MITS WEB PORTAL BILLING GUIDE FOR INSTITUTIONAL CLAIMS

Revised 2011.12.21

Fields marked with an asterisk (*) require an entry.

Information entered into a field must be "recorded" before the system can use it. (In much the same way, information entered into a spreadsheet cell is accepted only after the <Enter> key is pressed.) Selecting a display row in a panel causes information to be recorded, as does moving the cursor out of a date field. Recording sometimes causes a momentary "graying out" of the entire screen.

Within a panel, press the 'add' button to enter new information. Select a display row to edit existing information. Select a display row and press the 'delete' button to remove the information for an existing line item. Select a display row and press the 'copy' button (if it is available) to base a new entry on the information for an existing line item. The selected display row is highlighted in light blue.

Enter dates either with or without separators. If separators are omitted, enter all eight digits (MMDDCCYY). Pressing <Enter> formats the date as MM/DD/CCYY.

Institutional Claim: [Medicaid Provider Number - PROVIDER NAME]

BILLING INFORMATION

ICN (assigned and populated automatically when the claim is successfully submitted)

○

Provider ID (assigned and populated automatically from the provider's login)

○ This field shows the provider ID number (National Provider Identifier, NPI) that represents the billing or pay-to provider. This billing/pay-to provider ID number also appears in the Institutional Claim header of this panel along with the provider's name.

*Type Of Bill

○ Enter the code indicating the specific type of bill. The code must be four characters long; use a leading zero where needed. The characters represent the kind of facility, service (inpatient or outpatient), and frequency. Note: For inpatient hospital Medicare Part B crossover claims, only type of bill 12X will be accepted. For inpatient hospital stays, the claim type assigned will be outpatient crossover. For nursing facility (NF) claims, type of bill 21X will be accepted. The Type of Bill code set is defined by the National Uniform Billing Committee (NUBC).

Institutional Claim

Claim Type (populated automatically from the provider's claim selection)

○ For institutional claims, there are five possible claim types:
A = Medicare Part A cost-sharing (Medicare Part A/C crossover), in which primary payment information for Medicare Part A or a Medicare Part C advantage plan is submitted
C = Medicare Part B cost-sharing (Medicare Part B/C crossover), in which primary payment information for Medicare Part B or a Medicare Part C advantage plan is submitted
I = Inpatient Hospital (such as would be submitted on a UB claim form)
L = Inpatient Long-Term Care/Nursing Facility (such as would be submitted on a UB claim form)
O = Outpatient Hospital, Nursing Facility (such as would be submitted on a UB claim form)

Note: A crossover claim type (A, C) will not be assigned until the Medicare information is entered in the appropriate panel.

*Medicaid Billing Number

○ Enter the 12-digit Billing Number from the recipient's medical card or the online eligibility system.

Note: For a recipient who is a Qualified Medicare Beneficiary (QMB) on the date(s) of service, Medicare coverage is primary, and the Medicaid benefit is limited to Medicare cost-sharing (payment only of coinsurance and deductible).

*Date of Birth

○ The date of birth must match the birth date on file for the recipient's Medicaid Billing Number entered in the previous field. Make sure that both the recipient's Medicaid Billing Number and date of birth are entered correctly; if they do not correspond, you will not be able to proceed.

Last Name (populated automatically when both a Medicaid billing number and date of birth are successfully entered)

○

First Name, MI (populated automatically when both a Medicaid billing number and date of birth are successfully entered)

○

Institutional Claim

*Patient Account #

> ○ Enter the patient account number assigned by the provider to identify the
> individual.

Medical Record #

> ○ Enter a medical record number assigned by the provider, if applicable. This
> optional field is meant to assist providers in maintaining medical records.

*Attending Physician #

> ○ The NPI is the only acceptable identifier in this field.

Operating Physician #

> ○ The NPI is the only acceptable identifier in this field.

Other Physician #

> ○ The NPI is the only acceptable identifier in this field.

