Skilled Nursing Facility (SNF) Web Portal Billing Guide

DHS
Oregon Department of Human Services

Oregon Medicaid Nursing Facilities
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1 Introduction

The Secure Nursing Facility (SNF) Web Portal Billing Guide is designed to assist Nursing Facility providers who bill the Department of Human Services (DHS) for Medicaid services, to complete SNF Web portal claims correctly the first time. This guide gives you step-by-step instructions so that DHS can pay you more quickly. Use this billing guide along with the Oregon Administrative Rules Chapter 411 Division 070 (nursing facility payment rules), which contain information on policy and covered services specific to nursing facilities.

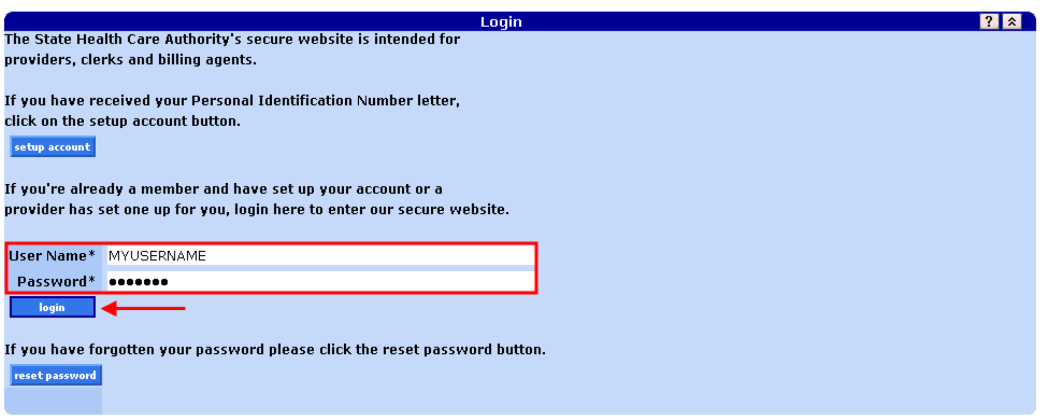
This billing guide outlines the requirements for completion of the SNF Web portal claim to sending your claim to DHS for payment processing, as well as helpful hints on how to avoid common billing errors.

2 Logging into the Web Portal

Access the provider Web portal by going to the following Web address: https://www.or-medicaid.gov (You must include the ‘s’ in ‘http**s**’).

Point to Account on the main menu and select Secure Site from the submenu (You may also click the ‘Providers Login to set up your Web portal accounts and verify eligibility for OHP clients’ link).

Type your username and password in the appropriate fields and click the login button.



For additional information regarding accessing the provider Web portal, please see the Web portal training materials located on the MMIS Web portal page.

http://www.oregon.gov/DHS/healthplan/webportal.shtml

You can also go to go to http://www.oregon.gov/DHS/MMIS and follow these steps:

- Click on ‘Training Information’
- Click on ‘Tools for Provider’
- Click on ‘Provider Web Portal’
- Click on ‘Provider Web Portal Handbook (PDF)’

3 Verifying Client Eligibility

Before submitting an SNF coinsurance claim, be sure to view the resident's eligibility information.

3.1 Verifying Eligibility on the Web Portal

To view a resident's eligibility information, log into the secure provider Web Portal and click the Eligibility menu item.

Client ID, From dates of service (DOS), and To DOS are required fields to perform a search to verify client eligibility. Additional client data can be entered if desired. **It is recommended that you limit the search to the specific month or dates of service for which you are submitting a claim.**

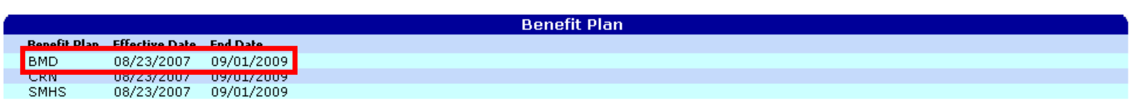
Once you have entered the minimum required data, click the Search button.

The eligibility search results display at the bottom of the page. The results consist of six screens:

- Client Information
- Benefit Plan
- TPL
- Managed Care
- Lockin
- Service Limitations

3.2 What Information to Look For

In order for your SNF coinsurance claim to process successfully, the Benefit Plan screen must show one of the following benefit plans for the entire statement period: BMD, BMM or MED. No other specific benefit plan information is required.



