural Terminology, 4th Edition) codes that describe medical procedures, and are copyrighted and maintained by the American Medical Association (AMA). These are 5-character codes for physician and non-physician services.

Level II:

Level II HCPCS codes identify products, supplies, and services. This classification is maintained jointly by CMS, the Health Insurance Association of America, and the Blue Cross and Blue Shield Association. These are 5-character codes for items and non-physician services not included with Level I codes.

This level also includes codes copyrighted by the American Dental Association's [CDT-5](#) (Current Dental Terminology, 5th Edition). These are 5-character codes in the D series for dental procedures.

Level III:

Level III HCPCS codes are developed by Medicare carriers for use at the local (carrier) level. These are 5-character in the W, X, Y or Z series representing physician and non-physician services that are not included in the Level I or Level II HCPCS codes.

The ICD-9 (International Classification of Diseases, v. 9) code set also includes [surgical procedure codes](#) that refer to diagnostic and surgical procedures.

Place of Service Codes – Professional Claims

[Place of Service](#) codes are required for professional claims to specify where a service was provided.

DRG Codes

[Diagnosis-Related Group \(DRG\)](#) codes refer to patient groups that have the same diagnoses, types of treatment, age, and other relevant criteria, and receive similar types of procedures. DRG codes are used for billing and reimbursement rates based on a set fee. These are 3-digit numeric codes.

NDC Codes

NDC (National Drug Code) codes identify the manufacturer of a drug, and the product and package size of all medications recognized by the Food and Drug Administration (FDA). These are 11-digit numeric codes.

1.2 Submitting a Professional Claim

The Professional Claim panel is used by the provider to enter required data and supplementary detail in order to:

- Submit a professional claim for reimbursement
- Correct denied claims for re-submission
- Adjust or void paid claims, or
- Copy an existing claim to create a new claim.

The Professional Claim page displays as follows.

Professional Claim: 8762470038 NPI - DEPARTMENT OF HEALTH

BILLING INFORMATION		SERVICE INFORMATION	
ICN	2210050600001	*Release of Information	INFORMATION ON FILE
Claim Type	M - CMS 1500 CLAIMS	From Date	11/01/2007
Provider ID	8762470038 NPI	To Date	11/01/2007
Medicaid Billing Number	6921985169	Signature Source	AUTH FOR HCFA-1500 BLOCK 13
*Date of Birth		Accident Related To	
Last Name		Accident State	
First Name, MI		Accident Country	[Search]
*Patient Account #		Accident Date	
Medical Record #		EPSDT Screening/ Family Planning	
Referring Provider #		Prior Authorization #	
*Medicare Assignment	ASSIGNED	Hospital Discharge Date	
Patient Amount Paid	\$1.00	Last Menstrual Period	
		TOTAL CHARGES	
		Total Charges	\$328.18
		Medicaid Allowed Amount	\$0.00
		TPL Paid Amount	\$0.00
		Total Medicaid Paid Amount	\$0.00
		Medicaid CoPay Amount	\$0.00
Notes			

Diagnosis

Sequence	Diagnosis Code	Description
A		

Type data below for new record.

delete add

*Sequence [] *Diagnosis Code [Search]

Other Payer

Last Name	First Name	MI	Date of Birth	Relationship	Gender	Policy ID	Paid Amount	Paid Date	Carrier Code
A							\$0.00		00001

Type data below for new record.

delete add

*Claim Filing Indicator [] *Insurance Carrier Name []

*Policy Holder Relationship to Insured [] *Carrier Code 00001

*Policy Holder Last Name [] Insured's Policy ID []

*Policy Holder First Name, MI [] *Payer Sequence []

Policy Holder Date of Birth [] Medicare ICN []

Gender []

*Paid Amount \$0.00

*Paid Date []

Allowed Amount \$0.00

Other Payer Amounts and Adjustment Reason Codes

The following panel is accessed via the sub-tabs at the bottom of the **Other Payer** header panel.

Other Payer Amounts and Adjustment Reason Codes (Carrier Code 00001)

CAS Group Code	Amount	ARC
A	\$0.00	

Type data below for new record.

delete add

*CAS Group Code []

Payer Line Level Amounts and Adjustment Reason Codes (ARC) *Amount/ARC \$0.00 []



Supporting Data for Delayed Submission / Resubmission	
<i>DISCLAIMER: Documentation to justify the use of this panel and data entered must be retained for future audit purposes.</i>	
Previously Denied ICN or TCN	<input type="text"/>
Claim Status Information	
Claim Status	Not Submitted yet

EOB Information				
Detail Number	EOB Code	EOB Description	ARC Code	ARC Description
0	1190	THE PAY TO PROVIDER IS AN ATYPICAL PROVIDER WHO REPORTED AN NPI TO OHIO HEALTH		
0	1191	THE RENDERING PROVIDER IS AN ATYPICAL PROVIDER WHO REPORTED AN NPI TO OHIO HEAL		
1	0155	PLEASE RESUBMIT WITH APPROPRIATE GROUP PROVIDER NUMBER IN CLINIC FIELD AND/OR I	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.

Professional Claim Submission – Primary Panel

The **Professional Claim** panel is comprised of the **Professional Claim**, **Diagnosis**, **Other Payer**, **Detail**, **NDC**, **Attachments**, **Supporting Data for Delayed Submission/Resubmission**, and **Claim Status** panels.

Professional Claim: 8984782436 NPI - JACK B DEWEY DDS PA	
BILLING INFORMATION	SERVICE INFORMATION
ICN	*Release of Information NOT ALLOWED TO RELEASE DATA
Claim Type M - CMS 1500 CLAIMS	From Date
Provider ID 8984782436 NPI	To Date
*Medicaid Billing Number <input type="text"/>	Signature Source <input type="text"/>
*Date of Birth <input type="text"/>	Accident Related To <input type="text"/>
Last Name	Accident State <input type="text"/>
First Name, MI	Accident Country <input type="text"/> [Search]
*Patient Account # 0	Accident Date <input type="text"/>
Medical Record # <input type="text"/>	EPSDT Screening/ Family Planning <input type="text"/>
Referring Provider # <input type="text"/>	Prior Authorization # <input type="text"/>
*Medicare Assignment NOT ASSIGNED	Hospital Discharge Date <input type="text"/>
Patient Amount Paid \$0.00	Last Menstrual Period <input type="text"/>
	TOTAL CHARGES
	Total Charges \$0.00
	Medicaid Allowed Amount \$0.00
	TPL Paid Amount \$0.00
	Total Medicaid Paid Amount \$0.00
	Medicaid CoPay Amount \$0.00
	Note Reference Code <input type="text"/>
	Notes <input type="text"/>

Tasks for this Panel

To **submit** the claim created in the Professional Claim panel:

1. Complete the relevant panels for the claim. See the following sections for detailed tasks to complete each panel.
2. Review the claim to ensure all **required** information has been entered, and is correct. Optional information should also be checked for accuracy. Refer to T4D027_Provider_Medicaid_Portal_User_Manual_Claims_Entry_06.doc.
3. Make sure all necessary **attachments and supporting documents**, if applicable, are ready to accompany the submission if being sent electronically. Hard-copy attachments can also be mailed.
4. Click the **submit** button.

5. If there are errors on the page, see the section **Resolving Errors on a Professional Claim**.

If the claim submission is successful, the Claim Status panel displays the status:

Claim Status Information	
Claim Status	Submitted

Field Descriptions – Professional Claim – Primary Panel

Field	Description	Field Type	Data Type	Length
Accident Country	Country in which accident occurred. Click [Search] to search for and select a country.	Field	Character	3
Accident Date	Date on which accident occurred.	Field	Date (MM/DD/CCYY)	10
Accident Related To	Indicates whether service was performed as result of an accident.	Field	Drop Down List Box	0
Accident State	State in which accident occurred.	Field	Drop Down List Box	0
Claim Type	Code that specifies the type of claim. Read-only.	Field	N/A	0
Date of Birth	Recipient's date of birth.	Field	Date (MM/DD/CCYY)	10
EPSDT Screening/Family Planning	Indicates whether the service is related to Child Health Check-Up.	Field	Drop Down List Box	0
First Name, MI	Recipient's first name and middle initial. Read-only.	Field	N/A	0
From Date	The beginning date of service for the claim. Read-only.	Field	N/A	0
Hospital Discharge Date	Date on which recipient was discharged from an inpatient hospital.	Field	Date (MM/DD/CCYY)	10
ICN	Claim's internal control number and, when present, the transaction control number from the Ohio MITS. Read-only.	Field	N/A	0
Last Menstrual Period	Last menstrual date.	Field	Date (MM/DD/CCYY)	10
Last Name	Recipient's last name. Read-only.	Field	N/A	0
Medicaid Allowed	Amount approved to pay for services	Field	N/A	0

Field	Description	Field Type	Data Type	Length
Amount	provided to a recipient. Read-Only.			
Medicaid Billing Number	Recipient's Medicaid identification number.	Field	Number	12
Medicaid Copay Amount (Claim)	Amount recipient is expected to pay for services rendered. Read-only.	Field	N/A	0
Medical Record #	Medical Record Number.	Field	Character	30
Medicare Assignment	Indicates whether or not Medicare assignment has been made.	Field	Drop Down List Box	0
Note Reference Code	Code identifying the type of note.	Field	Drop Down List Box	3
Notes	Additional notes for the claim.	Field	Character	80
Patient Account #	Patient's account number on the provider's system.	Field	Character	38
Patient Amount Paid	Amount the patient is responsible to pay.	Field	Number	9
Prior Authorization #	PA number that authorized the rendered services.	Field	Number	10
Provider ID	Identification number and service location of the provider. Read-only.	Field	N/A	0
Referring Provider #	Number that uniquely identifies the referring provider.	Field	Number	10
Release of Information	Release of information permission.	Field	Drop Down List Box	0
Signature Source	Indicates source of signature for release of information.	Field	Drop Down List Box	0
To Date	The ending date of service for the claim. Read-only.	Field	N/A	0
Total Charges	Total of charges from the detail line items. Read-only.	Field	N/A	0
Total Medicaid Paid Amount	Amount paid for this claim. Read-only.	Label	N/A	0
TPL Paid Amount	Total of TPL Amount from the detail line items. Read-only.	Field	N/A	0

Field Edits – Professional Claim – Primary Panel

Field	Field Type	Error Code	Error Message	To Correct
Accident Country	Field	0	Accident State or Country is required	Either Accident Country or Accident State must be completed when Auto Accident is selected in Accident Related To field.
Accident Date	Field	0	Accident Date is required	This field must be completed when Accident Related To is completed.
Accident State	Field	0	Accident State or Country is required	Either Accident State or Accident Country must be completed when Auto Accident is selected in Accident Related To field.
Date of Birth	Field	0	A valid Medicaid Billing Number and Date of Birth combination is required.	Enter a valid Medicaid billing number and date of birth.
Last Menstrual Period	Field	0	Last Menstrual Period must be less than or equal to Today.	Enter a date less than or equal to current date.
Medicaid Billing Number	Field	0	A valid Medicaid Billing Number is required.	This field must be completed.
Medicaid Billing Number	Field	1	Medicaid Billing Number is no longer active. The active ID 999999999 will be used.	This message is informational. The inactive ID has been automatically replaced with the active ID.
Medicaid Billing Number	Field	2	A valid Medicaid Billing Number and Date of Birth combination is required.	Enter a valid Medicaid billing number and date of birth.
Note Reference Code	Field	1	Note Reference Code is required.	Select a value from drop down.
Notes	Field	1	Notes are required.	Enter a description for Notes.
Patient Account #	Field	0	Patient Account # is required.	This field must be completed.
Patient Amount Paid	Field	1	Patient Amount Paid must be less than or equal to 999999.99.	Enter patient amount paid less than or equal to 999999.99
Provider ID	Field	0	Required.	This field must be completed.
Referring Provider #	Field	0	Referring Provider # is invalid.	Enter a valid referring provider number.

Field	Field Type	Error Code	Error Message	To Correct
Referring Provider #	Field	1	Referring Provider # must be either 7 or 10 digits.	Enter a valid 7 or 10 digits provider number.
Release of Information	Field	0	Release of Information Code is required.	This field must be completed.
Signature Source	Field	0	Signature Source is required.	This field must be completed.

Resolving Errors on a Professional Claim

If information is entered in a panel field that is incorrect in some way, or missing when it is required information, an error message is displayed by the system when an action of 'submit' is performed. When an error message associated with a field is presented, information about how to resolve it is offered by the system.

The two methods for resolving errors are:

- Messages panel
- Error icons.

The following messages were generated: section shown below in this Claim panel displays error information. .

The following messages were generated:
From DOS is required.
Procedure is required.
A valid Place Of Service is required
A valid Procedure Code is required
Units must be greater than 0.
Charges must be greater than \$0.00.
A valid Medicaid Billing Number is required
A valid Medicaid Billing Number and Date of Birth combination is required.
Click here to view the Professional Claim Handbook

Each message in the panel is a link to the field to be corrected. Note that the last link on the error messages panel is a link to the Claim Handbook for this claim type.

To **correct** errors using messages panel:

1. Click on the **error link** to jump to the field with the error.
2. Make any necessary correction.
3. Return to the messages panel and continue making all necessary corrections.
4. Click the **submit** button at the bottom of the Claim panel again. When the claim has successfully been submitted, this status will display in the **Claim Status** panel:

Claim Status Information
Claim Status Submitted

Error icons provide an alternate approach to resolving submission errors. Look for the  icons on the claims panels. When a claim is submitted, if the system detects any errors on the claim,

the  icon will appear next to any fields that require correction. Clicking on this icon opens a Help page for assistance with correcting the error.

Tasks for this Panel

To **correct** errors using error icons:

1. Click on the **error icon** . An **Online Help** page opens with instructions about how to correct the information in the field.
2. Make any necessary corrections.
3. Click the **submit** button again. When the claim has successfully been submitted, this status will display in the **Claim Status** panel:

Submitting Professional Claim Attachments – Attachment Upload

When the submission has been successful, the function for uploading attachments to the claim becomes available in the Hard Copy Attachments panel.

Tasks for this Panel

To **submit** an electronic attachment, follow these steps:

1. Click the **add** button.
2. Select a **Type of Document** from the list.
3. Click the **Browse** button to select a file to upload.
4. Click the **Upload Attachment** button.

