

# MIT'S WEB PORTAL BILLING GUIDE FOR DENTAL CLAIMS

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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.

**Dental 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)

\*Medicaid Billing Number

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

\*Date of Birth

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

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.

**Dental Claim: [Medicaid Provider Number - PROVIDER NAME]**

Last Name (populated automatically)

First Name, MI (populated automatically)

\*Patient Account #

Enter the patient account number assigned by the provider to identify the individual. (A default value of 0 is supplied because the field cannot be empty.)

Referring Provider #

If a physician or dentist authorized a referral, enter the NPI of the referring provider. An NPI is the only acceptable identifier in this field.

Patient Amount Paid

Enter the amount of recipient spenddown collected or applied.

NOTE: Do NOT enter the Medicaid co-pay amount for any service subject to co-payment (explained in rule 5101:3-1-09 of the Ohio Administrative Code). Such a co-pay amount is automatically deducted from the Medicaid payment made to a provider. Entering a Medicaid co-pay amount in this field will result in a duplicate deduction.

**SERVICE INFORMATION**

\*Release of Information

<Blank>
NO [default]
YES

This field indicates whether the provider has the authorization for the release of medical data.

From Date (populated automatically when the claim is successfully submitted)

If there are multiple detail lines with multiple dates of service, this field will show the earliest From Date of Service entered at the detail level.

**Dental Claim: [Medicaid Provider Number - PROVIDER NAME]**

To Date (populated automatically when the claim is successfully submitted)

If there are multiple detail lines with multiple dates of service, this field will show the latest To Date of Service entered at the detail level.

Emergency

<Blank>
NO [default]
YES

Completion of this field is optional, but you may select either 'No' to indicate that the service provided was not emergency-related or 'Yes' to indicate that the service provided was emergency-related.

Accident Related To

<Blank> [default]
AUTO ACCIDENT
EMPLOYMENT
OTHER ACCIDENT

If the service is related to an accident, choose the category most appropriate to the circumstances.

Accident State

<Blank> [default]
(50 states, listed individually)
DISTRICT OF COLUMBIA
GUAM
VIRGIN ISLANDS

If the service is related to an automobile accident, identify the state or territory in which the accident occurred.

Accident Country

If the service is related to an automobile accident, identify the country in which the accident occurred.

Accident Date

If the service is related to an automobile accident, enter the date on which the accident occurred.

**Dental Claim: [Medicaid Provider Number - PROVIDER NAME]**

**EPSDT**

<Blank> [default]
YES

**\*Place of Service**

Enter (or use the [Search] function to select) the code that best describes the place of service.

**Prior Authorization #**

Complete this field only if prior authorization is required and has been approved by ODJFS for a service listed on the claim. Use the ODJFS prior authorization 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.

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

This field displays the sum of all Medicaid allowed amounts for the line items.

TPL Paid Amount (populated automatically when the claim is successfully submitted)

This field displays the sum of the paid amounts reported in the 'Other Payer' panel. This TPL amount is applied toward the total claim payment.

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

This amount will be reduced by any TPL payment amounts.

**Dental Claim: [Medicaid Provider Number - PROVIDER NAME]**

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

- Medicaid co-payment amounts described in rule 5101:3-1-09 of the Ohio Administrative Code are automatically deducted from the Medicaid payment and will be displayed in this field, unless a Medicaid co-payment exclusion applies and a co-payment exclusion code is added in the 'Notes' field.

Note Reference Code

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

- Select 'ADD' if you are submitting a claim more than 365 days after the date of service because of either a hearing decision or a delay in a recipient's eligibility determination. Also enter an appropriate code and date in the 'Notes' field. Select 'ADD' if you are entering a Medicaid co-payment exclusion code in the 'Notes' field.

Notes

- When a claim is submitted more than 365 days after the date of service because of either a hearing decision or a delay in a recipient's eligibility determination by the County Department of Job and Family Services (CDJFS), enter the appropriate reason code. The claim must be submitted within 180 days after the hearing decision or eligibility determination date.  
Hearing decision format: APPEALS XXXXXXXX CCYYMMDD  
(XXXXXXXX is the hearing number and CCYYMMDD is the date on the hearing decision letter.)  
Eligibility determination format: DECISION CCYYMMDD  
(CCYYMMDD is the date on the eligibility determination notice from the CDJFS.)
- When a Medicaid co-payment exclusion applies, as described in rule 5101:3-1-09 of the Ohio Administrative Code, select 'ADD' in the 'Note Reference Code' field and enter a 10-character exclusion reason code in this field.  
Format for emergency exclusion: COPAY EMER  
Format for hospice exclusion: COPAY HSPC  
Format for pregnancy exclusion: COPAY PREG  
(There must be a space after the word 'COPAY'.)


**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.

**\*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 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 third-party insurance other than Medicare, select 'COMMERCIAL INSURANCE CO.'.

**Other Payer**

**\*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**

Gender

<Blank> [default]
FEMALE
MALE
UNKNOWN

\*Paid Amount

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

\*Paid Date

Enter the date on which the carrier processed the claim.

Allowed Amount

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

\*Carrier Code

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



**Other Payer**

**\*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 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.

**\*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.

**Detail**

In the 'Detail' panel, each service 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.

Item (populated automatically)

\*Procedure Code

Enter the five character/digit Current Dental Terminology (CPT) code which corresponds to the service.

Tooth Number

Enter the appropriate tooth number or tooth letter.

Quadrant

Use of this field is conditional.

Rendering Provider

An NPI is the only acceptable identifier in this field.

Status (populated automatically when the claim is successfully submitted)

\*DOS

Enter the date on which the service was provided.

\*Units


Enter the number of units appropriate to the service.

\*Charges

Enter the usual and customary charge for the service.

**Detail**

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

 This field shows the amount payable for the service before any TPL is deducted.

## 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**

<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 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.

**Surfaces (Detail Item #)**

Press the 'add' button to specify a particular tooth surface for all restorations.

\*Surface

<Blank> [default]
BUCCAL
DISTAL
FACIAL
INCISAL
LINGUAL
MESIAL
OCCLUSAL



**Attachments**

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

**\*Type of Document**

<Blank> [default]
DENTAL MODELS
DIAGNOSTIC REPORT
EXPLANATION OF BENEFITS
OPERATIVE NOTE
PERIODONTAL CHARTS
RADIOLOGY FILMS
RADIOLOGY REPORTS
REFERRAL FORM (OHIO 6653)
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)

submit

cancel