4 Accessing the Institutional/UB-04 Web Claim Form

To access the Institutional/UB-04 web Claim form, point to Claims on the main menu and select Institutional from the submenu.

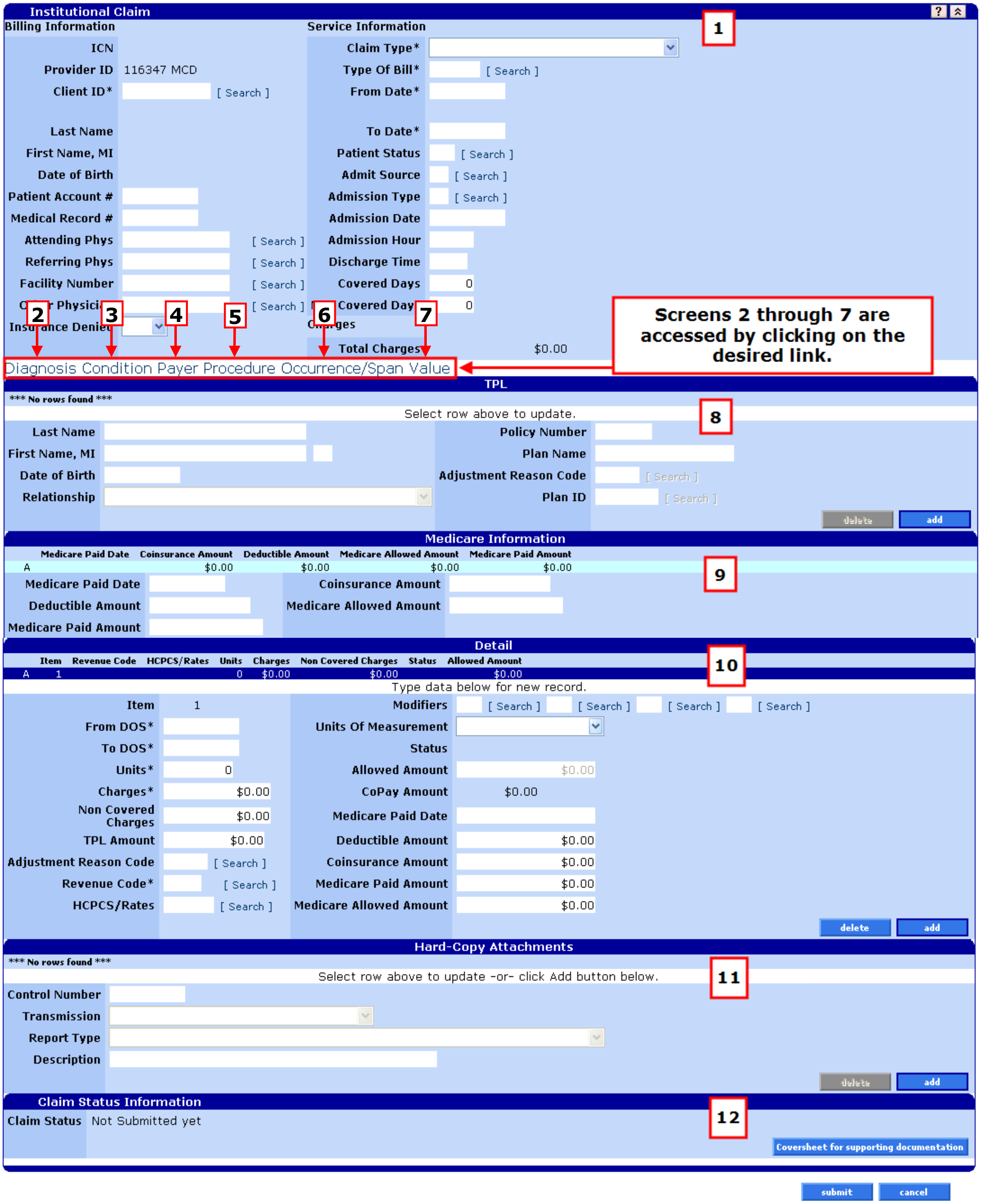
A blank Institutional/UB-04 claim for displays. The Institutional/UB-04 Web claim form consists of the following screens:

1. Institutional Claim Header
2. Diagnosis
3. Condition
4. Payer
5. Procedure
6. Occurrence/Span
7. Value
8. Third-Party Liability (TPL)
9. Medicare Information
10. Detail
11. Hard Copy Attachments
12. Claim Status Information

To submit an SNF coinsurance claim successfully, you must fill out the following screens:

1. Institutional Claim Header
2. Diagnosis
4. Payer
6. Occurrence/Span
9. Medicare Information
10. Detail

4.1 Blank Institutional/UB04 Web Claim Form



Institutional Claim

Billing Information

ICN	
Provider ID	116347 MCD
Client ID*	[Search]
Last Name	
First Name, MI	
Date of Birth	
Patient Account #	
Medical Record #	
Attending Phys	[Search]
Referring Phys	[Search]
Facility Number	[Search]
Other Physician	[Search]
Insurance Denied	

Service Information

Claim Type*	
Type Of Bill*	[Search]
From Date*	
To Date*	
Patient Status	[Search]
Admit Source	[Search]
Admission Type	[Search]
Admission Date	
Admission Hour	
Discharge Time	
Covered Days	0
Non Covered Days	0
Non Covered Charges	
Total Charges	$0.00

1

2 3 4 5 6 7

Diagnosis Condition Payer Procedure Occurrence/Span Value

Screens 2 through 7 are accessed by clicking on the desired link.

TPL

*** No rows found ***

Select row above to update.

8

Last Name		Policy Number	
First Name, MI		Plan Name	
Date of Birth		Adjustment Reason Code	[Search]
Relationship		Plan ID	[Search]

delete add

Medicare Information

	Medicare Paid Date	Coinsurance Amount	Deductible Amount	Medicare Allowed Amount	Medicare Paid Amount
A		$0.00	$0.00	$0.00	$0.00

9

Medicare Paid Date		Coinsurance Amount	
Deductible Amount		Medicare Allowed Amount	
Medicare Paid Amount			

Detail

	Item	Revenue Code	HCPCS/Rates	Units	Charges	Non Covered Charges	Status	Allowed Amount
A	1			0	$0.00	$0.00		$0.00

10

Type data below for new record.

Item	1	Modifiers	[Search] [Search] [Search] [Search]
From DOS*		Units Of Measurement	
To DOS*		Status	
Units*	0	Allowed Amount	$0.00
Charges*	$0.00	CoPay Amount	$0.00
Non Covered Charges	$0.00	Medicare Paid Date	
TPL Amount	$0.00	Deductible Amount	$0.00
Adjustment Reason Code	[Search]	Coinsurance Amount	$0.00
Revenue Code*	[Search]	Medicare Paid Amount	$0.00
HCPCS/Rates	[Search]	Medicare Allowed Amount	$0.00

delete add

Hard-Copy Attachments

*** No rows found ***

Select row above to update -or- click Add button below.

11

Control Number	
Transmission	
Report Type	
Description	

delete add

Claim Status Information

12

Claim Status Not Submitted yet

Coversheet for supporting documentation

submit cancel

5 Submitting an SNF Coinsurance Claim

IMPORTANT NOTE:

In order for DHS to identify and track days 1 through 20 (which Medicaid does not pay) and days 21 through 100 (which Medicaid does pay), you must submit a claim to DHS for any and all days the resident is in your facility. DHS will calculate which days are covered by Medicaid and pay each claim accordingly. This may result in claims submitted to DHS that receive a 'zero paid' status.

For example:

If a resident is admitted to your facility on 1/20/2009, you must bill DHS for the month of January with dates of service 1/20/2009 through 1/31/2009. Your claim will 'zero pay' and 12 units will be counted towards the first 20 days that Medicaid does not pay.