Field Descriptions – Professional Claim – Attachments

Field	Description	Field Type	Data Type	Length
add	Inserts a new record in the Diagnosis, Other Payer/Crossover, Detail, or Hard-Copy Attachments panel. Proper permissions are required to perform an add.	Button	N/A	0
delete	Deletes the selected record from the Diagnosis, Other Payer/Crossover, Detail, or Hard-Copy Attachments panel. Proper permissions are required to perform a delete.	Button	N/A	0
Transmission Type	Defines the transmission method (fax, mail, upload) by which attachments are to be sent.	Field	Drop Down List Box	0
Type of Document	The code indicating the title or contents of a document, report, or supporting item.	Field	Drop Down List Box	0
Transmission Type (List)	Defines the transmission method (fax, mail, upload) by which attachments are to be sent.	Listview	Character	1
Type of Document (List)	The code indicating the title or contents of a document, report, or supporting item.	Listview	Character	1

Submitting Professional Claim Attachments – Attachment Cover – Claim

The electronic document attachment cover sheet for claim submission is shown below.

EDMS COVER SHEET

Name: Date: No. of Pages: (Including this cover sheet)

Phone:

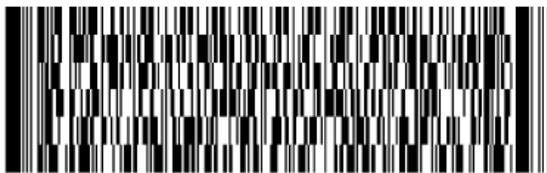
Document Type:

- Provider Recipient Correspondence Prior authorization Supporting documents for claim
 Accounts receivable Payment deduction Expenditure Hospital cost settlement
 LTC cost settlement Declaration of election of hospice benefit Attending physician written certification
 Revocation of hospice benefit Statement of termination of hospice benefit
 Selection of a different hospice provider IDG written certification Programs
 RetroDUR profile RetroDUR survey RetroDUR reports RetroDUR other documents

Sub Categories for Prior Authorization Documents

- Compression Garments Decubitus Care Equipment Dental Dressings, Surgical
 Enteral Nutrition & Supplies EPSDT Hospital Beds Hospital Inpatient Hospital Outpatient Hearing Aids
 Incontinence Supplies Increased State Plan Home Health Misc Equipment Orthodontics Orthotics (MTA)
 Orthotics/Prosthetics (Nurses) PDN Repairs Respiratory (MTA) Respiratory (Nurses)
 Supplies (Misc) Speech Generating Devices Transportation Therapies Vision Wheelchairs Others

Index Field & Values (if applicable):

ATN:	Recipient ID:	Prior Authorization Number:
<input type="text"/>	<input type="text"/>	<input type="text"/>
NPI:	Medicaid Provider ID:	
<input type="text"/>	<input type="text"/>	<i>Use only if you do not have NPI.</i>
ICN:	Contact Tracking Number:	
<input type="text"/>	<input type="text"/>	
Financial Record Number:	Status:	Program Control Number:
<input type="text"/>	<input type="text"/>	<input type="text"/>
Hospice Enrollment ID:	Hospice Attachment ID:	Intervention ID:
<input type="text"/>	<input type="text"/>	<input type="text"/>
		

Confidentiality Notice:

The sender of this facsimile transmission intends to communicate the contents of this transmission only to the Ohio Department of Job and Family Services. This transmission may contain information that is privileged, confidential or otherwise exempt from disclosure under applicable law. If you are not the designated recipient or the employee or agent responsible for delivering this transmission to the designated recipient, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If you have received this transmission in error, please notify us immediately by telephone at 1-800-686-1516 and promptly destroy the original transmission. Thank you for your assistance.

JFS 00000 (Rev. 06/10/2011 v2)

Ohio Department of Job and Family Services

To download a copy of this attachment cover sheet from the ODJFS Web site, click [here](#) (Ctrl key + click), or copy the following URL address and paste it into your browser's address field:

http://jfs.ohio.gov/OHP/providers/MITSEDMS_Cover_IT4.pdf.

Tasks for this Panel

To **add** Mail hard-copy attachments:

1. Press the **add** button.
2. The required fields for entering information display in the **Hard-Copy Attachments** panel.
3. Enter the Control Number. Select **Mail** for the **Transmission** value. Select a **Report Type** to describe the general content of the attachment.
4. Determine if additional attachments should accompany the claim.
5. If no additional hard-copy mail attachments are to accompany the claim, information entered for this panel is complete.
6. If no additional attachments will accompany the claim, it ready to submit.

To **add** an additional electronic attachment:

1. Press the **add** button.
2. The required fields for entering information display in the **Hard-Copy Attachments** panel.
3. Enter the **Control Number**. Select **Electronic Upload** for the **Transmission** value. Select a **Report Type** to describe the general content of the attachment.
4. Determine that no additional attachments should accompany the claim.
5. If no additional electronic attachments should accompany the claim, the claim is ready to submit.

To **delete** the current attachment information:

1. On a new claim or an adjudicated claim, select the detail row for deletion and press the **delete** button.
2. The message displays: **Are you sure this is the row you want marked for deletion?** Press **OK** to delete the row of Hard-Copy Attachment information entered in the panel.
3. Enter new attachment information, if desired.

Field Descriptions – Attachment Cover – Claim

Field	Description	Field Type	Data Type	Length
Claim ICN	The claim's internal control number.	Label	Number	13
Control Number	Control number assigned to the attachment for identification purposes.	Label	Number	80
Date of Service	Date of first service on the claim.	Label	Date (MM/DD/CCYY)	10
Medicaid ID	The recipient's Medicaid identification number.	Label	Alphanumeric	12
Patient Account #	The patient's account number on the Provider's system.	Label	Alphanumeric	38

Field	Description	Field Type	Data Type	Length
Provider ID	Identification number and service location of the provider.	Label	Alphanumeric	15

Suspended Professional Claim – EOB Panel

The Claim Status Information panel will display as in the following example for a suspended professional claim.

Claim Status Information				
Claim Status	SUSPENDED			
Claim ICN	00000000000000			
Paid Amount	\$0.00			
EOB Information				
Detail Number	EOB Code	EOB Description	ARC Code	ARC Description
0	0660	CALCULATED PAYMENT EQUALS ZERO. OTHER INS PAID MORE THAN MEDICAID ALLOWABLE.	42	Charges exceed our fee schedule or maximum allowable amount.
1	9998	CLAIM IS PENDING. CLAIM WILL APPEAR AS PAID OR DENIED ON A FUTURE REMITTANCE VO	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co
1	9918	PRICING ADJUSTMENT - MAX FEE PRICING APPLIED	147	Provider contracted/negotiated rate expired or not on file.
1	9999	PROCESSED PER MEDICAID POLICY	92	Claim Paid in full.

Tasks for this Panel

To **check** claim errors for resubmission:

1. Use information in the EOB information panel to identify and correct issues with the claim before resubmitting.

To **associate** a resubmitted claim with a previous claim:

1. Complete the **Previously Denied ICN or TCN** field.

Field Descriptions – Suspended Professional Claim – EOB Panel

Field	Description	Field Type	Data Type	Length
cancel	Cancels all changes applied to all panels on the page.	Button	N/A	0
resubmit	Submit modifications made to a denied claim for adjudication.	Button	N/A	0
ARC [Other Payer Amt & Adj Reason Codes Detail]	Code identifying the detailed reason the adjustment was made.	Field	Alphanumeric	5
Claim ICN	Internal control number that is assigned to the claim for identification purposes. Read-only.	Label	N/A	0
Claim Status	Adjudication status of the claim.	Label	N/A	0

Field	Description	Field Type	Data Type	Length
	Read-only.			
Paid Amount [Other Payer]	Amount paid by an Other Payer plan.	Field	Number	11
Paid Amount [Other Payer]	Paid Amount by Other Payer.	Listview	Number	11
Previously Denied ICN or TCN	Represents the previously denied ICN or TCN relating to a Provider for Claim Type Professional/Physician. Located on Delayed Submission/Resubmission panel.	Field	Number	18

Field Edits – Suspended Professional Claim – EOB Panel

Field	Field Type	Error Code	Error Message	To Correct
ARC [Other Payer Amt & Adj Reason Codes]	Field	1	ARC in Other Payer Amounts and Adjustment Reason Codes item [Other payer row number], row [Row Number] is required.	Enter an ARC Value
ARC [Other Payer Amt & Adj Reason Codes]	Field	2	ARC Value is used multiple times in Other Payer Amount and Adjustment Reason Codes Panel	Correct the ARC value
Paid Amount [Other Payer Detail]	Field	1	Paid amount in Other Payer Detail (Detail item number), row [row number] must be greater than or equal to zero.	Enter paid amount value greater than or equal to zero.
Paid Amount [Other Payer Detail]	Field	2	Paid Amount must be less than or equal to 9999999.99.	Enter a Paid Amount value less and or equal to 9999999.99.
Paid Amount [Other Payer]	Field	0	Paid Amount is required.	Enter a valid currency value on all claim details.
Paid Amount [Other Payer]	Field	1	Entry of Paid Amount or Paid Date is not allowed without non-Medicare Other Payer.	Clear the value for this field on all claim details.
Previously	Field	1	Previously Denied ICN or	Enter a valid "Previously

Field	Field Type	Error Code	Error Message	To Correct
Denied ICN or TCN			TCN is invalid	Denied ICN or TCN" - has to be for the same Provider and same Claim Type.

Denied Professional Claim

The Claim Status Information panel displays the current status of a claim as well as EOB reference information.

Claim Status Information	
Claim Status	DENIED
Claim ICN	2210050600001
Denied Date	
Paid Amount	\$0.00

Tasks for this Panel

To **resubmit** a denied claim:

1. Use information in the EOB information panel to identify and correct issues with the claim before resubmitting.
2. Click the **re-submit** button.

Field Descriptions – Denied Professional Claim – EOB Panel

Field	Description	Field Type	Data Type	Length
cancel	Cancels all changes applied to all panels on the page.	Button	N/A	0
resubmit	Submit modifications made to a denied claim for adjudication.	Button	N/A	0
ARC [Other Payer Amt & Adj Reason Codes Detail]	Code identifying the detailed reason the adjustment was made.	Field	Alphanumeric	5
Claim ICN	Internal control number that is assigned to the claim for identification purposes. Read-only.	Label	N/A	0
Claim Status	Adjudication status of the claim. Read-only.	Label	N/A	0
Paid Amount [Other Payer]	Amount paid by an Other Payer plan.	Field	Number	11
Paid Amount [Other Payer]	Paid Amount by Other Payer.	Listview	Number	11

Field	Description	Field Type	Data Type	Length
Previously Denied ICN or TCN	Represents the previously denied ICN or TCN relating to a Provider for Claim Type Professional/Physician. Located on Delayed Submission/Resubmission panel.	Field	Number	18

Field Edits – Denied Professional Claim – EOB Panel

Field	Field Type	Error Code	Error Message	To Correct
ARC [Other Payer Amt & Adj Reason Codes]	Field	1	ARC in Other Payer Amounts and Adjustment Reason Codes item [Other payer row number], row [Row Number] is required.	Enter an ARC Value
ARC [Other Payer Amt & Adj Reason Codes]	Field	2	ARC Value is used multiple times in Other Payer Amount and Adjustment Reason Codes Panel	Correct the ARC value
Paid Amount [Other Payer Detail]	Field	1	Paid amount in Other Payer Detail (Detail item number), row [row number] must be greater than or equal to zero.	Enter paid amount value greater than or equal to zero.
Paid Amount [Other Payer Detail]	Field	2	Paid Amount must be less than or equal to 9999999.99.	Enter a Paid Amount value less and or equal to 9999999.99.
Paid Amount [Other Payer]	Field	0	Paid Amount is required.	Enter a valid currency value on all claim details.
Paid Amount [Other Payer]	Field	1	Entry of Paid Amount or Paid Date is not allowed without non-Medicare Other Payer.	Clear the value for this field on all claim details.
Previously Denied ICN or TCN	Field	1	Previously Denied ICN or TCN is invalid	Enter a valid "Previously Denied ICN or TCN" - has to be for the same Provider and same Claim Type.

1.3 Submitting an Institutional Claim

The Claim Institutional panel is used by the provider to enter required data and supplementary detail so that an institutional claim can be submitted for reimbursement, to correct denied claims for re-submission, to adjust or void paid claims, and to copy a claim to create a new claim.

The **Institutional Claim** page displays as follows.

Institutional Claim: 8984782436 NPI - JACK B DEWEY DDS PA	
BILLING INFORMATION	SERVICE INFORMATION
ICN	*Release of Information NOT ALLOWED TO RELEASE DATA
Provider ID 8984782436 NPI	*From Date
*Type Of Bill [Search]	*To Date
Claim Type	Admission Date
*Medicaid Billing Number	Admission Hour
*Date of Birth	Admission Type
Last Name	Admit Source [Search]
First Name, MI	Discharge Hour
*Patient Account #	Patient Status [Search]
Medical Record #	*Covered Days 0
*Attending Physician #	Non Covered Days 0
Operating Physician #	Coinsurance Days 0
Other Physician #	Lifetime Reserve Days
	Prior Authorization #/ Precertification #
	TOTAL CHARGES
*Patient Amount Paid \$0.00	Total Charges \$0.00
	Total Non Covered Charges \$0.00
	Total Covered Charges \$0.00
	Medicaid CoPay Amount \$0.00
	Note Reference Code
	Notes

Condition ICD-9 Procedure Occurrence/Span Value

The following panel is accessed via the sub-tabs at the bottom of the **Institutional Claims** header panel.