*Patient Amount Paid

> ○ For hospitals, enter the amount of recipient spenddown collected or applied. (A
> default value of $0.00 is supplied because the field cannot be empty.) Note: Do
> NOT enter the Medicaid emergency room co-payment amount here.
>
> ○ For NFs, enter the amount of patient liability.

Institutional Claim

SERVICE INFORMATION

*Release of Information

<Blank>
INFORMATION ON FILE
INFORMED CONSENT TO RELEASE BY FEDERAL STATUTES
LIMITED OR RESTRICTED ABILITY TO RELEASE DATA
NOT ALLOWED TO RELEASE DATA [default]
ON FILE
SIGNED STMT PERMITTING RELEASE

○ This field indicates whether the provider has authorization for the release of medical data. A default value of 'Not Allowed to Release Data' will be entered. (The choices listed for Release of Information are defined in the Electronic Data Interchange guidelines.)

*From Date

○ Enter the beginning date of service for the period covered by this claim.

*To Date

○ Enter the ending date of service for the period covered by this claim.

Note: For outpatient claims with a single date of service, this date is the same as the 'From Date'. For outpatient claims with multiple dates of service, this date is the latest date of any service for which the claim is being submitted.

Admission Date

○ For inpatient services, enter the date of admission.

Admission Hour

○ Enter the time when the person was admitted for care. Specify four digits.

Institutional Claim

*Admission Type

<Blank> [default]
1 - EMERGENCY
2 - URGENT
3 - ELECTIVE
4 - NEWBORN
5 - TRAUMA
9 - INFORMATION NOT AVAILABLE

○ Enter a code to indicate the priority of this admission or visit. (The Admission Type code set is defined by the NUBC.)

Note: The use of Admission Type 9 will cause the denial of hospital claims.

Admit Source

○ Enter a code to indicate the point of patient origin for this admission or visit. (The Admit Source code set is defined by the NUBC.)

Discharge Hour

○ Enter the time when the person was discharged. Specify four digits.

*Patient Status

○ Enter a code to indicate the disposition or discharge status of the patient at the end of the period covered by this claim. Specify two digits. (The Patient Status code set is defined by the NUBC.)

*Covered Days

○ Enter the number of days of Medicaid eligibility or coverage for the dates of service. A default value of 0 is supplied.

Non Covered Days

○ Enter the number of days of Medicaid non-eligibility or non-coverage for the dates of service.

Coinsurance Days

○ Enter the number of Medicare coinsurance days for the dates of service.

Institutional Claim

Lifetime Reserve Days

○ Enter the number of Medicare lifetime reserve days for the dates of service.

Prior Authorization # / Precertification #

○ Complete this field only if prior authorization or precertification is required and has been granted by ODJFS for a service on the claim. Use the ODJFS prior authorization/precertification number assigned for the service.

TOTAL CHARGES

Total Charges (populated automatically when the claim is successfully submitted)

○ This field displays the sum of all line item charges submitted.

Total Non Covered Charges (populated automatically when the claim is successfully submitted)

○ This field displays the sum of all line item charges reported as non-covered.

Total Covered Charges (populated automatically when the claim is successfully submitted)

○ This field displays the difference obtained when non-covered charges are subtracted from total charges.

Note: The claim adjudication process will use this total for payment calculations.

Medicaid CoPay Amount (populated automatically when the claim is successfully submitted)

○

Note Reference Code

<Blank> [default]
ADD - Additional Information
CER - Certification Narrative
UPI - Updated Information

○

Institutional Claim

Notes

<div style="border:1px solid black; padding:10px">
○
</div>

Four additional panels ('Condition', 'ICD-9 Procedure', 'Occurrence/Span', 'Value') may be accessed through links at the bottom of the main 'Institutional Claim' panel. Entry of information into these panels depends on the claim being submitted and the related requirements for that claim.

Condition

*Sequence

> ⭕ Enter the appropriate sequence number for the condition code.

*Condition Code

> ⭕ Enter the condition code. (The Condition code set is defined by the NUBC.)