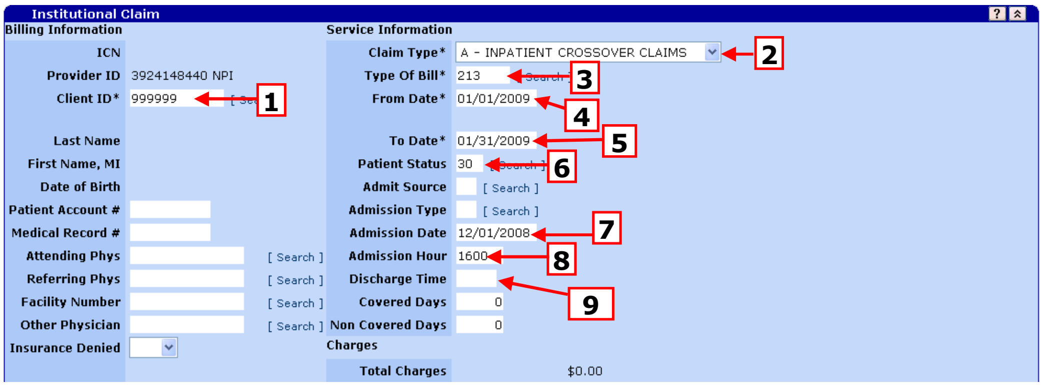
When you bill for the month of February, DHS will calculate which days are covered by Medicaid and which days are not. Assuming no breaks in service, the first 8 units (2/1 to 2/8) will complete the first 20 day calculation and you will not be paid for those days. Medicaid will begin paying on 2/9 (day 21) will continue to calculate up to day 100 as subsequent claims are submitted.

When there are breaks in service, DHS will calculate the number of days as described above based on each claim submitted. However, you must submit one individual Institutional Web or UB-04 paper claim form for each statement period, including statement periods that fall within days 1 through 20. See the applicable note in the 'Completing the Header Screen' section.

Note: The Occurrence Code and qualifying dates are critical in order to receive payment for skilled nursing facility coinsurance or for the 20-day6 post hospital extended care (PHEC) benefit.

5.1 Completing the Header Screen

The header screen contains general information about the claim. To complete the header screen:



1. **Client ID:** Enter the resident's state Medicaid ID/Prime Number.

2. **Claim Type:** Select claim type 'A- Inpatient Crossover Claims' from the dropdown list. **Note:** technically these are not 'Crossover' claims; these are claims where the client has Medicare coverage.

3. **Type of Bill:** Enter the appropriate type of bill code.

TOB	Description
211	Admit through Discharge Claim: Encompasses an entire span of service (admission through discharge) for which the facility expects reimbursement.
212	First Claim: Use this code when the resident is admitted to the facility and this is the first of an expected series of claims.
213	Continuing Claim: Use when one or more claims for the span of service have already been submitted, and further claims are expected to be submitted at a later date.
214	Last Claim: Use this code when the resident is discharged from the facility and this is the last in a series of claims. The "through" date of this claim (FL 6) is the discharge date or date of death for this service span.

4. **From Date:** Enter the beginning date of the service to be billed for this claim.

5. **To Date:** Enter the last date of service you are billing for or the patient's discharge date, which ever applies.

6. **Patient Status:** Enter a patient status code indicating the patient's status at the end of the statement period.

Status Code	Description
30- Still a Patient	Use status code 30 when the resident is still a patient in your facility at the end of the statement period. When the patient status code is 30, you will be paid for the last date of service in the statement period.
All other codes	Use all other status codes to indicate the patient's status at the time they were discharged from your facility. (For example: Status code 02-Discharged/Transferred To Another Short Term General Hospital For Inpatient Care) When using all other status codes (other than 30), you will not be paid for the last date of service in the statement period.

Note: Any time there is a break in service, you must submit a separate Institutional Web or UB-04 paper claim form for each statement period. Additionally, you must indicate the appropriate patient status code for each individual statement period.

For example:

- 12/01/08 - Resident is admitted to the nursing facility
- 12/05/08 - Resident goes to the hospital and is expected to return
- 12/06/08 - Resident returns from the hospital and remains at the facility through the end of the month

In this example, you must submit two separate Institutional Web claim forms:

- One with dates of service 12/01/08 through 12/05/08 and patient status code 02 indicating the resident was transferred to the hospital. Your claim will 'zero pay' and four units (12/1 to 12/4) will be counted towards the first 20 days that Medicaid does not pay.

- One with dates of service 12/06/08 through 12/31/08 and patient status code 30 indicating the resident is still a patient at your facility. The first 16 units (12/6 to 12/21) will count towards the first 20 days that Medicaid does not pay. Medicaid will begin paying for 12/22 (day 21) and you will be paid for 12/22 through 12/31.

7. **Admission Date:** Enter the date the resident was originally admitted to your facility.

    - If this is the first claim you are submitting to DHS for this qualifying stay, the admission date will be the same as the date in field 5.