Condition			
Sequence	Condition	Description	
A			
Type data below for new record.			
delete add			
*Sequence	[Search]	*Condition	[Search]

ICD-9 Procedure			
Sequence	ICD-9 Procedure Code	Description	ICD-9 Procedure Date
A			
Type data below for new record.			
delete add			
*Sequence	[Search]		
*ICD-9 Procedure Code	[Search]	ICD-9 Procedure Date	

Occurrence/Span				
Sequence	Occurrence Code	Description	From Date	To Date
A				
Type data below for new record.				
delete add				
*Sequence			*From Date	
*Occurrence Code	[Search]		To Date	

Value			
Sequence	Value	Description	Amount
A			0
Type data below for new record.			
delete add			
*Sequence			
*Value	[Search]	*Amount	0

Diagnosis			
Sequence	Diagnosis Code	Description	Present on Admission
A			
Type data below for new record.			
<input type="button" value="delete"/> <input type="button" value="add"/>			
*Sequence	<input type="text"/>	*Diagnosis Code	<input type="text"/> [Search]
Present on Admission	<input type="text"/>		

Other Payer									
Last Name	First Name	MI	Date of Birth	Relationship	Gender	Policy ID	Paid Amount	Paid Date	Carrier Code
A							\$0.00		00001
Type data below for new record.									
<input type="button" value="delete"/> <input type="button" value="add"/>									
*Claim Filing Indicator	<input type="text"/>			*Insurance Carrier Name	<input type="text"/>				
*Policy Holder Relationship to Insured	<input type="text"/>			*Carrier Code	<input type="text"/> 00001				
*Policy Holder Last Name	<input type="text"/>			Insured's Policy ID	<input type="text"/>				
*Policy Holder First Name, MI	<input type="text"/>	<input type="text"/>		*Payer Sequence	<input type="text"/>				
Policy Holder Date of Birth	<input type="text"/>			Medicare ICN	<input type="text"/>				
Gender	<input type="text"/>								
*Paid Amount	<input type="text"/> \$0.00								
*Paid Date	<input type="text"/>								
Allowed Amount	<input type="text"/> \$0.00								

Other Payer Amounts and Adjustment Reason Codes

The following panel is accessed via the sub-tabs at the bottom of the **Other Payer** and **Other Payer Detail** header panels.

Other Payer Amounts and Adjustment Reason Codes (Carrier Code 00001)		
CAS Group Code	Amount	ARC
A	\$0.00	
Type data below for new record.		
<input type="button" value="delete"/> <input type="button" value="add"/>		
*CAS Group Code	<input type="text"/>	
Payer Line Level Amounts and Adjustment Reason Codes (ARC)	*Amount/ARC	<input type="text"/> \$0.00 <input type="text"/>

Detail									
Item	Date of Service	Revenue Code	HCP/CS/HIPPS Rate Codes	Units	Total Charges	Non Covered Charges	Status		
A	1			0	\$0.00	\$0.00			
Type data below for new record.									
<input type="button" value="delete"/> <input type="button" value="add"/> <input type="button" value="copy"/>									
Item	1			*Units	<input type="text"/> 0				
Date of Service	<input type="text"/>			*Units Of Measurement	<input type="text"/>				
To DOS	<input type="text"/>			Per Diem Rate	<input type="text"/> \$0.00				
*Revenue Code	<input type="text"/> [Search]			*Total Charges	<input type="text"/> \$0.00				
HCP/CS/HIPPS Rate Codes	<input type="text"/> [Search]			Non Covered Charges	<input type="text"/> \$0.00				
Modifiers	<input type="text"/> [Search] <input type="text"/> [Search]			Medicaid Allowed Amount	<input type="text"/> \$0.00				
	<input type="text"/> [Search] <input type="text"/> [Search]			Status	<input type="text"/>				

NDC Other Payer - Detail

The following panel is accessed via the sub-tabs at the bottom of the **Detail** header panel.

NDC (Detail Item 1)						
NDC Sequence Number	NDC	Drug Name	Unit of Measure	Prescription Number	Drug Unit Price	Unit Quantity Submitted
A	1				\$0.00	0.000
Type data below for new record.						
<input type="button" value="delete"/> <input type="button" value="add"/>						
*NDC	<input type="text"/> [Search]		*Drug Unit Price	<input type="text"/> \$0.00		
Drug Name	<input type="text"/>		*Unit Quantity Submitted	<input type="text"/> 0.000		
*Unit of Measure	<input type="text"/>					
Prescription Number	<input type="text"/>					

Other Payer Detail (Detail Item 1)		
Carrier Code	Paid Date	Paid Amount
A		\$0.00

Type data below for new record.

delete

LINE LEVEL AMOUNTS AND ADJUSTMENT REASON CODES

*Carrier Code

*Paid Date

*Paid Amount

Other Payer Amounts and Adjustment Reason Codes - Detail

Other Payer Amounts and Adjustment Reason Codes - Detail (Select Detail Above)		
CAS Group Code	Amount	ARC
A		\$0.00

Type data below for new record.

delete

*CAS Group Code

Payer Line Level Amounts and Adjustment Reason Codes(ARC)

*Amount/ARC

Attachments		
Type of Document	Transmission Type	Description
A		

Type data below for new record.

delete

For attachments submitted via mail, not electronically attached, please send to the appropriate address. A button for printing a cover page and a button to view mailing addresses will appear after the claim has been submitted.

For documents transmitted via Upload, an upload button will appear after the claim has been submitted. Only file types of gif, tiff, bmp, jpg, ppt, doc, xls, pdf, txt, and mdi can be uploaded.

*Type of Document

*Transmission Type

Description

Supporting Data for Delayed Submission / Resubmission

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

Previously Denied ICN or TCN

Claim Status Information

Claim Status Not Submitted yet

EOB Information				
Detail Number	EOB Code	EOB Description	ARC Code	ARC Description
0	0308	INVALID DATE OF SERVICE	16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)

Institutional Claim Submission – Primary Panel

The Claim Institutional panel is used by the provider to enter required data and supplementary detail so that an institutional claim can be submitted for reimbursement, to correct denied claims for re-submission, to adjust or void paid claims, and to copy a claim to create a new claim.

Institutional Claim: 9984782436 NPI - JACK B DEWEY DDS PA	
BILLING INFORMATION	SERVICE INFORMATION
ICN	*Release of Information NOT ALLOWED TO RELEASE DATA
Provider ID 8984782436 NPI	*From Date
*Type Of Bill [Search]	*To Date
Claim Type	Admission Date
*Medicaid Billing Number	Admission Hour
*Date of Birth	Admission Type
Last Name	Admit Source [Search]
First Name, MI	Discharge Hour
*Patient Account #	Patient Status [Search]
Medical Record #	*Covered Days 0
*Attending Physician #	Non Covered Days 0
Operating Physician #	Coinsurance Days 0
Other Physician #	Lifetime Reserve Days
	Prior Authorization #/ Precertification #
	TOTAL CHARGES
*Patient Amount Paid \$0.00	Total Charges \$0.00
	Total Non Covered Charges \$0.00
	Total Covered Charges \$0.00
	Medicaid CoPay Amount \$0.00
	Note Reference Code
	Notes

Condition ICD-9 Procedure Occurrence/Span Value

Tasks for this Panel

To **submit** the claim created in the Institutional Claim panel, follow the steps below:

1. Review the claim to ensure all **required** information has been entered, and is correct. Optional information should also be checked for accuracy. Refer to T4D027_Provider_Medicaid_Portal_User_Manual_Claims_Entry_06.doc.
2. Make sure all necessary **attachments and supporting documents**, if applicable, are ready to accompany the submission if being sent electronically. Hard-copy attachments can also be mailed.
3. Click the **submit** button.
4. If there are errors on the page, see the section **Resolving Errors on an Institutional Claim**.

If the claim submission is successful, the Claim Status panel will display this status:

Claim Status Information
Claim Status Submitted

Field Descriptions – Institutional Claim Panel

Field	Description	Field Type	Data Type	Length
Admission Date	Date that the recipient was admitted by the provider for inpatient care, outpatient care, or start of care.	Field	Date (MM/DD/CCYY)	10
Admission Hour	Time the patient was admitted for	Field	Number	4

Field	Description	Field Type	Data Type	Length
	inpatient or outpatient care.			
Admission Type	Code that indicates the priority of the admission for inpatient or outpatient care.	Field	Drop Down List Box	0
Admit Source	Code that indicates why the patient was admitted for care. Click [Search] to search for and select an admit source code.	Field	Character	1
Attending Physician #	Attending Physician # is the identification number of the physician who would be expected to certify and recertify the medical necessity of the services rendered and/or who has primary responsibility for the patient's medical care and treatment.	Field	Number	10
Coinsurance Days	Number of coinsurance days for the statement period of the claim	Field	Number	4
Covered Days	Number of days covered for the statement period of the claim.	Field	Number	4
Date of Birth	Recipient's date of birth. Read-only.	Field	Date (MM/DD/CCYY)	10
Discharge Hour	Hour the patient was discharged from the facility.	Field	Number	4
First Name, MI	Recipient's first name and middle initial. Read-only.	Field	N/A	0
From Date	Date on which the statement period on the claim began.	Field	Date (MM/DD/CCYY)	10
ICN	Claim's internal control number and, when present, the transaction control number from the Ohio MITS. Read-only.	Field	N/A	0
Last Name	Recipient's last name. Read-only.	Field	N/A	0
Lifetime Reserve Days	Number of life time reserve days for the statement period of the claim	Field	Number	4
Medicaid Billing Number	Recipient's Medicaid identification number.	Field	Number	12
Medical Record #	Medical Record # is the Medical record number for this record.	Field	Number	30

Field	Description	Field Type	Data Type	Length
Non Covered Days	Number of days not covered for the statement period of the claim.	Field	Number	4
Note Reference Code	Code identifying the type of note.	Field	Drop Down List Box	3
Notes	Holds extra information about the claims.	Field	Character	80
Operating Physician #	Operating Physician # is the identification number of physician who performed services.	Field	Number	10
Other Physician #	Other Physician # is the identification number of another physician who performed services.	Field	Number	10
Patient Account #	Patient Account # is the Patient's account number on the provider's system.	Field	Number	38
Patient Amount Paid	Amount the patient is responsible to pay.	Field	Number	10
Patient Status	Code that indicates the status of the patient as of the ending service date for the period covered by the institutional claim. Click [Search] to search for and select a patient status.	Field	Number	2
Prior Authorization #/ Precertification #	Prior Authorization and precertification number for the recipient.	Field	Number	30
Provider ID	Identification number and service location of the provider. Read-only.	Field	N/A	0
Release of Information	Release of information permission.	Field	Drop Down List Box	0
To Date	Date on which the statement period on the claim ended.	Field	Date (MM/DD/CCYY)	10
Total Charges	Total of charges from the detail line items. Read-only.	Field	N/A	0
Type Of Bill	Code that indicates the specific type of facility and billing sequence. Click [Search] to search for and select a type of bill code.	Field	Number	4

Field	Description	Field Type	Data Type	Length
Claim Type	Type of claim	Label	N/A	0
Medicaid Copay Amount	Total of copay amount from the detail line items. Read-only.	Label	N/A	0
Total Charges	Dollar amount charged for the service provided.	Label	N/A	0
Total Covered Charges	Total of covered charges from the detail line items. Read-only.	Label	N/A	0
Total Non Covered Charges	Total of non-covered charges from the detail line items. Read-only.	Label	N/A	0

Field Edits – Institutional Claim Panel

Field	Field Type	Error Code	Error Message	To Correct
Admission Date	Field	2	Admission Date must be less than or equal to Today.	Ensure that the date is on or before today's date.
Admission Hour	Field	0	Admission Hour must be at least 2 characters in length.	Enter at least two digits.
Admission Hour	Field	1	Admission Hour is required.	Add a valid Admission Hour.
Admission Hour	Field	2	Admission Hour is not valid.	Enter a valid value for Admission Hour.
Admission Type	Field	1	Admission Type is required.	This field must be completed.
Admit Source	Field	1	Admit Source is required.	This field must be completed.
Attending Physician #	Field	0	Attending Physician # is required.	This field must be completed for Inpatient and Outpatient claim type.
Covered Days	Field	1	Covered Days is required.	This field must be completed.
Covered Days	Field	2	Total Charges must be greater than \$0.00 for at least one detail line.'	For Long Term Care Claims, at least one detail line must have Total Charges.
Date of Birth	Field	0	A valid Medicaid Billing Number and Date of Birth combination is required.	Enter a valid Medicaid Billing Number and date of birth.

Field	Field Type	Error Code	Error Message	To Correct
Discharge Hour	Field	0	Discharge Hour must be at least 2 characters in length.	Enter at least two digits.
Discharge Hour	Field	1	Discharge Hour is required.	This field must be completed.
Discharge Hour	Field	2	Discharge Hour is not valid.	Enter a valid value for Discharge Hour.
From Date	Field	0	From Date is required.	This field must be completed.
From Date	Field	2	From Date must be less than or equal to Today.	Ensure that the date is on or before today's date.
Medicaid Billing Number	Field	0	A valid Medicaid Billing Number is required.	This field must be completed.
Medicaid Billing Number	Field	1	Medicaid Billing Number is no longer active. The active ID 999999999 will be used.	This message is informational. The inactive ID has been automatically replaced with the active ID.
Medicaid Billing Number	Field	2	A valid Medicaid Billing Number and Date of Birth combination is required.	Enter a valid Medicaid Billing Number and date of birth.
Non Covered Days	Field	1	Non Covered Days is required.	Add Non Covered Days.
Non Covered Days	Field	2	Non Covered Charges must be greater than \$0.00 for at least one detail line when Non-Covered Days greater than 0.	For Long Term Care Claims when the Non Covered Days has a value, then at least one detail must have Non Covered Charges.
Note Reference Code	Field	1	Note Reference Code is required.	Select a value from drop down.
Notes	Field	1	Notes are required.	Enter a description for Notes.
Operating Physician #	Field	0	Operating Physician # must be either 7 or 10 digits.	Enter a valid 7 or 10 digits provider number.
Operating Physician #	Field	1	Operating Physician # is invalid.	Enter a valid provider number.
Other Physician #	Field	0	Other Physician # must be either 7 or 10 digits.	Enter a valid 7 or 10 digits provider number.
Other Physician #	Field	1	Other Physician # is invalid.	Enter a valid provider number.