ICD 9 Procedure Code

*Sequence

○ Select the appropriate sequence for the procedure code.

*ICD 9 Procedure Code

○ Enter the ICD-9 procedure code.

*Date

○ Enter the date of service.

Occurrence/Span

*Sequence

> ○   Select the appropriate sequence for the occurrence code.

*Occurrence Code

> ○   Enter the occurrence code or occurrence span code. (The Occurrence and Occurrence Span code sets are defined by the NUBC.)

*From Date

> ○   Enter the date of the occurrence or the beginning date of the occurrence span.

To Date

> ○   Enter the end date of the occurrence span, if applicable.

Value

*Sequence

○ Select the appropriate sequence for the value code.

*Value

○ Enter the value code. (The Value code set is defined by the NUBC.)

○ On NF claims, enter the lump sum amount with value code 31; the words 'Patient Liability Amount' will be displayed. Enter additional value codes as applicable for NF crossover claims.

*Amount

○ Enter the dollar amount associated with the value code.

Diagnosis

Enter each diagnosis code to the highest level of specificity. Omit the decimal point. Repeat the steps until all diagnosis codes have been added to the claim.

*Sequence

<Blank> [default]
Principal
Admitting
Other

○ Select the appropriate indicator. (This diagnosis sequence code set is defined by the NUBC.)

*Diagnosis Code

○ Enter the diagnosis code that corresponds to the selected sequence code.

Present on Admission

<Blank> [default]
Yes
No
No Information on Record
Clinically Undetermined
Unreported/Not Used
Exempt from POA reporting

○ (The Present on Admission code set is defined by the NUBC.)

Other Payer

Press the 'add' button to specify that another source, such as commercial insurance or Medicare, is the primary payer for the recipient.

Note: Information for each payer (other than Medicaid) must be entered separately. For example, if a recipient has both Medicare and commercial insurance, then create a different entry for each carrier. This panel does not need to be completed when Medicaid is the primary payer and there is no other payer.

*Claim Filing Indicator

<Blank> [default]
AUTOMOBILE MEDICAL
BLUE CROSS/BLUE SHIELD
CENTRAL CERTIFICATION
CHAMPUS
COMMERCIAL INSURANCE CO.
DISABILITY
EXCLUSIVE PROVIDER ORGANIZATION (EPO)
HEALTH MAINTENANCE ORGANIZATION
HMO MEDICARE RISK
INDEMNITY INSURANCE
LIABILITY
LIABILITY MEDICAL
MEDICAID
MEDICARE PART A
MEDICARE PART B
OTHER FEDERAL PROGRAM
OTHER NON-FEDERAL PROGRAMS
POINT OF SERVICE (POS)
PREFERRED PROVIDER ORGANIZATION (PPO)
SELF-PAY
TITLE V
UNKNOWN
VETERAN ADMINISTRATION PLAN
WORKERS' COMPENSATION HEALTH CLAIM

◯   Never select 'MEDICAID'. (It appears on this list because it is included in the 5010 version of the 837 transaction.)
For Medicare Part A, select 'MEDICARE PART A'.
For Medicare Part B, select 'MEDICARE PART B'.
For a Medicare Advantage Plan, also known as Medicare Part C, select 'HMO MEDICARE RISK'.
For third-party insurance other than Medicare, select 'COMMERCIAL INSURANCE CO.'.

Other Payer Amounts and Adjustment Reason Codes (Select Detail Above)

*Policy Holder Relationship to Insured

<Blank> [default]
CADAVER
DONOR
CHILD
CHILD WHERE INSURED HAS NO FIN RESP
DEPENDENT OF A MINOR DEPENDENT
EMANCIPATED MINOR
EMPLOYEE
FATHER
FOSTER CHILD
GRANDCHILD
GRANDPARENT
HANDICAPPED DEPENDENT
INJURED PLAINTIFF
LIFE PARTNER
MOTHER
NEPHEW OR NIECE
ORGAN DONOR
OTHER RELATIONSHIP
SELF
SIGNIFICANT OTHER
SPONSORED DEPENDENT
SPOUSE
STEPCHILD
UNKNOWN
WARD

⭕ If the policy holder or subscriber is the recipient, select 'SELF'.