    - If this is not the first claim you are submitting to DHS for this qualifying stay, the admission date **will not** be the same as the date in field 5.

8. **Admission Hour:** Enter the time of day that the resident was originally admitted to your facility (this is referring to the admission that took place on the date noted in item 7 above).

9. **Discharge Time**: If the resident has been discharged, enter the time of day they were discharged.

    - If a discharge hour is present, the value in the Patient Status field should **not** be 30.

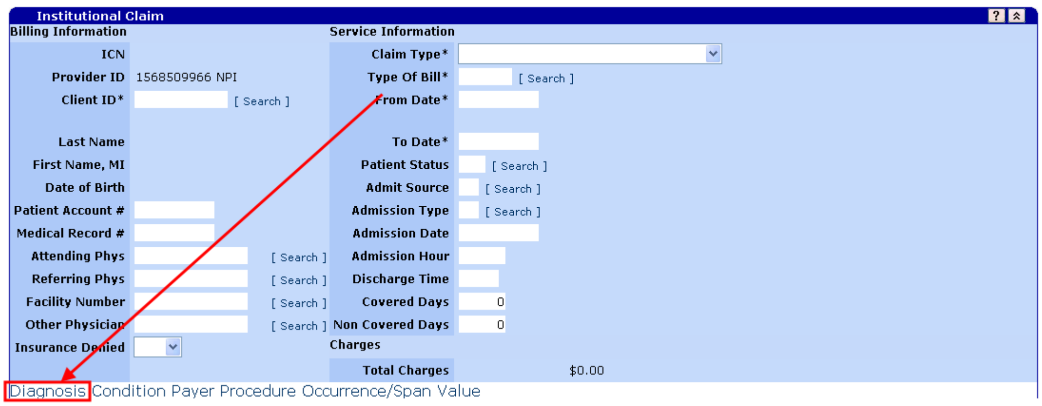
    - If the resident is still a patient, do not enter a discharge time. If the resident is still a patient, the value in the Patient Status field should be 30.

5.2 Completing the Diagnosis Screen

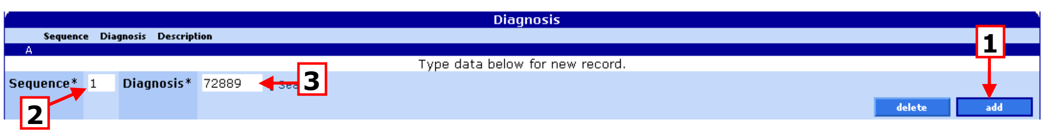
The Diagnosis screen is where you enter the diagnosis related to the qualifying hospital stay. This information should be provided to you by the discharging hospital.

Note: You are not required to enter an admitting diagnosis on SNF coinsurance claims. Only a primary diagnosis is required.

To access the Diagnosis screen, click the Diagnosis link located at the bottom of the header screen.



The screen refreshes and the Diagnosis screen appears below the header screen. To complete the Diagnosis screen:

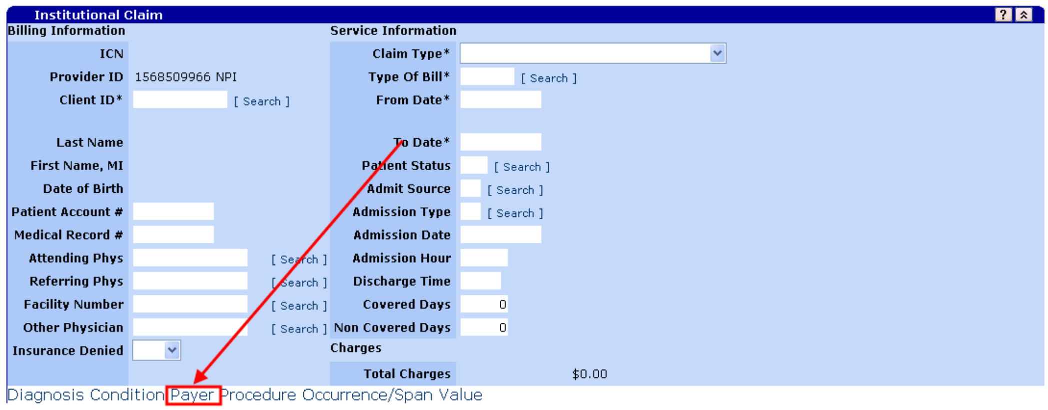


1. Click the Add button to activate the fields.
2. **Sequence:** Enter a 1 in the Sequence field to indicate this is the primary diagnosis.
3. **Diagnosis:** Enter the diagnosis code that was provided to you by the hospital. **Hint:** do not use the decimal point when entering the diagnosis code.