Field	Field Type	Error Code	Error Message	To Correct
Patient Account #	Field	0	Patient Account # is required.	Add a valid Patient Account #.
Patient Amount Paid	Field	0	Patient Liability must be greater than or equal to \$0.00.	Ensure that the amount is not less than zero.
Patient Amount Paid	Field	1	Patient Amount Paid is required.	Enter the Patient Amount Paid.
Patient Status	Field	0	A valid Patient Status is required.	This field must be completed.
Patient Status	Field	1	Patient Status is required.	This field must be completed.
Patient Status	Field	2	Patient Status is invalid.	Enter a valid Patient Status.
To Date	Field	0	To Date is required.	This field must be completed for the header. The Occurrence/Span To Date is optional.
To Date	Field	2	To Date must be less than or equal to Today.	Ensure that the date is on or before today's date.
To Date	Field	3	To Date must be greater than or equal to From Date.	Ensure that the date is on or after From Date.
Total Charges	Field	2	Total Charges must be less than or equal to 999999.99.	Ensure the amount is not greater than \$999,999.99.
Type Of Bill	Field	0	A valid Type Of Bill is required.	This field must be completed.
Total Charges	Label	0	Charges must be greater than \$0.00.	Enter a valid charge amount.

Resolving Errors on an Institutional Claim

If information is entered in a panel field that is incorrect in some way, or missing when it is required information, an error message is displayed by the system when an action of 'submit' is performed.

The two methods for resolving errors are:

- Messages panel
- Error icons.

The following messages were generated: section shown below in this Claim panel displays error information. .

The following messages were generated:

Attending Physician # is required.
 Discharge Hour is required.
 From Date is required.
[Patient Account # is required.](#)
 To Date is required.
 A valid Diagnosis is required
 Sequence is required.
 A valid Type Of Bill is required
 A valid Revenue Code is required
 Units of Measurement is required.
 Invalid Revenue Code.
 Units must be greater than 0.
 Total Charges must be greater than \$0.00.
 A valid Medicaid Billing Number is required
 Release of Information Code is required.
 A valid Medicaid Billing Number and Date of Birth combination is required.
 A Principal Diagnosis is required.
 Covered Days is required.
[Click here to view the Institutional Claim Handbook](#)

Each message in the panel is a link to the field to be corrected. Note that the last link on the error messages panel is a link to the Claim Handbook for this claim type.

To **correct** errors using messages panel:

1. Click on the **error link** to jump to the field with the error.
2. Make any necessary correction.
3. Return to the messages panel and continue making all necessary corrections.
4. Click the **submit** button at the bottom of the Claim panel again. When the claim has successfully been submitted, this status will display in the **Claim Status** panel:

Claim Status Information

Claim Status Submitted

Error icons provide an alternate approach to resolving submission errors. Look for the  icons on the claims panels. When a claim is submitted, if the system detects any errors on the claim, the  icon will appear next to any fields that require correction. Clicking on this icon opens a Help page for assistance with correcting the error.

Institutional Claim: 8984782436 NPI - JACK B DEWEY DDS PA

BILLING INFORMATION	SERVICE INFORMATION
<p>ICN</p> <p>Provider ID 8984782436 NPI</p> <p>*Type Of Bill [Search]</p> <p>Claim Type</p> <p>*Medicaid Billing Number</p> <p>*Date of Birth</p> <p>Last Name</p> <p>First Name, MI</p> <p>*Patient Account #</p> <p>*Medical Record #</p> <p>*Attending Physician #</p> <p>Operating Physician #</p> <p>Other Physician #</p> <p>*Patient Amount Paid \$0.00</p>	<p>*Release of Information NOT ALLOWED TO RELEASE DATA</p> <p>*From Date</p> <p>*To Date</p> <p>Admission Date</p> <p>Admission Hour</p> <p>Admission Type</p> <p>Admit Source [Search]</p> <p>Discharge Hour</p> <p>Patient Status [Search]</p> <p>*Covered Days 0</p> <p>Non Covered Days 0</p> <p>Coinsurance Days 0</p> <p>Lifetime Reserve Days</p> <p>Prior Authorization #/ Precertification #</p> <p>TOTAL CHARGES</p> <p>Total Charges \$0.00</p> <p>Total Non Covered Charges \$0.00</p> <p>Total Covered Charges \$0.00</p> <p>Medicaid CoPay Amount \$0.00</p> <p>Note Reference Code</p> <p>Notes</p>

Condition ICD-9 Procedure Occurrence/Span Value

To correct errors using error icons:

1. Click on the **error icon** . An **Online Help** page opens with instructions about how to correct the information in the field.
2. Make any necessary corrections.
3. Click the **submit** button again. When the claim has successfully been submitted, this status will display in the **Claim Status** panel:

Claim Status Information

Claim Status Submitted

Submitting Institutional Claim Attachments – Attachment Upload

When the submission has been successful, the function for uploading attachments to the claim becomes available in the Hard Copy Attachments panel.

Attachments

Type of Document	Transmission Type
A	
Type data below for new record.	
<p>delete add</p> <p>For attachments submitted via mail, not electronically attached, please send to the appropriate address. A button for printing a cover page and a button to view mailing addresses will appear after the claim has been submitted.</p> <p>For documents transmitted via Upload, an upload button will appear after the claim has been submitted. Only file types of gif, tiff, bmp, jpg, ppt, doc, xls, pdf, txt, and mdi can be uploaded.</p> <p>*Type of Document</p> <p>*Transmission Type</p>	

Tasks for this Panel

To **submit** an **electronic** attachment, follow these steps:

1. Click the **add** button.

2. Select a **Type of Document** from the list.
3. Click the **Browse** button to select a file to upload.
4. Click the **Upload Attachment** button.

Field Descriptions – Institutional Claim – Attachments

Field	Description	Field Type	Data Type	Length
add	Inserts a new record in the Diagnosis, Other Payer/Crossover, Detail, or Hard-Copy Attachments panel. Proper permissions are required to perform an add.	Button	N/A	0
delete	Deletes the selected record from the Diagnosis, Other Payer/Crossover, Detail, or Hard-Copy Attachments panel. Proper permissions are required to perform a delete.	Button	N/A	0
Transmission Type	Defines the transmission method (fax, mail, upload) by which attachments are to be sent.	Field	Drop Down List Box	0
Type of Document	The code indicating the title or contents of a document, report, or supporting item.	Field	Drop Down List Box	0
Transmission Type (List)	Defines the transmission method (fax, mail, upload) by which attachments are to be sent.	Listview	Character	1
Type of Document (List)	The code indicating the title or contents of a document, report, or supporting item.	Listview	Character	1

Submitting Institutional Claim Attachments – Attachment Cover – Claim

The electronic document attachment cover sheet for claim submission is shown below.

EDMS COVER SHEET

Name: Date: No. of Pages: (Including this cover sheet)

Phone:

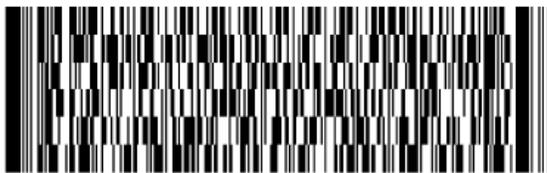
Document Type:

- Provider Recipient Correspondence Prior authorization Supporting documents for claim
 Accounts receivable Payment deduction Expenditure Hospital cost settlement
 LTC cost settlement Declaration of election of hospice benefit Attending physician written certification
 Revocation of hospice benefit Statement of termination of hospice benefit
 Selection of a different hospice provider IDG written certification Programs
 RetroDUR profile RetroDUR survey RetroDUR reports RetroDUR other documents

Sub Categories for Prior Authorization Documents

- Compression Garments Decubitus Care Equipment Dental Dressings, Surgical
 Enteral Nutrition & Supplies EPSDT Hospital Beds Hospital Inpatient Hospital Outpatient Hearing Aids
 Incontinence Supplies Increased State Plan Home Health Misc Equipment Orthodontics Orthotics (MTA)
 Orthotics/Prosthetics (Nurses) PDN Repairs Respiratory (MTA) Respiratory (Nurses)
 Supplies (Misc) Speech Generating Devices Transportation Therapies Vision Wheelchairs Others

Index Field & Values (if applicable):

ATN:	Recipient ID:	Prior Authorization Number:
<input type="text"/>	<input type="text"/>	<input type="text"/>
NPI:	Medicaid Provider ID:	
<input type="text"/>	<input type="text"/>	<i>Use only if you do not have NPI.</i>
ICN:	Contact Tracking Number:	
<input type="text"/>	<input type="text"/>	
Financial Record Number:	Status:	Program Control Number:
<input type="text"/>	<input type="text"/>	<input type="text"/>
Hospice Enrollment ID:	Hospice Attachment ID:	Intervention ID:
<input type="text"/>	<input type="text"/>	<input type="text"/>
		

Confidentiality Notice:

The sender of this facsimile transmission intends to communicate the contents of this transmission only to the Ohio Department of Job and Family Services. This transmission may contain information that is privileged, confidential or otherwise exempt from disclosure under applicable law. If you are not the designated recipient or the employee or agent responsible for delivering this transmission to the designated recipient, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If you have received this transmission in error, please notify us immediately by telephone at 1-800-686-1516 and promptly destroy the original transmission. Thank you for your assistance.

JFS 00000 (Rev. 06/10/2011 v2)

Ohio Department of Job and Family Services

To download a copy of this attachment cover sheet from the ODJFS Web site, click [here](#) (Ctrl key + click), or copy the following URL address and paste it into your browser's address field:

http://jfs.ohio.gov/OHP/providers/MITSEDMS_Cover_IT4.pdf.

Tasks for this Panel

To **add** Mail hard-copy attachments:

1. Press the **add** button.
2. The required fields for entering information display in the **Hard-Copy Attachments** panel.
3. Enter the Control Number. Select **Mail** for the **Transmission** value. Select a **Report Type** to describe the general content of the attachment.
4. Determine if additional attachments should accompany the claim.
5. If no additional hard-copy mail attachments are to accompany the claim, information entered for this panel is complete.
6. If no additional attachments will accompany the claim, it ready to submit.

To **add** an additional electronic attachment:

1. Press the **add** button.
2. The required fields for entering information display in the **Hard-Copy Attachments** panel.
3. Enter the **Control Number**. Select **Electronic Upload** for the **Transmission** value. Select a **Report Type** to describe the general content of the attachment.
4. Determine that no additional attachments should accompany the claim.
5. If no additional electronic attachments should accompany the claim, the claim is ready to submit.

To **delete** the current attachment information:

1. On a new claim or an adjudicated claim, select the detail row for deletion and press the **delete** button.
2. The message displays: **Are you sure this is the row you want marked for deletion?** Press **OK** to delete the row of Hard-Copy Attachment information entered in the panel.
3. Enter new attachment information, if desired.

Field Descriptions – Attachment Cover – Claim

Field	Description	Field Type	Data Type	Length
Claim ICN	The claim's internal control number.	Label	Number	13
Control Number	Control number assigned to the attachment for identification purposes.	Label	Number	80
Date of Service	Date of first service on the claim.	Label	Date (MM/DD/CCYY)	10
Medicaid ID	The recipient's Medicaid identification number.	Label	Alphanumeric	12
Patient Account #	The patient's account number on the Provider's system.	Label	Alphanumeric	38

Field	Description	Field Type	Data Type	Length
Provider ID	Identification number and service location of the provider.	Label	Alphanumeric	15

Suspended Institutional Claim – EOB Panel

The Claim Status Information panel will display as in the following example for a suspended institutional claim.

Claim Status Information				
Claim Status	SUSPENDED			
Claim ICN	00000000000000			
Paid Amount	\$0.00			
EOB Information				
Detail Number	EOB Code	EOB Description	ARC Code	ARC Description
0	0660	CALCULATED PAYMENT EQUALS ZERO. OTHER INS PAID MORE THAN MEDICAID ALLOWABLE.	42	Charges exceed our fee schedule or maximum allowable amount.
1	9998	CLAIM IS PENDING. CLAIM WILL APPEAR AS PAID OR DENIED ON A FUTURE REMITTANCE VO	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co
1	9918	PRICING ADJUSTMENT - MAX FEE PRICING APPLIED	147	Provider contracted/negotiated rate expired or not on file.
1	9999	PROCESSED PER MEDICAID POLICY	92	Claim Paid in full.

Tasks for this Panel

To **check** claim errors for resubmission:

1. Use information in the EOB information panel to identify and correct issues with the claim before resubmitting.

Field Descriptions – Suspended Institutional Claim – EOB Panel

See the Institutional Claim Submission - Primary Panel section.

Denied Institutional Claim

The Claim Status Information panel will display as in the following example for a denied institutional claim.

Claim Status Information				
Claim Status	DENIED			
Claim ICN				
Denied Date	04/30/2008			
Paid Amount	\$0.00			
EOB Information				
Detail Number	EOB Code	EOB Description	ARC Code	ARC Description
0	0308	INVALID DATE OF SERVICE	16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)

Tasks for this Panel

To **resubmit** a denied claim:

1. Make changes as indicated in the EOB Information panel.
2. Click the **re-submit** button.

Field Descriptions – Suspended Institutional Claim – EOB Panel

See the Institutional Claim Submission - Primary Panel

1.4 Submitting Dental Claims

The Claim Dental panel is used by the provider to enter required data and supplementary detail so that an dental claim can be submitted for reimbursement, to correct denied claims for re-submission, to adjust or void paid claims, and to copy a claim to create a new claim.

The **Dental Claim** page displays as follows.

Dental Claim: 8984782436 NPI - JACK B DEWEY DDS PA	
BILLING INFORMATION	SERVICE INFORMATION
ICN	*Release of Information <input type="text" value="NO"/>
Provider ID 8984782436 NPI	From Date
*Medicaid Billing Number <input type="text"/>	To Date
*Date of Birth <input type="text"/>	Emergency <input type="text"/>
Last Name	Accident Related To <input type="text"/>
First Name, MI	Accident State <input type="text"/>
*Patient Account # <input type="text" value="0"/>	Accident Country <input type="text" value="{ Search }"/>
Referring Provider # <input type="text"/>	Accident Date <input type="text"/>
Patient Amount Paid <input type="text" value="\$0.00"/>	EPSDT <input type="text"/>
	*Place of Service <input type="text" value="{ Search }"/>
	Prior Authorization # <input type="text"/>
	TOTAL CHARGES
	Total Charges \$0.00
	Medicaid Allowed Amount \$0.00
	TPL Paid Amount \$0.00
	Total Medicaid Paid Amount \$0.00
	Medicaid CoPay Amount \$0.00
	Note Reference Code <input type="text"/>
	Notes <input type="text"/>

Other Payer									
Last Name	First Name	MI	Date of Birth	Relationship	Gender	Policy ID	Paid Amount	Paid Date	Carrier Code
A							\$0.00		00001
Type data below for new record.									
delete		add							
*Claim Filing Indicator <input type="text"/>					*Insurance Carrier Name <input type="text"/>				
*Policy Holder Relationship to Insured <input type="text"/>					*Carrier Code <input type="text" value="00001"/>				
*Policy Holder Last Name <input type="text"/>					Insured's Policy ID <input type="text"/>				
*Policy Holder First Name, MI <input type="text"/>					*Payer Sequence <input type="text"/>				
Policy Holder Date of Birth <input type="text"/>					Medicare ICN <input type="text"/>				
Gender <input type="text"/>									
*Paid Amount <input type="text" value="\$0.00"/>									
*Paid Date <input type="text"/>									
Allowed Amount <input type="text" value="\$0.00"/>									

Other Payer Amounts and Adjustment Reason Codes

The following panel is accessed via the sub-tabs at the bottom of the **Other Payer** header panel.