*Policy Holder Last Name

⭕ If the 'Policy Holder Relationship to Insured' is specified as 'SELF', this field will be automatically populated. Otherwise, enter the information.

*Policy Holder First Name, MI

⭕ If the 'Policy Holder Relationship to Insured' is specified as 'SELF', this field will be automatically populated. Otherwise, enter the information.

Policy Holder Date of Birth

⭕ If the 'Policy Holder Relationship to Insured' is specified as 'SELF', this field will be automatically populated. Otherwise, enter the information.

Other Payer Amounts and Adjustment Reason Codes (Select Detail Above)

Gender

<Blank> [default]
FEMALE
MALE
UNKNOWN

〇

*Paid Amount

〇   Enter the amount paid by the particular insurance carrier for the claim.

*Paid Date

〇   Enter the date on which the carrier processed the claim.

Allowed Amount

〇   Do not enter anything in this field. The amount allowed by the particular insurance carrier will be calculated automatically from the adjustment amounts and Adjustment Reason Codes reported.

*Insurance Carrier Name

〇

*Carrier Code

〇   Enter the Payer Identification (ID) code of the Medicare plan or insurance company. Do not enter the carrier code listed on the individual's Medicaid card. The Payer ID code may be obtained from the individual's Medicare or private insurance card, an explanation of benefits (EOB) or electronic remittance advice (ERA) issued by the payer, or the payer itself. Each payer defines its own Payer ID code. ODJFS does not maintain a list of Payer ID codes.

Insured's Policy ID

〇

Other Payer Amounts and Adjustment Reason Codes (Select Detail Above)

*Payer Sequence

<Blank> [default]
PRIMARY
SECONDARY
TERTIARY

○ Indicate the role of the payer in processing the claim. For example, if a recipient's Medicare pays only after the recipient's commercial insurance, select 'PRIMARY' for the commercial insurance entry and 'SECONDARY' for the Medicare entry.

Medicare ICN

○ For claims processed by Medicare as the primary payer (either traditional Medicare Part A or B, or a Medicare Advantage Plan aka Medicare Part C), enter the Medicare ICN assigned by the Medicare carrier for the service on the Medicare Explanation of Benefits, remittance advice, or 835 Health Care Claim Payment/Advice transaction.

Other Payer Amounts and Adjustment Reason Codes (Select Detail Above)

Select the 'Other Payer Amounts and Adjustment Reason Codes' link at the bottom of the 'Other Payer' panel to enter claim-level monetary amounts and Claim Adjustment Reason Codes (CARCs, or ARCs for short) for a particular payer.

Note: The 'Other Payer' panel displays the non-Medicaid payers associated with a particular claim. The 'Other Payer Amounts and Adjustment Reason Codes' panel displays the payment amounts and ARCs associated with a particular payer.

Be sure to enter all claim-level monetary amounts and ARCs for the payer.

*CAS Group Code

<Blank> [default]
CO-Contractual Obligations
CR-Correction and Reversals
OA-Other adjustments
PI-Payer Initiated Reductions
PR-Patient Responsibility

○ Select the Claim Adjustment Segment (CAS) Group Code received from the carrier on the explanation of benefits, remittance advice, or 835 transaction.

Payer Line Level Amounts and Adjustment Reason Codes (ARC)

*Amount

○ Enter the amount, in dollars, corresponding to a particular claim-level ARC received from the carrier on the explanation of benefits, remittance advice, or 835 transaction.

ARC

○ Enter the claim-level ARC (for which there is a corresponding dollar amount) received from the carrier on the explanation of benefits, remittance advice, or 835 transaction. (The Washington Publishing Company defines the ARC code set. The entire listing of codes can be found at http://www.wpc-edi.com/codes.)