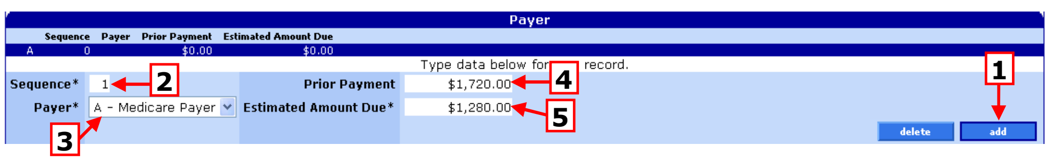
5.3 Completing the Payer Screen

The Payer screen is where you enter information about payers that have made payments previously. (i.e. Medicare)

To access the Payer screen, click the Payer link located at the bottom of the header screen.



The screen refreshes and the Payer screen appears below the header screen. To complete the Payer screen:



1. Click the Add button to activate the fields.

2. **Sequence**: Enter a 1 in the Sequence field (because Medicare is primary payer).

3. **Payer**: Select 'A-Medicare Payer' from the dropdown list.

4. **Prior Payment**: Enter the amount that Medicare paid on this claim.

   Note: This value may be more than what you originally billed Medicare. If so, be sure to enter the total Medicare/Plan *allowed amount* in the 'Charges' field on the Detail screen.

5. **Estimated Amount Due**: Enter the amount you are billing Medicaid (the coinsurance amount).

Note: If the amount you are requesting from Medicaid is zero, (for example a claim for days 1-20 only) enter a zero in this field.

5.4 Completing the Occurrence/Span Screen

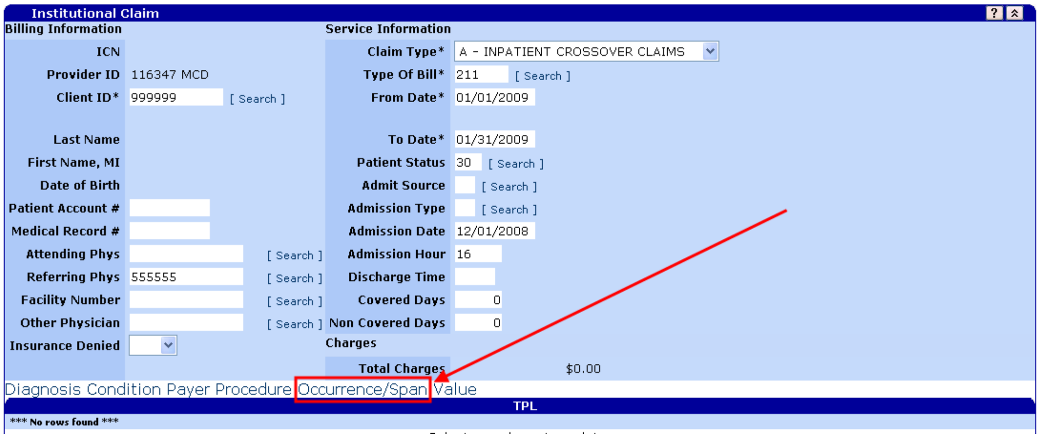
The Occurrence/Span screen is where you enter information about the original qualifying hospital stay. This is the stay that qualifies the resident to be in your facility.

You must indicate an occurrence code of '70' and the from and through dates of the qualifying hospital stay. The same from and through dates should be used on **every** claim submitted for services provided after this qualifying hospital stay (i.e. When you submit multiple claims for the same month due to breaks in service, each claim must contain the same qualifying stay dates. Each claim submitted after that must also contain the same qualifying stay dates).

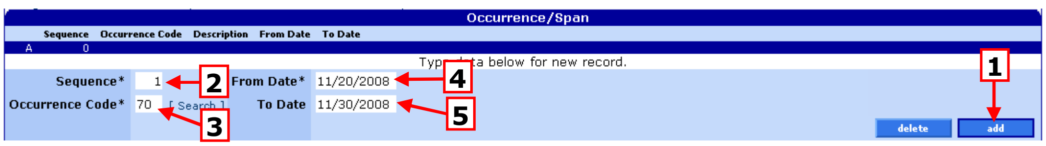
Do not include information about return visits to the hospital for follow-up care on the Occurrence/Span screen. Return visits do not impact the original qualifying stay dates.