Other Payer Amounts and Adjustment Reason Codes (Carrier Code 00001)		
CAS Group Code	Amount	ARC
A	\$0.00	
Type data below for new record.		
delete		add
*CAS Group Code <input type="text"/>		
Payer Line Level Amounts and Adjustment Reason Codes (ARC)		
*Amount/ARC	<input type="text" value="\$0.00"/>	<input type="text"/>

Detail							
Item	DOS	Procedure Code	Units	Tooth Number	Quadrant	Charges	Medicaid Allowed Amount
A	1		0			\$0.00	\$0.00

Type data below for new record.

delete add copy

Item 1 *DOS

*Procedure Code [Search] *Units 0

Tooth Number [Search] *Charges \$0.00

Quadrant [Search] Medicaid Allowed Amount \$0.00

Rendering Provider

Status

Other Payer - Detail

The following panel is accessed via the sub-tabs at the bottom of the **Detail** header panel.

Other Payer Detail (Detail Item 1)		
Carrier Code	Paid Date	Paid Amount
A		\$0.00

Type data below for new record.

delete add

LINE LEVEL AMOUNTS AND ADJUSTMENT REASON CODES

*Carrier Code

*Paid Date

*Paid Amount \$0.00

Other Payer Amounts and Adjustment Reason Codes - Detail

The following panel is accessed via the sub-tabs at the bottom of the **Other Payer Detail** header panel.

Other Payer Amounts and Adjustment Reason Codes (Carrier Code 00001)		
CAS Group Code	Amount	ARC
A	\$0.00	

Type data below for new record.

delete add

*CAS Group Code

Payer Line Level Amounts and Adjustment Reason Codes (ARC) *Amount/ARC \$0.00

Surfaces (Detail Item 1)
Surface
A

Type data below for new record.

delete add

*Surface

Attachments	
Type of Document	Transmission Type
A	

Type data below for new record.

delete add

For attachments submitted via mail, not electronically attached, please send to the appropriate address. A button for printing a cover page and a button to view mailing addresses will appear after the claim has been submitted.

For documents transmitted via Upload, an upload button will appear after the claim has been submitted. Only file types of gif, tiff, bmp, jpg, ppt, doc, xls, pdf, txt, and mdi can be uploaded.

*Type of Document

*Transmission Type

Supporting Data for Delayed Submission / Resubmission	
<i>DISCLAIMER: Documentation to justify the use of this panel and data entered must be retained for future audit purposes.</i>	
Previously Denied ICN or TCN	<input type="text"/>
Claim Status Information	
Claim Status	Not Submitted yet

submit cancel

EOB Information				
Detail Number	EOB Code	EOB Description	ARC Code	ARC Description
1	9918	PRICING ADJUSTMENT - MAX FEE PRICING APPLIED	A6	Prior hospitalization or 30 day transfer requirement not met.
1	6252	PROCEDURE CODE EXCEEDS UNITS OF SERVICE LIMIT	119	Benefit maximum for this time period or occurrence has been reached.

re-submit cancel

Dental Claim Entry – Primary Panel

The panel used for Dental Claim entry is designed for entering required data and supplementary detail. The Dental Claim entry panel is comprised of the **Dental Claim, Other Payer, Detail, Surfaces (Detail Item 1), Attachments, Supporting Data for Delayed Submission / Resubmission,** and **Claim Status Information** panels.

When first accessed, the **Dental Claim** page displays as shown below.

Dental Claim: 8984782436 NPI - JACK B DEWEY DDS PA

BILLING INFORMATION	SERVICE INFORMATION
ICN	*Release of Information <input type="text" value="NO"/>
Provider ID 8984782436 NPI	From Date
*Medicaid Billing Number <input type="text"/>	To Date
*Date of Birth <input type="text"/>	Emergency <input type="text"/>
Last Name	Accident Related To <input type="text"/>
First Name, MI	Accident State <input type="text"/>
*Patient Account # <input type="text" value="0"/>	Accident Country <input type="text" value="{ Search }"/>
Referring Provider # <input type="text"/>	Accident Date <input type="text"/>
Patient Amount Paid <input type="text" value="\$0.00"/>	EPSDT <input type="text"/>
	*Place of Service <input type="text" value="{ Search }"/>
	Prior Authorization # <input type="text"/>
	TOTAL CHARGES
	Total Charges \$0.00
	Medicaid Allowed Amount \$0.00
	TPL Paid Amount \$0.00
	Total Medicaid Paid Amount \$0.00
	Medicaid CoPay Amount \$0.00
	Note Reference Code <input type="text"/>
	Notes <input type="text"/>

Tasks for this Panel

To **submit** the claim created in the Dental Claim panel, follow the steps below:

1. Review the claim to ensure all **required** information has been entered, and is correct. Optional information should also be checked for accuracy. Refer to T4D027_Provider_Medicaid_Portal_User_Manual_Claims_Entry_06.doc.
2. Make sure all necessary **attachments and supporting documents**, if applicable, are ready to accompany the submission if being sent electronically. Hard-copy attachments can also be mailed.
3. Click the **submit** button.
4. If there are errors on the page, see the section **Resolving Errors on a Dental Claim**.

If the claim submission is successful, the Claim Status panel will display this status:

Claim Status Information

Claim Status Submitted

Field Descriptions – Dental Claim Entry – Primary Panel

Field	Description	Field Type	Data Type	Length
Accident Country	The country code where the accident occurred if outside the US. Only required for 'auto accident' and outside the country.	Field	Alphanumeric	2
Accident Date	The date the accident occurred.	Field	Date (MM/DD/CCYY)	10
Accident Related To	Indicates whether service was provided as result of an accident.	Field	Drop Down List Box	0
Accident State	The State where the accident occurred.	Field	Drop Down List Box	0
Date of Birth	Recipient's date of birth.	Field	Date (MM/DD/CCYY)	10
Emergency	Indicates whether service was provided as result of an emergency situation.	Field	Drop Down List Box	0
EPSDT	Indicates whether service is related to Child Health Check Up.	Field	Drop Down List Box	0
First Name, MI	Recipient's first name and middle initial. Read-only.	Field	Character	0
ICN	Claim's internal control number and, when present, the transaction control number from the Ohio MITS. Read-only.	Field	Number	0
Last Name	Recipient's last name. Read-only.	Field	Character	0
Medicaid Allowed Amount [Header]	Amount approved to pay for services provided to a recipient. Read-Only.	Field	Number	0
Medicaid Billing Number	Recipient Medicaid Billing Number.	Field	Number	12
Medicaid Copay Amount	Amount paid as co-pay. Read-Only	Field	Number	0
Note Reference Code	Code identifying the type of note.	Field	Drop Down List Box	3
Notes	Additional notes for the claim.	Field	Character	80
Patient Account #	Patient's account number on the provider's system.	Field	Character	38

Field	Description	Field Type	Data Type	Length
Patient Amount Paid	The amount the patient paid.	Field	Number	9
Place of Service	Place of service (POS). Location where the service was rendered. Click [Search] to search for and select a place of service.	Field	Character	2
Prior Authorization #	Prior Authorization number that authorized the rendered services.	Field	Number	10
Provider ID	Identification number and service location of the provider. Read-only.	Field	Alphanumeric	0
Referring Provider #	Identification number of the provider who referred the recipient to the billing provider.	Field	Number	10
Release of Information	Release of information permission.	Field	Drop Down List Box	0
TPL Paid Amount	Total of TPL Amount from the detail line items. Read-only.	Field	Number	0
To Date	The ending date of service for the claim. Read-only.	Field	Date (MM/DD/CCYY)	0
Total Charges	Total of charges from the detail line items. Read-only.	Field	Number	0
Total Medicaid Paid Amount	Total amount paid. Read-only.	Field	Number	0

Field Edits – Dental Claim Entry – Primary Panel

Field	Field Type	Error Code	Error Message	To Correct
Date of Birth	Field	0	Date of Birth: Invalid. Format is mm/dd/ccyy.	Ensure the field contains only valid dates.
Date of Birth	Field	2	A valid Medicaid Billing Number and Date of Birth combination is required.	Enter a valid Medicaid Billing Number and date of birth.
Medicaid Billing Number	Field	0	A valid Medicaid Billing Number is required.	Enter a valid Medicaid Billing Number.
Medicaid Billing Number	Field	1	Medicaid Billing Number is no longer active. The active ID 999999999 will be used.	This message is informational. The inactive ID has been automatically replaced with the active ID.

Field	Field Type	Error Code	Error Message	To Correct
Medicaid Billing Number	Field	2	A valid Medicaid Billing Number and Date of Birth combination is required.	Enter a valid Medicaid Billing Number and date of birth.
Note Reference Code	Field	1	Note Reference Code is required.	Select a value from drop down.
Notes	Field	1	Notes are required.	Enter a description for Notes.
Patient Account #	Field	0	Patient Account # is required.	This field must be completed.
Patient Amount Paid	Field	0	Patient Amount Paid must be less than or equal to 999999.99.	Enter an amount less than or equal to 999999.99
Place of Service	Field	0	A valid Place of Service is required.	This field must be completed.
Referring Provider #	Field	0	Referring Provider # is invalid.	Enter a valid provider number.
Referring Provider #	Field	1	Referring Provider # must be either 7 or 10 digits.	Enter a valid 7 or 10 digits provider number.
Release of Information	Field	0	Release of information is required.	This field must be completed.

Resolving Errors on a Dental Claim

If information is entered in a panel field that is incorrect in some way, or missing when it is required information, an error message is displayed by the system when an action of 'submit' is performed. The two methods for resolving errors are:

- Messages panel
- Error icons.

The following messages were generated: section shown below in this Claim panel displays error information. .

The following messages were generated:

A valid Place of Service is required
 A valid Medicaid Billing Number is required
 DOS is required.
 A valid Procedure is required
 Units must be greater than 0.
 Charges must be greater than 0.
 A valid Medicaid Billing Number and Date of Birth combination is required.
[Click here to view the Dental Claim Handbook](#)

Each message in the panel is a link to the field to be corrected. Note that the last link on the error messages panel is a link to the Claim Handbook for this claim type.

To **correct** errors using message panel:

1. Click on the **error link** to jump to the field with the error.
2. Make any necessary correction.
3. Return to the messages panel and make all necessary corrections.
4. Click the **submit** button again. When the claim has successfully been submitted, this status will display in the **Claim Status** panel:



Error icons provide an alternate approach to resolving submission errors. Look for the  icons on the claims panels. When a claim is submitted, if the system detects any errors on the claim, the  icon will appear next to any fields that require correction. Clicking on this icon opens a Help page for assistance with correcting the error.

The screenshot shows a web form titled "Dental Claim: 8984782436 NPI - JACK B DEWEY DDS PA". The form is divided into two main sections: "BILLING INFORMATION" and "SERVICE INFORMATION".

BILLING INFORMATION:

- ICN: 8984782436 NPI
- Provider ID: 8984782436 NPI
- *Medicaid Billing Number: [Empty field]
- *Date of Birth: [Empty field]
- Last Name: [Empty field]
- First Name, MI: [Empty field]
- *Patient Account #: 0
- Referring Provider #: [Empty field]
- Patient Amount Paid: \$0.00

SERVICE INFORMATION:

- *Release of Information: NO
- From Date: [Empty field]
- To Date: [Empty field]
- Emergency: [Empty field]
- Accident Related To: [Empty field]
- Accident State: [Empty field]
- Accident Country: [Empty field] [Search]
- Accident Date: [Empty field]
- EPSDT: [Empty field]
- *Place of Service: [Empty field] [Search]
- Prior Authorization #: [Empty field]

TOTAL CHARGES:

- Total Charges: \$0.00
- Medicaid Allowed Amount: \$0.00
- TPL Paid Amount: \$0.00
- Total Medicaid Paid Amount: \$0.00
- Medicaid CoPay Amount: \$0.00
- Note Reference Code: [Empty field]
- Notes: [Empty text area]

Red error icons are present next to the *Date of Birth, *Patient Account #, *Place of Service, and *Release of Information fields.

To correct errors using error icons:

1. Click on the **error icon** . An **Online Help** page opens with instructions about how to correct the information in the field.
2. Make any necessary corrections.
3. Click the **submit** button again. When the claim has successfully been submitted, this status will display in the **Claim Status** panel:



Submitting Dental Claim Attachments – Attachment Upload

When the submission has been successful, the function for uploading attachments to the claim becomes available in the Hard Copy Attachments panel.

Tasks for this Panel

To **submit** an **electronic** attachment, follow these steps:

1. Click the **add** button.
2. Select a **Type of Document** from the list.
3. Click the **Browse** button to select a file to upload.
4. Click the **Upload Attachment** button.

Field Descriptions – Dental Claim – Attachments

Field	Description	Field Type	Data Type	Length
add	Inserts a new record in the Diagnosis, Other Payer/Crossover, Detail, or Hard-Copy Attachments panel. Proper permissions are required to perform an add.	Button	N/A	0
delete	Deletes the selected record from the Diagnosis, Other Payer/Crossover, Detail, or Hard-Copy Attachments panel. Proper permissions are required to perform a delete.	Button	N/A	0
Transmission Type	Defines the transmission method (fax, mail, upload) by which attachments are to be sent.	Field	Drop Down List Box	0
Type of Document	The code indicating the title or contents of a document, report, or supporting item.	Field	Drop Down List Box	0
Transmission Type (List)	Defines the transmission method (fax, mail, upload) by which attachments are to be sent.	Listview	Character	1
Type of Document	The code indicating the title or	Listview	Character	1

Field	Description	Field Type	Data Type	Length
(List)	contents of a document, report, or supporting item.			