Detail

In the 'Detail' panel, each service or supply is represented as a line item. Each line is numbered in the order in which it is entered. Display rows are arranged in descending order; later line items are displayed above earlier line items.

Note: Some information for a line item may be entered separately in the 'NDC (Detail Item #)' and 'Other Payer Detail' panels. Be sure to select the correct line before entering information into these panels. The selected line is shown in the headers, such as 'NDC (Detail Item 2)'; the default value is item 1.

Item (populated automatically)

○   This field displays the line item number.

Date of Service

○   For outpatient claims, enter the date on which the service or supply was provided. A separate line is required for each date of service.

To DOS (populated automatically)

○   For outpatient claims, this field will be automatically populated with the date entered in the 'Date of Service' field. A date span is not permitted on outpatient claims.

*Revenue Code

○   Enter a revenue center code on inpatient and outpatient claims. Do not use a leading zero. (The Revenue Center code set is defined by the NUBC.)

○   Nursing Facility: On a claim for a short-term convalescent stay, enter revenue center code 160 if the recipient is still enrolled in a waiver and 101 if the recipient is not enrolled in a waiver.

HCPCS/HIPPS Rate Codes

<Blank>
HCPCS [default]
HIPPS

○   When necessary for outpatient claims, select 'HCPCS' and enter the appropriate CPT or HCPCS code in the accompanying field.

Detail

Modifiers [4]

○ When applicable, enter each two-character procedure code modifier associated with the supply or service; up to four modifiers may be specified.
Note: Modifiers are not shown in the display rows near the top of the panel. Select a display row to see the modifiers that have been entered in the data fields.

*Units

○ Enter the number of units appropriate to the service or supply being reported.

*Units Of Measurement

| <Blank> [default] |
| Days |
| Unit |

○ Select the appropriate value being reported for 'Units' (days or units).

Per Diem Rate

○ For inpatient hospital and long-term care claims, enter the daily room rate.

*Total Charges

○ On hospital claims, enter the total charges (covered and non-covered) associated with the service being reported for this line item and date of service.

○ On NF claims, enter the total charges (covered only) associated with the service being reported for this line item and date of service.

Non Covered Charges

○ Enter any charges that are non-covered for service being reported for this line item and date of service. (On hospital claims, these charges are included in the 'Total Charges' amount.)

Note: On inpatient hospital claims, report covered days/charges for room and board and non-covered days/charges for room and board on separate lines.

Medicaid Allowed Amount (populated automatically when the claim is successfully submitted)

○ This field shows the amount payable for the service or supply before any TPL or Medicare payment is deducted.

Detail

Status (populated automatically when the claim is successfully submitted)

○

NDC (Detail Item #)

Hospitals are not required to report a National Drug Code (NDC) on a claim. If a hospital chooses to do so, an NDC can be reported only on a line specifying revenue center code 636 and a valid HCPCS J-code.

Select the 'NDC' link at the bottom of the 'Detail' panel to open the 'NDC (Detail Item #)' panel.

Before entering information for a line item in the 'NDC (Detail Item #)' panel, select the line in the 'Detail' panel for revenue center code 636. Once that detail line is selected, press the 'add' button in the 'NDC (Detail Item #)' panel. The header in the 'NDC (Detail Item #)' panel will change according to the selection—'NDC (Detail Item 1)', 'NDC (Detail Item 2)', and so on.

*NDC

○   The NDC code set is defined by the U.S. Food and Drug Administration (FDA).

Drug Name (populated automatically when the NDC is successfully entered)

○

*Unit of Measure

<Blank> [default]
F2-International Unit
GR-Gram
ML-Milliliter
UN-Unit

○   Select the appropriate unit of measure from the table.

Prescription Number

○

*Drug Unit Price

○

*Unit Quantity Submitted

○

Other Payer Detail (Detail Item #)

If another payer has been entered in the 'Other Payer' panel, then select the 'Other Payer – Detail' link at the bottom of the 'Detail' panel to open the 'Other Payer Detail (Detail Item #)' panel.