If the patient is admitted to the hospital for a reason that justifies a new qualifying stay (Per Medicare rules) be sure to begin using the new qualifying stay dates on subsequent claims.

To access the Occurrence/Span screen, click the Occurrence/Span link located at the bottom of the header screen.



The screen refreshes and the Occurrence/Span screen appears below the header screen. To complete the Occurrence/Span screen:



1. Click the Add button to activate the fields.

2. **Sequence**: Enter a 1 in the Sequence field.

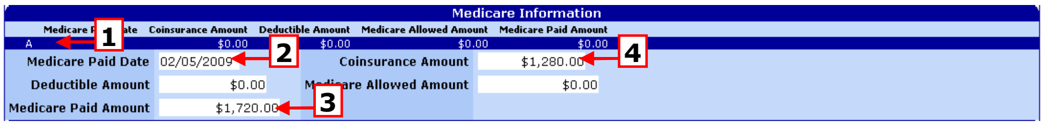
3. **Occurrence Code**: Enter 70 in the Occurrence Code field.

4. **From Date**: Enter the admission date for the qualifying hospital stay.

5. **To Date**: Enter the discharge date for the qualifying hospital stay.

5.5 Completing the Medicare Information Screen

The Medicare Information screen is where you enter Medicare payment information. To complete the Medicare Information screen:



1. Click the data row at the top of the screen to activate the fields.
2. **Medicare Paid Date**: Enter the date Medicare paid this claim.
3. **Medicare Paid Amount**: Enter the amount that Medicare paid on this claim.

   Note: This value may be more than what you originally billed Medicare. If so, be sure to enter the total Medicare/Plan allowed *amount* in the 'Charges' field on the Detail screen.
4. **Coinsurance Amount**: Enter the Coinsurance amount (the amount you are requesting from Medicaid).

   Note: If the amount you are requesting from Medicaid is zero, (for example a claim for days 1-20 only) enter a zero in this field.

5.5.1 Adjusting the Coinsurance Amount for Claims Originally Submitted on Paper

When a claim is submitted on paper, the coinsurance amount is entered in field 39 with a corresponding value code. Value codes are not used on Web portal claims.

If you are using the Web portal to make an adjustment to the coinsurance amount for a claim that was originally submitted on paper, adjust the Coinsurance Amount on the Medicare Information screen. (field 4 above) Do not make changes on the Value code screen on the Web portal.

5.6 Completing the Detail Screen

The Detail screen is where you enter information about the specific item you are billing. For SNF coinsurance claims, you must always bill for revenue code 0022. Do not bill for other revenue codes on the same claim form.

Note: When there are breaks in service, you must submit one Institutional Web or UB-04 paper claim form for each statement period. You cannot submit multiple detail line items representing nonconsecutive statement periods in the same month.

To complete the detail screen:

1. **From DOS**: Enter the beginning date for the service covered by this claim. This should be the same date that was entered in the From Date field on the header screen.

2. **To DOS**: Enter the ending date for the service covered by this claim. This should be the same date that was entered in the To Date field on the header screen.

3. **Units**: Enter the total units represented by the date range in fields 1 and 2.

   When the patient status code is 30, (Patient Status field on the header screen) include the last day in the date range in the number of units billed.

   When the patient status code is anything other than 30, do not include the last day in the date range in the number of units billed.

Note: DHS will calculate which of these units are covered by Medicaid and which are not. Do not perform this calculation manually and attempt to reflect it in the number of units billed.

4. **Charges**: Enter the Medicare/Plan allowed amount for this claim.

   Note: Be sure to use the total allowed amount from your Medicare/Plan EOB. The total allowed amount may be more than what you originally billed Medicare/the plan.

5. **Adjustment Reason Code**: This field is only required if the client has third part insurance that did not make a payment on this claim. The value in this field should explain why no payment was made. (For example, if the client has a third party insurance policy that does not pay SNF claims, the MMIS requires an ARC code explaining that the policy did not make a payment because it is a non-covered service.)