Submitting Dental Claim Attachments – Attachment Cover – Claim

The electronic document attachment cover sheet for claim submission is shown below.

EDMS COVER SHEET

Name: Date: No. of Pages: (Including this cover sheet)

Phone:

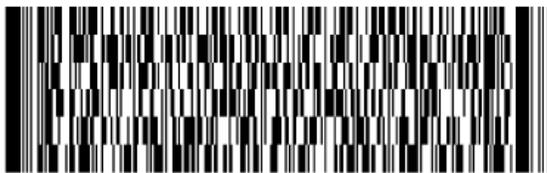
Document Type:

- Provider Recipient Correspondence Prior authorization Supporting documents for claim
 Accounts receivable Payment deduction Expenditure Hospital cost settlement
 LTC cost settlement Declaration of election of hospice benefit Attending physician written certification
 Revocation of hospice benefit Statement of termination of hospice benefit
 Selection of a different hospice provider IDG written certification Programs
 RetroDUR profile RetroDUR survey RetroDUR reports RetroDUR other documents

Sub Categories for Prior Authorization Documents

- Compression Garments Decubitus Care Equipment Dental Dressings, Surgical
 Enteral Nutrition & Supplies EPSDT Hospital Beds Hospital Inpatient Hospital Outpatient Hearing Aids
 Incontinence Supplies Increased State Plan Home Health Misc Equipment Orthodontics Orthotics (MTA)
 Orthotics/Prosthetics (Nurses) PDN Repairs Respiratory (MTA) Respiratory (Nurses)
 Supplies (Misc) Speech Generating Devices Transportation Therapies Vision Wheelchairs Others

Index Field & Values (if applicable):

ATN:	Recipient ID:	Prior Authorization Number:
<input type="text"/>	<input type="text"/>	<input type="text"/>
NPI:	Medicaid Provider ID:	
<input type="text"/>	<input type="text"/>	<i>Use only if you do not have NPI.</i>
ICN:	Contact Tracking Number:	
<input type="text"/>	<input type="text"/>	
Financial Record Number:	Status:	Program Control Number:
<input type="text"/>	<input type="text"/>	<input type="text"/>
Hospice Enrollment ID:	Hospice Attachment ID:	Intervention ID:
<input type="text"/>	<input type="text"/>	<input type="text"/>
		

Confidentiality Notice:

The sender of this facsimile transmission intends to communicate the contents of this transmission only to the Ohio Department of Job and Family Services. This transmission may contain information that is privileged, confidential or otherwise exempt from disclosure under applicable law. If you are not the designated recipient or the employee or agent responsible for delivering this transmission to the designated recipient, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If you have received this transmission in error, please notify us immediately by telephone at 1-800-686-1516 and promptly destroy the original transmission. Thank you for your assistance.

JFS 00000 (Rev. 06/10/2011 v2)

Ohio Department of Job and Family Services

To download a copy of this attachment cover sheet from the ODJFS Web site, click [here](#) (Ctrl key + click), or copy the following URL address and paste it into your browser's address field:

http://jfs.ohio.gov/OHP/providers/MITSEDMS_Cover_IT4.pdf.

Tasks for this Panel

To **add** Mail hard-copy attachments:

1. Press the **add** button.
2. The required fields for entering information display in the **Hard-Copy Attachments** panel.
3. Enter the Control Number. Select **Mail** for the **Transmission** value. Select a **Report Type** to describe the general content of the attachment.
4. Determine if additional attachments should accompany the claim.
5. If no additional hard-copy mail attachments are to accompany the claim, information entered for this panel is complete.
6. If no additional attachments will accompany the claim, it ready to submit.

To **add** an additional electronic attachment:

1. Press the **add** button.
2. The required fields for entering information display in the **Hard-Copy Attachments** panel.
3. Enter the **Control Number**. Select **Electronic Upload** for the **Transmission** value. Select a **Report Type** to describe the general content of the attachment.
4. Determine that no additional attachments should accompany the claim.
5. If no additional electronic attachments should accompany the claim, the claim is ready to submit.

To **delete** the current attachment information:

1. On a new claim or an adjudicated claim, select the detail row for deletion and press the **delete** button.
2. The message displays: **Are you sure this is the row you want marked for deletion?** Press **OK** to delete the row of Hard-Copy Attachment information entered in the panel.
3. Enter new attachment information, if desired.

Field Descriptions – Attachment Cover – Claim

Field	Description	Field Type	Data Type	Length
Claim ICN	The claim's internal control number.	Label	Number	13
Control Number	Control number assigned to the attachment for identification purposes.	Label	Number	80
Date of Service	Date of first service on the claim.	Label	Date (MM/DD/CCYY)	10
Medicaid ID	The recipient's Medicaid identification number.	Label	Alphanumeric	12
Patient Account #	The patient's account number on the Provider's system.	Label	Alphanumeric	38

Field	Description	Field Type	Data Type	Length
Provider ID	Identification number and service location of the provider.	Label	Alphanumeric	15

Suspended Dental Claim – EOB Panel

The Claim Status Information panel will display as in the following example for a suspended dental claim.

Claim Status Information				
Claim Status: SUSPENDED				
Claim ICN: 00000000000000				
Paid Amount: \$0.00				
EOB Information				
Detail Number	EOB Code	EOB Description	ARC Code	ARC Description
0	0660	CALCULATED PAYMENT EQUALS ZERO. OTHER INS PAID MORE THAN MEDICAID ALLOWABLE.	42	Charges exceed our fee schedule or maximum allowable amount.
1	9998	CLAIM IS PENDING. CLAIM WILL APPEAR AS PAID OR DENIED ON A FUTURE REMITTANCE VO	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co
1	9918	PRICING ADJUSTMENT - MAX FEE PRICING APPLIED	147	Provider contracted/negotiated rate expired or not on file.
1	9999	PROCESSED PER MEDICAID POLICY	92	Claim Paid in full.

Tasks for this Panel

To check claim errors for resubmission:

1. Use information in the EOB information panel to identify and correct issues with the claim before resubmitting.

Field Descriptions – EOB Panel

See the Dental Claim Entry - Primary Panel.

Denied Dental Claim

The Claim Status Information panel will display as in the following example for a denied dental claim.

Claim Status Information				
Claim Status: DENIED				
Claim ICN: 00000000000000				
Denied Date: 06/25/2008				
Paid Amount: \$0.00				
EOB Information				
Detail Number	EOB Code	EOB Description	ARC Code	ARC Description
0	0660	CALCULATED PAYMENT EQUALS ZERO. OTHER INS PAID MORE THAN MEDICAID ALLOWABLE.	42	Charges exceed our fee schedule or maximum allowable amount.
1	9998	CLAIM IS PENDING. CLAIM WILL APPEAR AS PAID OR DENIED ON A FUTURE REMITTANCE VO	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co
1	9918	PRICING ADJUSTMENT - MAX FEE PRICING APPLIED	147	Provider contracted/negotiated rate expired or not on file.
1	9999	PROCESSED PER MEDICAID POLICY	92	Claim Paid in full.

re-submit cancel

Tasks for this Panel

To resubmit a denied claim:

1. Make changes as indicated in the EOB information panel.

2. Click the **re-submit** button.

Field Descriptions – Denied Claim

See the Dental Claim Entry - Primary Panel.

2 LOCATING A PREVIOUSLY SUBMITTED CLAIM

Providers use the Claim Search page to search all claims associated with their provider ID. They may narrow their search using the criteria fields.

From the Claims Search Results, the provider can:

- Research the status or details of a previous claim
- Copy data from a previous claim into a new claim
- Re-submit a denied claim
- Adjust a previously submitted or suspended claim.

2.1 Claim Search Based on Provider ID

The Claim Search -Search panel is used by the provider to perform a search on claim detail line items that are associated with the provider's ID number. Types of claims can be selected to specify which claims are displayed in the search results.

Claim Search – Search

The Claim Search-Search panel is used by the provider to search all claims associated with the provider's ID number. Search results can be narrowed by using the criteria fields.

Search Results will only include non-finalized claims and claims with a finalized date >= 03/23/2007
The actual Check Issue Date will occur during the weekly remittance cycle

Tasks for this Panel

To **search** for a claim:

1. Enter an **ICN/TCN**, **Medicaid Billing Number**, **Rendering Provider ID**, **Prescription Number**, or **RA Date** in the appropriate fields.
2. Select a **Claim Type**, **Status**, and **Date of Service** from the drop-downs.
3. If selecting a date range for the **DOS**, first select **Date Range** from the **Date of Service** drop-down, then you can enter a **From/Thru DOS**, limited to a twelve month time span.

Field Descriptions – Claim Search – Search

Field	Description	Field Type	Data Type	Length
Clear	Clears all the search criteria.	Button	N/A	0
Search	Displays the Search Results based on the	Button	N/A	0

Field	Description	Field Type	Data Type	Length
	criteria entered on the search panel.			
Amount Billed	Dollar amount billed for the claim.	Field	Number	9
Claim Type	Type of claim.	Field	Drop Down List Box	0
Date of Service	Allows the user to filter the search by date of service. When Date of Service is selected as a search criteria field, the RA Date field is disabled.	Field	Drop Down List Box	0
From DOS	Beginning date of service for date range search. This field is enabled when Date Range is selected for Date of Service.	Field	Date (MM/DD/CCYY)	10
ICN/TCN	Contains either the internal control number (ICN) or the transaction control number (TCN) that cross references a converted claim from the old system.	Field	Number	18
Medicaid Billing Number	Recipient's Medicaid identification number.	Field	Number	12
Prescription Number	Number that uniquely identifies a drug dispensed to a recipient.	Field	Number	7
RA Date	Remittance advice date. The drop-down list box is populated with the RA dates and check number for the current user. The dates appear in descending order. When the RA date is selected as a search criteria field, the Date of Service field is disabled.	Field	Drop Down List Box	0
Records	Allows the user to specify the number of rows returned from the search.	Field	Drop Down List Box	0
Rendering Provider ID	ID number of the provider who performed the service. Click [Search] to search for and select a rendering provider ID.	Field	Number	10
Status	Indicates the status of the claim in the system.	Field	Drop Down List Box	0
Thru DOS	Ending date of service for date range search. This field is enabled when Date Range is selected for Date of Service.	Field	Date (MM/DD/CCYY)	10

Field Edits – Claim Search – Search

Field	Field Type	Error Code	Error Message	To Correct
Claim Type	Field	0	Selection of Claim Type OR Status is required.	Select either Claim Type or Status.
Date of Service	Field	0	Date of Service, ICN/TCN or RA Date is required.	Enter or select values for one of the required fields.
From DOS	Field	0	From DOS cannot be greater than today's date.	Ensure that the date is on or before today's date.
From DOS	Field	1	From DOS and Thru DOS must be within 12 month range.	Value range in the From DOS to the Thru DOS fields cannot exceed 12 months.
From DOS	Field	2	From/Thru DOS: Invalid Date. Format is mm/dd/ccyy.	Enter a valid date.
From DOS	Field	3	From DOS is required when Date Range is selected.	Enter a From DOS.
ICN/TCN	Field	0	No other criteria are allowed when ICN/TCN is entered.	Delete or select blank values for other criteria.
RA Date	Field	0	Date of Service, ICN/TCN or RA Date is required.	Select either Date of Service, ICN/TCN or RA Date Criteria.
RA Date	Field	1	No other criteria are allowed when RA Date is entered.	Delete or select blank values for other criteria.
Status	Field	0	Selection of Claim Type OR Status is required.	Select either Claim Type or Status.
Thru DOS	Field	0	Thru DOS cannot be greater than today's date.	Ensure that the date is on or before today's date.
Thru DOS	Field	1	From DOS must be less than or equal to Thru DOS.	Ensure that the date is on or after From DOS.
Thru DOS	Field	2	From DOS and Thru DOS must be within 12 month range	Value range in the From DOS to the Thru DOS fields cannot exceed 12 months.
Thru DOS	Field	3	Thru DOS is required when Date Range is selected.	Enter a Thru DOS.
Thru DOS	Field	4	From/Thru DOS: Invalid Date. Format is mm/dd/ccyy.	Enter a valid date.

Search Results – Claim Search

The Search Results-Claim Search panel displays the claim information matching the search criteria entered on the Claim Search-Search panel.