Before entering information for a line item in the 'Other Payer Detail (Detail Item #)' panel, select the display row for the line in the 'Detail' panel. The header in the 'Other Payer Detail (Detail Item #)' panel will change according to the selection—'Other Payer Detail (Detail Item 1)', 'Other Payer Detail (Detail Item 2)', and so on.

LINE LEVEL AMOUNTS AND ADJUSTMENT REASON CODES

*Carrier Code

> ⭕ The entries in the drop-down list are populated automatically from the 'Carrier Code' field in the 'Other Payer' panel.

*Paid Date

> ⭕

*Paid Amount

> ⭕ Enter the amount paid by the particular insurance carrier for the line item.

Other Payer Amounts and Adjustment Reason Codes – Detail (Select Detail Above)

Select the 'Other Payer Amounts and Adjustment Reason Codes – Detail' link at the bottom of the 'Other Payer Detail (Detail Item #)' panel to enter line-level monetary amounts and Claim Adjustment Reason Codes (CARCs, or ARCs for short) for a particular payer.

*CAS Group Code

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CO-Contractual Obligations
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OA-Other adjustments
PI-Payer Initiated Reductions
PR-Patient Responsibility

○ Select the Claim Adjustment Segment (CAS) Group Code received from the carrier on the explanation of benefits, remittance advice, or 835 transaction.

Payer Line Level Amounts and Adjustment Reason Codes (ARC)

*Amount

○ Enter the amount, in dollars, corresponding to a particular line-level ARC received from the carrier on the explanation of benefits, remittance advice, or 835 transaction.

ARC

○ Enter the line-level ARC (for which there is a corresponding dollar amount) received from the carrier on the explanation of benefits, remittance advice, or 835 transaction.

Attachments

Press the 'add' button to prepare an attachment for submission.

*Type of Document

<Blank> [default]
ADMISSION SUMMARY
CERTIFICATION
DENTAL MODELS
DIAGNOSTIC REPORT
DISCHARGE SUMMARY
EXPLANATION OF BENEFITS
MODELS
NURSING NOTES
OPERATIVE NOTE
PHYSICAL THERAPY CERTIFICATION
PHYSICAL THERAPY NOTES
PHYSICIAN ORDER
PRESCRIPTION
PROSTHETICS OR ORTHOTIC CERTIFICATION
RADIOLOGY FILMS
RADIOLOGY REPORTS
REFERRAL FORM (OHIO 6653)
REPORT OF TESTS AND ANALYSIS REPORT
SUPPORT DATA FOR CLAIM

○ An attachment is required for the adjudication of certain claims. When a required attachment is submitted with a claim, the claim will be suspended for review. An attachment that is not required will not be reviewed; the accompanying claim will be processed as though there were no attachment. The mere presence of an attachment will not cause a claim to be suspended for review. Therefore, submit an attachment only when an attachment is required.

*Transmission Type

<Blank> [default]
MAIL
UPLOAD

○ An attachment that is uploaded will automatically be linked to the claim by Internal Control Number (ICN). An 'upload' button will appear after the claim has been submitted. Only file types gif, tiff, bmp, jpg, ppt, doc, xls, pdf, txt, and mdi can be uploaded.

○ An attachment that is mailed to ODJFS after the claim is submitted through the portal must be accompanied by an EDMS cover page and sent to the appropriate mailing address. A button for printing a cover page and a button for displaying addresses will appear after the claim has been submitted.

Supporting Data for Delayed Submission / Resubmission

Previously Denied ICN or TCN

> ○ If (1) this claim is a resubmission or correction of a claim that has been denied within the past 180 days for reasons other than lack of timely filing and (2) the interval between the date of service and the current submission date (today) is more than 365 days, then enter the Internal Control Number (ICN) or Transaction Control Number (TCN) of the previously denied claim.
>
> Documentation to support the use of this panel must be retained for audit purposes.

Claim Status Information

Claim Status (populated automatically when the 'submit' button is pressed)

⭕

| submit | cancel |