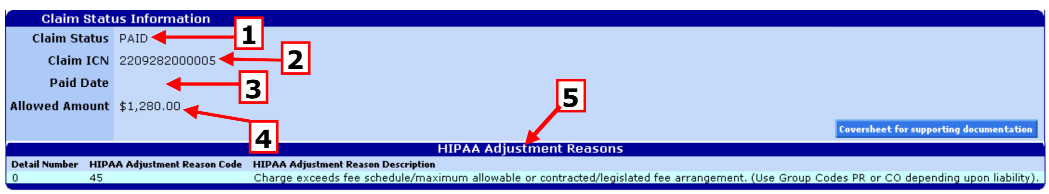
6. **Revenue Code**: Enter revenue code 0022.

5.7 Submitting Your Claim

Prior to submitting your claim, the Claim Status Information screen displays 'Not submitted yet.' Review all of the information you have entered to ensure it is correct. When you have verified the accuracy and you are ready to submit your claim, click the Submit button at the bottom of the claim.

5.8 Claim Submission Results

After clicking the submit button, the page refreshes and the adjudication results for your claim display. The results include the following fields:



1. **Claim Status**- Your claim will receive a status of 'Paid,' 'Denied,' or 'Suspended.'

2. **ICN**- This is the unique **I**nternal **C**ontrol **N**umber for this claim. This is the MMIS-generated claim reference number.

3. **Paid Date**- After you submit your claim, the paid date on this screen will be blank because the claim has not yet gone through the weekly financial cycle. A paid date will display in this field after the next financial cycle runs (typically over the weekend).

4. **Allowed Amount**- This is the amount the MMIS has determined is allowed for your claim. This amount will reflect the determination of which days are covered by Medicaid and which days are not. For example, if your claim contained day one (1) through days ten (10) and charges of $1,000.00, the allowed amount would be zero because Medicaid does not pay for days one (1) through ten (10).

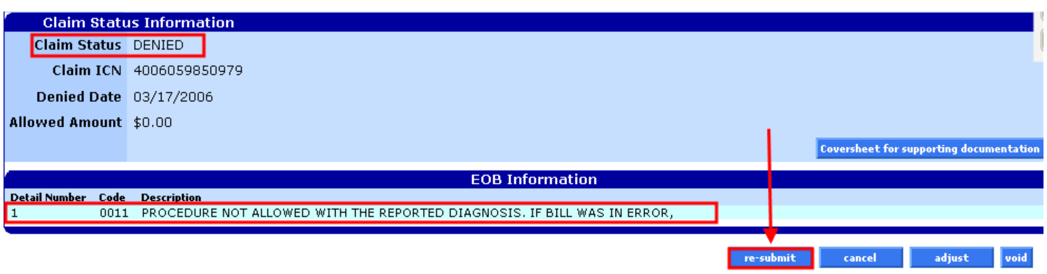
5. **HIPAA Adjustment Reasons**- HIPAA Adjustment Reason Codes (ARCs) are the codes DHS has determined best identifies the detailed reason a claim processing decision was made. These codes may indicate why your claim denied or why the allowed amount is less than what was billed. Please note that some ARCs are informational only and do not impact the claim status or allowed amount.

   Note: If you click the submit button and the claim status still says 'Not Submitted Yet,' scroll to the top of the page and look for informational messages regarding missing data or other errors preventing the claim from being submitted.

5.8.1 Denied Claims

If your claim denies, view the ARCs and attempt to determine what caused the denial. If the denial reason is correctable, then, go to the appropriate screen/field and correct the error. After you have corrected the error, click the re-submit button at the bottom of the claim. Hint: make note of the ICN created for this claim.

If you exit this claim and later decide you did not achieve the desired result, you will need to enter the ICN in the Claim Search screen to locate the claim and submit a correction.



5.8.2 Additional Information

Additional information regarding web portal billing is available at DHS' website:

http://www.oregon.gov/DHS/healthplan/webportal.shtml#billing,

For instructions on how to resubmit a denied claim, select the 'Institutional Web Billing Instructions' document and go to the 'How to resubmit a denied claim' section.

For information regarding adjusting paid claims, select the 'Web Adjustment Instructions' document.

For assistance with the web portal or password resets contact Provider Access Services at 800.336.6016 or by email at Team.Provider-Access@state.or.us