Search Results									
ICN	TCN	Medicaid Billing Number	From DOS	To DOS	Claim Type	Status	RA Date	Amount Billed	Paid
2007318052076		4250583048	01/16/2007	01/16/2007	DENTAL CLAIMS	DENIED	12/10/2007	\$52.00	\$0.00
2007318052115		4250583048	01/16/2007	01/16/2007	DENTAL CLAIMS	DENIED	12/10/2007	\$52.00	\$0.00
2007318052085		4250583048	01/16/2007	01/16/2007	DENTAL CLAIMS	DENIED	12/10/2007	\$52.00	\$0.00
2007318052024		4215877210	01/10/2007	01/10/2007	DENTAL CLAIMS	DENIED	12/10/2007	\$266.00	\$0.00
2007318051928		4215877210	01/10/2007	01/10/2007	DENTAL CLAIMS	DENIED	12/10/2007	\$266.00	\$0.00
2007318050858		0728754885	01/09/2007	01/09/2007	DENTAL CLAIMS	DENIED	12/10/2007	\$5.20	\$0.00
2007318051462		0728754885	01/09/2007	01/09/2007	DENTAL CLAIMS	DENIED	12/10/2007	\$5.20	\$0.00
2007318051874		4176609403	01/08/2007	01/08/2007	DENTAL CLAIMS	DENIED	12/10/2007	\$335.00	\$0.00
2007318052031		4176609403	01/08/2007	01/08/2007	DENTAL CLAIMS	DENIED	12/10/2007	\$335.00	\$0.00
2007291050312		0648940887	01/02/2007	01/02/2007	DENTAL CLAIMS	DENIED	10/23/2007	\$52.00	\$0.00
2008192009187	10704350466001200	4953063142	01/16/2007	01/16/2007	DENTAL CLAIMS	DENIED	0	\$52.00	\$0.00
2008192009687	10704350465002400	4250583048	01/16/2007	01/16/2007	DENTAL CLAIMS	DENIED	0	\$52.00	\$0.00

Tasks for this Panel

To view ICN information from the search results:

1. Click on an **ICN** link to open a new window of client information.

Field Descriptions – Search Results – Claim Search

Field	Description	Field Type	Data Type	Length
Amount Billed	Amount billed for the claim. Format: 9999999.99.	Listview	Number	9
Claim Type	Indicates the type of claim.	Listview	Character	20
From DOS	From date of service for the claim.	Listview	Date (MM/DD/CCYY)	10
ICN	Internal control number which uniquely identifies a claim meeting the selection criteria.	Listview	Character	13
Medicaid ID	Recipient's Medicaid identification number.	Listview	Character	12
Paid	Amount paid on this claim.	Listview	Number	9
RA Date	Date of the remittance advice where this claim was processed by the Financial cycle.	Listview	Date (MM/DD/CCYY)	10
Status	Identifies the status of the claim within the system.	Listview	Date (MM/DD/CCYY)	20
TCN	Cross reference identification number from the legacy system identified by a transaction control number (TCN).	Listview	Number	20
To DOS	To date of service for the claim.	Listview	Date (MM/DD/CCYY)	10

Field Edits – Search Results – Claim Search

Field	Field Type	Error Code	Error Message	To Correct
All fields	Field	1	Claim Type [x] is not defined.	The claim type is not defined within the Ohio Web Portal. Contact Web Portal Technical Support to resolve the issue.

2.2 Detailed Claim Search

To search for a claim by billing or service information, or to submit a new claim, the Professional, Institutional, or Dental Claim Search panels are used.

Claim Search Detail – Search

The Claim Search Detail-Search panel is used by the provider to perform a search on claim detail line items that are associated with the provider's ID number. Search results can be narrowed by using the criteria fields.

Search Results will only include non-finalized claims and claims with a finalized date \geq 03/23/2007
The actual Check Issue Date will occur during the weekly remittance cycle

Tasks for this Panel

To **search** claim detail:

1. Enter a **Procedure**, **Revenue Code**, **NDC**, or **From/Thru DOS** in the appropriate fields.
2. Select a **Claim Type**, **Status**, and **RA Date** from the drop-downs.
3. Click **search**.

Field Descriptions – Claim Search Detail – Search

Field	Description	Field Type	Data Type	Length
Clear	Clears all the search criteria.	Button	N/A	0
Search	Displays the Search Results based on the criteria entered on the search panel.	Button	N/A	0
Claim Type	Type of claim. Valid values include: Dental, Institutional, Pharmacy, or Professional.	Field	Drop Down List Box	0
From DOS	Beginning date of service for date range search. This field is enabled when Date Range	Field	Date (MM/DD/CCYY)	10

Field	Description	Field Type	Data Type	Length
	is selected for Date of Service.			
NDC	Filter the search using the specified National Drug Code (NDC). Click [Search] to search for and select an NDC.	Field	Character	11
Procedure	Filter the search using the specified procedure code. Click [Search] to search for and select a procedure code.	Field	Character	6
RA Date	Remittance advice (RA) date. The drop-down list box is populated with the RA dates and number for the current user. The dates appear in descending order.	Field	Drop Down List Box	10
Records	Allows the user to specify the number of rows to display on each search results page.	Field	Drop Down List Box	0
Revenue Code	Filter the search using the specified revenue code. Click [Search] to search for and select a revenue code.	Field	Character	4
Status	Filter the search using the specified claim status.	Field	Drop Down List Box	0
Thru DOS	Ending date of service for date range search. This field is enabled when Date Range is selected for Date of Service.	Field	Date (MM/DD/CCYY)	10

Field Edits – Claim Search Detail – Search

Field	Field Type	Error Code	Error Message	To Correct
All fields	Field	0	Invalid number / Invalid date / Invalid character data.	Ensure that the field matches the datatype as documented in the field descriptions above. Number fields must only contain digits 0 - 9; date fields must only contain valid dates; character fields must only contain A - Z and 0 - 9.
From DOS	Field	0	From DOS and Thru DOS must be within 12 month range.	Value range in the From DOS to the Thru DOS fields cannot exceed 12 months.
From DOS	Field	1	From DOS must be less than or equal to Thru DOS.	Select Thru DOS greater than or equal to From DOS.
From	Field	2	RA Date OR	Select either RA Date or From DOS/Thru DOS

Field	Field Type	Error Code	Error Message	To Correct
DOS			From/Thru DOS criteria are required.	criteria.
Thru DOS	Field	0	From DOS and Thru DOS must be within 12 month range.	Value range in the From DOS to the Thru DOS fields cannot exceed 12 months.
Thru DOS	Field	1	From DOS must be less than or equal to Thru DOS.	Select Thru DOS greater than or equal to From DOS.
Thru DOS	Field	2	RA Date OR From/Thru DOS criteria are required.	Select either RA Date or From DOS/Thru DOS criteria.

Search Results – Claim Search Detail

The Search Results-Claim Search Detail panel displays the detail claim information matching the search criteria entered on the Claim Search Detail-Search panel.

Search Results									
ICN	Medicaid Billing Number	Patient Acct#	From DOS	Thru DOS	Status	Units	Amt Billed	Paid	Service
2008192010364	4460134969		01/16/2007	01/16/2007	DENIED	1	\$636.00	\$0.00	D5120
2008192010364	4460134969		01/16/2007	01/16/2007	DENIED	1	\$636.00	\$0.00	D5110
2008192010364	4460134969		01/16/2007	01/16/2007	DENIED	1	\$636.00	\$0.00	D0150

Tasks for this Panel

There are no tasks for this panel.

Field Descriptions – Search Results – Claim Search Detail

Field	Description	Field Type	Data Type	Length
Amt Billed	Dollar amount charged for the service provided.	Listview	Number	9
From DOS	Starting date of service for the claim. Format: MM/DD/CCYY.	Listview	Date (MM/DD/CCYY)	8
ICN	Internal control number that uniquely identifies a claim.	Listview	Character	13
Paid	Amount paid by Medicaid for the service provided.	Listview	Number	9
Patient Acct#	Recipient's account or medical record number on the provider's system.	Listview	Character	15

Field	Description	Field Type	Data Type	Length
Recipient ID	Recipient's Medicaid identification number.	Listview	Character	12
Service	Code that identifies the service provided. The code can either be the procedure code, revenue code, NDC code, or a combination of procedure code and revenue code.	Listview	Character	11
Status	Indicates the claim status. Values are: D=Denied, P=Paid, or S=Suspended.	Listview	Character	1
Thru DOS	Ending date of service for the claim. Format: MM/DD/CCYY.	Listview	Date (MM/DD/CCYY)	8
Units	Number of units billed for the service. Only whole units are displayed. Format: 999.	Listview	Number	3

Field Edits – Search Results – Claim Search Detail

Field	Field Type	Error Code	Error Message	To Correct
All fields	Field	1	Claim Type [x] is not defined.	The claim type is not defined within the Ohio Web Portal. Contact Web Portal Technical Support to resolve the issue.

3 WORKING WITH PREVIOUSLY SUBMITTED CLAIMS

From the Claim Status panel, a paid claim can be resubmitted, adjusted, voided or copied. For more information see the following sections.

Claim Status Information				
Claim Status	PAID			
Claim ICN	00000000000000			
Paid Date	07/02/2008			
Paid Amount	\$4.50			
EOB Information				
Detail Number	EOB Code	EOB Description	ARC Code	ARC Description
0	0660	CALCULATED PAYMENT EQUALS ZERO, OTHER INS PAID MORE THAN MEDICAID ALLOWABLE.	42	Charges exceed our fee schedule or maximum allowable amount.
1	9998	CLAIM IS PENDING. CLAIM WILL APPEAR AS PAID OR DENIED ON A FUTURE REMITTANCE VO	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Co
1	9918	PRICING ADJUSTMENT - MAX FEE PRICING APPLIED	147	Provider contracted/negotiated rate expired or not on file.
1	9999	PROCESSED PER MEDICAID POLICY	92	Claim Paid in full.

3.1 Resubmitting a Claim

A suspended claim can be resubmitted after making changes. The resubmission is assigned its own ICN.

To **resubmit** a denied or suspended claim:

1. Check the error code information in the **EOB Information** panel.
2. Make changes, if needed, to any panels on the Claims page. For example, change a diagnosis on the **Diagnosis** panel. Or make no changes if the client was not eligible and is now eligible.
3. Complete the **Previously Denied ICN or TCN** field.
4. Click the **re-submit** button at the bottom of the page. The resubmission is assigned its own ICN.

EOB Information				
Detail Number	EOB Code	EOB Description	ARC Code	ARC Description
0	0308	INVALID DATE OF SERVICE	16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)

3.2 Adjusting a Claim

If a claim is in a paid status but needs to be adjusted, the claim information can be changed as needed before adjusting. To adjust a previously paid claim, the provider must first perform an inquiry in the Claim Inquiry panel to retrieve the claim.

This task applies to professional, institutional, and dental claims.

To **adjust** a paid claim:

1. Search for the claim to be adjusted. Refer to section **2.1 Claim Search**.
2. Enter the desired information for the adjustment in the appropriate fields. To adjust information in a specific **claim detail line**:

- a. Highlight the claim detail line to be adjusted in the **Detail** panel. The information for the selected claim line populates the corresponding fields in the lower portion of the panel.
 - b. Change the desired information in any of those fields.
3. Click the **adjust** button beneath the Claim Status panel at the bottom of the page.

Claim Status Information				
Claim Status	PAID			
Claim ICN	2010333000064			
Paid Date	12/01/2010			
Paid Amount	\$120.65			
EOB Information				
Detail Number	EOB Code	EOB Description	ARC Code	ARC Description
1	9918	PRICING ADJUSTMENT - MAX FEE PRICING APPLIED	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).

4. The claim is adjusted and assigned its own adjustment ICN.

Claim Status Information				
Claim Status	PAID			
Claim ICN	5811119000001			
Paid Date				
Paid Amount	\$120.65			
EOB Information				
Detail Number	EOB Code	EOB Description	ARC Code	ARC Description
1	9918	PRICING ADJUSTMENT - MAX FEE PRICING APPLIED	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability). Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.) This change to be effective 7/1/2010: Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)
2	4530	INVALID TOOTH NUMBER FOR BILLED PROCEDURE	A1	
Adjustment Information				
ICN	Date Adjusted			
5811119000001	04/29/2011			
2010333000064	04/29/2011			

3.3 Voiding a Claim

If a paid claim will be completely recouped, the provider can void the claim. The provider must first perform an inquiry in the Claim Inquiry panel to retrieve the claim.

This task applies to professional, institutional, and dental claims.

To void a claim:

1. View the **Claim Status Information/EOB Information** panels.
2. Click the **void** button at the bottom of the page. A new claim is created and assigned its own adjustment ICN.

Claim Status Information				
Claim Status	PAID			
Claim ICN	2010333000064			
Paid Date	12/01/2010			
Paid Amount	\$120.65			
EOB Information				
Detail Number	EOB Code	EOB Description	ARC Code	ARC Description
1	9918	PRICING ADJUSTMENT - MAX FEE PRICING APPLIED	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).

3.4 Copying a Detail Line on a Claim

Once a claim has been submitted and paid, the provider can copy that claim and modify it, rather than creating a new claim, saving keystrokes and time. For example, a claim can be copied for a client from a prior visit and modified for the current visit, or a claim with a widely used procedure code can be modified and submitted for different clients.

This task applies to professional, institutional, and dental claims.

To copy a paid claim:

1. Open the claim you want to copy.
2. From the **Detail** panel, select a row for the detail you want to copy. Then click the copy button.
3. The claim is copied with all of the existing data. The **submit** and **cancel** buttons display at the bottom of the new page.
4. If an  icon displays next to a field, enter or re-enter the information and click **copy claim** again.

Detail							
Item	FDOS	Units	Charges	Medicaid Allowed Amount	Status	Place of Service	Procedure Code
A	1	0	\$0.00	\$0.00			

Type data below for new record.

<input type="button" value="delete"/> <input type="button" value="add"/> <input type="button" value="copy"/>	Item 1 *From DOS <input type="text"/> To DOS <input type="text"/> *Units <input type="text" value="0"/> *Charges <input type="text" value="\$0.00"/> Medicaid Allowed Amount <input type="text" value="\$0.00"/> Rendering Provider <input type="text"/> Status <input type="text"/>	*Place Of Service <input type="text"/> [Search] *Procedure Code <input type="text"/> [Search] Emergency <input type="text"/> EPSDT Screening/ Family Planning <input type="text"/> Diagnosis Code <input type="text"/> Pointer* <input type="text"/> Modifiers <input type="text"/> [Search] <input type="text"/> [Search] <input type="text"/> [Search] <input type="text"/> [Search]
--------------------------------------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

NDC Other Payer - Detail ClaimCheck

EOB Information				
Detail Number	EOB Code	EOB Description	ARC Code	ARC Description
0	0308	INVALID DATE OF SERVICE	16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)

3.5 Viewing a Pharmacy Claim

The Claim Pharmacy panel is used by the provider to view a pharmacy claim that has been previously submitted through the Ohio MITS Web Portal. The Claim Pharmacy panel is comprised of the Pharmacy Claim, Detail, Claim Status Information, and Explanation of Benefits (EOB) panels.

Pharmacy Claim: 1962593657 NPI - BLAKE PHARMACY					
Billing Information			Prescription Information		
ICN	4910270001103	41004800001064152	Claim Type	P - PHARMACY CLAIMS	
Provider ID	1962593657 NPI		Prescription #	1958112	
Medicaid Billing Number	313135943601		Date Dispensed	02/17/2010	
Last Name	HUGHES		Date Prescribed	02/17/2010	
First Name, MI	JEANNETTE		New/Refill	00	
Date of Birth	08/08/1937		Days Supply	6	
Prescriber ID	1588640031		Dispense/Written		
Prescriber Name			PA Auth #		
Pregnancy	Unknown		Diagnosis		
Emergency			Charges		
Nursing Facility			Total Charges	\$13.14	
Insurance Denied			Total TPL Amount	\$0.00	
Submission/Clarification Code	Not Specified		Dispensing Fee	\$0.00	
Rendering Physician	1962593657 NPI		DUR Overrides		
Signature			Intervention	Not Specified	
			Outcome	Not Specified	
			Conflict Code	Not Specified	
Detail					
Item	NDC Code	Quantity	Charges	TPL Amount	Allowed Amount
1	00603-1585-58	120.00	\$4.56	\$0.00	\$6.36
Select row above to view.					
Item	1	Charges	\$4.56		
Quantity	120.00	TPL Amount	\$0.00		
NDC Code	00603158558	Allowed Amount	\$6.36		
Claim Status Information					
Claim Status	PAID				
Claim ICN	4910270001103				
Paid Date	09/29/2010				
Paid Amount	\$6.36				
EOB Information					
Detail Number	EOB Code	EOB Description	ARC Code	ARC Description	
0	2037	RECIPIENT NUMBER HAS BEEN DEACTIVATED	16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.) This change to be effective 7/1/2010: Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	
Adjustment Information					
ICN	Date Adjusted				
4010048000394	09/27/2010				

Tasks for this Panel

To **view** information in for an existing pharmacy claim:

1. Enter valid values in the **ICN/HSID** field. The page refreshes displaying the **Detail**, **Claim Status**, and **EOB Information** panels.
2. Select a row from the Detail panel to view specifics about that claim.

Field Descriptions – Claim Pharmacy

Field	Description	Field Type	Data Type	Length
Allowed Amount	Amount approved to pay for services provided to a	Field	Number	9

Field	Description	Field Type	Data Type	Length
	recipient. Read-Only.			
Allowed Amount (Claim Status)	Amount approved to pay for services provided to a recipient. Read-Only.	Field	Number	9
Charges	Dollar amount charged for the service provided.	Field	Number	9
Claim Type	Code that specifies the type of pharmacy claim. Valid values: Pharmacy and Compound Drug.	Field	Drop Down List Box	0
Conflict Code	Code indicating that there is a conflict between the prescription and patient medical record as indicated by the pharmacist.	Field	Drop Down List Box	0
Date Adjusted	Adjusted date of the related claim. (This field to be determined.)	Field	Date (MM/DD/CCYY)	10
Date Dispensed	Date the pharmacy filled the prescription.	Field	Date (MM/DD/CCYY)	10
Date Prescribed	Date the physician wrote the prescription.	Field	Date (MM/DD/CCYY)	10
Date of Birth	Recipient's date of birth. Read-only.	Field	Date (MM/DD/CCYY)	10
Days' Supply	Number of days a prescribed drug should last a recipient.	Field	Number	3
Denied Date	Date claim was denied.	Field	Date (MM/DD/CCYY)	10
Diagnosis	Diagnosis code that is associated with the claim.	Field	Character	7
Dispense/Written	Dispense as written indicator.	Field	Drop Down List Box	0
Dispensing Fee	Fee associated with dispensing the drug.	Field	Number	9
Emergency	Indicates whether service was provided as result of an emergency situation.	Field	Drop Down List Box	0
First Name, MI	Recipient's first name and	Field	Character	15

Field	Description	Field Type	Data Type	Length
	middle initial. Read-only.			
ICN [Adjustment Information]	Related claim's internal control number. Clicking on this row will display the claim.	Field	Number	13
ICN/HSID	Claim's internal control number and health service identification (HSID) number from First Health Web portal.	Field	Number	13
Insurance Denied	Indicates if other insurance carrier denied the claim.	Field	Drop Down List Box	0
Intervention	Indicates the pharmacist's interaction when a conflict code has been established. Valid values are: Not Specified, No Interface, Prescriber Consulted, Patient Consulted, High Dose, and Pharmacist.	Field	Drop Down List Box	0
Item	Detail line number. Read-Only.	Field	Number	3
Last Name	Recipient's last name. Read-only.	Field	Character	15
Medicaid ID	Recipient's Medicaid identification number. (This field to be determined.)	Field	Number	9
NDC Code	National Drug Code (NDC) used to identify a specific drug.	Field	Drop Down List Box	0
New/Refill	Code that indicates whether the prescription is new or a refill.	Field	Number	2
Nursing Facility	Indicates whether the drug was prescribed in a nursing home facility.	Field	Drop Down List Box	0
Outcome	Indicates the action taken by the pharmacist after warnings are returned from ProDUR. This is pulled from the Outcome Codes and Types table.	Field	Drop Down List Box	0
PA Auth #	PA number that authorized the drugs to be prescribed.	Field	Number	10

Field	Description	Field Type	Data Type	Length
Pregnancy	Code indicating that the patient is pregnant, not pregnant, or not sure.	Field	Drop Down List Box	0
Prescriber ID	License number of the provider who prescribed the drugs to the recipient. The provider does not have to be enrolled in Medicaid.	Field	Character	10
Prescriber Name	Name of the prescriber. Read-only.	Field	Character	20
Prescription #	Number that uniquely identifies a drug dispensed to a recipient.	Field	Number	9
Provider ID	Identification number and service location of the provider. Read-only.	Field	Character	15
Quantity	Number of units of the drug that were dispensed to the recipient.	Field	Number	6
Recipient ID	Recipient identification number.	Field	Character	0
Rendering Physician	Identification number of the physician who rendered services.	Field	Character	10
Signature	Indicates whether the signature is on file or not.	Field	Drop Down List Box	0
Status Information	Adjudication status of the claim. Read-only.	Field	Character	30
Submission/Clarification Code	Code indicating that the pharmacist is clarifying the submission. Valid values: Not Specified, No Override, Other Override, Vacation Supply, Lost Prescription, Therapy Change, Starter Does, Medically Necessary, Process Compound for Approved Ingredients, Encounters, Meets Plan Limitations, and Other.	Field	Drop Down List Box	0
TPL Amount	Amount paid by a Third Party	Field	Number	9

Field	Description	Field Type	Data Type	Length
	Liability (TPL) plan.			
Total Charges	Total of the detail line item charges. Read-only.	Field	Number	9
Total TPL Amount	Total of detail line item TPL Amount. Read-only.	Field	Number	9
Allowed Amount (List)	Amount approved to pay for services provided to a recipient. Read-Only.	Listview	Number	9
Charges (List)	Dollar amount charged for the service provided.	Listview	Number	9
Code	EOB code associated with the claim.	Listview	Character	0
Description	Description of the EOB code.	Listview	Character	0
Detail Number	EOB detail line number.	Listview	Character	0
Item (List)	Detail line number. Read-Only.	Listview	Number	3
NDC Code (List)	National Drug Code (NDC) used to identify a specific drug.	Listview	Character	0
Quantity (List)	Number of units of the drug that were dispensed to the recipient.	Listview	Number	6
TPL Amount (List)	Amount paid by a Third Party Liability (TPL) plan.	Listview	Number	9

4 TRADING FILES WITH ODJFS

4.1 Attachment Uploads

The Attachment Uploads panel enables a user to upload files for claims, prior authorizations, and provider enrollments.

Attachment Upload			
Type of Document	Reference		Received
EXPLANATION OF BENEFITS	2309351050001 017033877000014989101		YES
OPERATIVE NOTE	2309351050001 017033877000014989102		IN PROCESS
PERIODONTAL CHARTS	2309351050001 017033877000014989103		IN PROCESS
RADIOLOGY REPORTS	2309351050001 017033877000014989104		YES
SUPPORT DATA FOR CLAIM	2309351050001 017033877000014989105		NO

Please note the following important parameters when uploading files:

- File size cannot be greater than 50MB (51200KB).
- Only file types of gif, tiff, bmp, jpg, ppt, doc, xls, pdf, txt, and mdi can be uploaded.
- For claim attachments: Select row from the list above and then use the below panel to select the file for upload.

Attachment Upload	
upload attachment	
Type of Document	EXPLANATION OF BENEFITS
Reference	2309351050001 017033877000014989101
*File to Upload	<input type="text"/> Browse...

Tasks for this Panel

To **upload** an attachment:

- Select a row in the **Attachment Upload** list section of the panel.
- Click the **browse** button and select the file to upload.
- Click the **upload attachment** button.

Field Descriptions – Attachment Uploads

Field	Description	Field Type	Data Type	Length
Browse	Allows the user to navigate and select a local file to upload.	Button	N/A	0
upload attachment	Initiate the file upload.	Button	N/A	0
File to Upload	The navigational path of the file to be uploaded including the file name. Is a required field.	Field	Character	256
Upload	Bound file input - for direction on which file to upload.	Field	Character	0
Reference	Control number assigned to the attachment for identification purposes.	Label	N/A	0
Type of Document	Description of the uploaded file.	Label	N/A	0
Received	Indicates if the attachment has been received (This	Listview	Character	10

Field	Description	Field Type	Data Type	Length
	field will visible only for Claims attachment).			
Reference	Control number assigned to the attachment for identification purposes.	Listview	Character	35
Type of Document	Description of the uploaded file.	Listview	Character	75

Field Edits – Attachment Uploads

Field	Field Type	Error Code	Error Message	To Correct
upload attachment	Button	0	File format must be one of the following: bmp, doc, gif, jpg, mdi, pdf, ppt, tiff, txt, and xls.	Select a file of the proper format to be uploaded.
File to Upload	Field	0	Please select a file to upload.	Click the Browse button to select a file to upload into the Web Portal.

4.2 Attachment Cover – Claim

The electronic document attachment cover sheet for claim submission is shown below.

EDMS COVER SHEET

Name: Date: No. of Pages: (Including this cover sheet)

Phone:

Document Type:

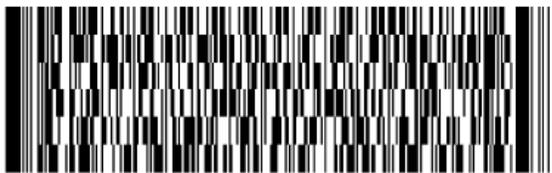
- Provider Recipient Correspondence Prior authorization Supporting documents for claim
 Accounts receivable Payment deduction Expenditure Hospital cost settlement
 LTC cost settlement Declaration of election of hospice benefit Attending physician written certification
 Revocation of hospice benefit Statement of termination of hospice benefit
 Selection of a different hospice provider IDG written certification Programs
 RetroDUR profile RetroDUR survey RetroDUR reports RetroDUR other documents

Sub Categories for Prior Authorization Documents

- Compression Garments Decubitus Care Equipment Dental Dressings, Surgical
 Enteral Nutrition & Supplies EPSDT Hospital Beds Hospital Inpatient Hospital Outpatient Hearing Aids
 Incontinence Supplies Increased State Plan Home Health Misc Equipment Orthodontics Orthotics (MTA)
 Orthotics/Prosthetics (Nurses) PDN Repairs Respiratory (MTA) Respiratory (Nurses)
 Supplies (Misc) Speech Generating Devices Transportation Therapies Vision Wheelchairs Others

Index Field & Values (if applicable):

ATN:	Recipient ID:	Prior Authorization Number:
<input type="text"/>	<input type="text"/>	<input type="text"/>
NPI:	Medicaid Provider ID:	
<input type="text"/>	<input type="text"/>	<i>Use only if you do not have NPI.</i>
ICN:	Contact Tracking Number:	
<input type="text"/>	<input type="text"/>	
Financial Record Number:	Status:	Program Control Number:
<input type="text"/>	<input type="text"/>	<input type="text"/>
Hospice Enrollment ID:	Hospice Attachment ID:	Intervention ID:
<input type="text"/>	<input type="text"/>	<input type="text"/>



Confidentiality Notice:

The sender of this facsimile transmission intends to communicate the contents of this transmission only to the Ohio Department of Job and Family Services. This transmission may contain information that is privileged, confidential or otherwise exempt from disclosure under applicable law. If you are not the designated recipient or the employee or agent responsible for delivering this transmission to the designated recipient, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If you have received this transmission in error, please notify us immediately by telephone at 1-800-686-1516 and promptly destroy the original transmission. Thank you for your assistance.

JFS 00000 (Rev. 06/10/2011 v2)

Ohio Department of Job and Family Services

To download a copy of this attachment cover sheet from the ODJFS Web site, click [here](#) (Ctrl key + click), or copy the following URL address and paste it into your browser's address field:

http://jfs.ohio.gov/OHP/providers/MITSEDMS_Cover_IT4.pdf.

Tasks for this Panel

To **add** Mail hard-copy attachments:

1. Press the **add** button.
2. The required fields for entering information display in the **Hard-Copy Attachments** panel.
3. Enter the Control Number. Select **Mail** for the **Transmission** value. Select a **Report Type** to describe the general content of the attachment.
4. Determine if additional attachments should accompany the claim.
5. If no additional hard-copy mail attachments are to accompany the claim, information entered for this panel is complete.
6. If no additional attachments will accompany the claim, it ready to submit.

To **add** an additional electronic attachment:

1. Press the **add** button.
2. The required fields for entering information display in the **Hard-Copy Attachments** panel.
3. Enter the **Control Number**. Select **Electronic Upload** for the **Transmission** value. Select a **Report Type** to describe the general content of the attachment.
4. Determine that no additional attachments should accompany the claim.
5. If no additional electronic attachments should accompany the claim, the claim is ready to submit.

To **delete** the current attachment information:

1. On a new claim or an adjudicated claim, select the detail row for deletion and press the **delete** button.
2. The message displays: **Are you sure this is the row you want marked for deletion?** Press **OK** to delete the row of Hard-Copy Attachment information entered in the panel.
3. Enter new attachment information, if desired.

Field Descriptions – Attachment Cover – Claim

Field	Description	Field Type	Data Type	Length
Claim ICN	The claim's internal control number.	Label	Number	13
Control Number	Control number assigned to the attachment for identification purposes.	Label	Number	80
Date of Service	Date of first service on the claim.	Label	Date (MM/DD/CCYY)	10
Medicaid ID	The recipient's Medicaid identification number.	Label	Alphanumeric	12
Patient Account #	The patient's account number on the Provider's system.	Label	Alphanumeric	38

Field	Description	Field Type	Data Type	Length
Provider ID	Identification number and service location of the provider.	Label	Alphanumeric	15