
Oregon Health Plan Provider Web Portal

Institutional Claim

Program-specific instructions are included in
supplemental guides for each program



Providers Page

Claims menu,
click Institutional

The screenshot shows the top navigation bar of the Oregon Health Authority website. The menu items are: Home, Contact Us, Directory Search, Clients, Account, Claims, Eligibility, Trade Files, Prior Authorization, Providers, and Get help. The 'Providers' menu is open, showing sub-options: Search, Dental, Institutional (highlighted), Pharmacy, and Professional. Below the navigation bar is a blue warning banner with the following text: 'Warning: Use of this network is restricted to authorized users. All users must comply with Oregon Health Authority privacy and security policies. User activity may be monitored and/or recorded. Anyone using this network expressly consents to such monitoring and/or recording. BE ADVISED: if possible criminal activity is detected, these records, along with certain personal information, may be provided to law enforcement officials.' Below the warning banner, there are two lines of text: 'Security incidents should be directed to the Security Incident Response Team at (503) 945-6812.' and 'All other issues, including Password Resets, should be directed to Provider Services at (800) 336-6016.'

Institutional Claim

Sections:

1. Institutional Claim (header)
2. Additional sections menu
3. TPL: Third-Party Liability
4. Medicare Information
5. Detail
6. Hard-Copy Attachments
7. Claim Status Information
8. Outpatient APC

The screenshot shows a web-based form for an Institutional Claim. The form is divided into several sections, each indicated by a numbered callout:

- 1. Institutional Claim (header):** This section contains 'Billing Information' (ICN, Provider ID, Client ID, Last Name, First Name, Date of Birth, Patient Account #, Medical Record #, Attending Phys, Taxonomy, Zip+4, Referring Phys, Facility Number, Other Physician, Taxonomy, Zip+4) and 'Service Information' (Claim Type, Type Of Bill, From Date, To Date, Patient Status, Admit Source, Admission Type, Admission Date, Admission Hour, Discharge Time, Charges, Total Charges).
- 2. Additional sections menu:** A horizontal menu bar with options like 'Insurance Denied', 'Diagnosis Condition Payer Procedure Occurrence/Span Value', and 'TPL'.
- 3. TPL: Third-Party Liability:** A section for updating TPL information, including fields for Last Name, First Name, Date of Birth, Relationship, Policy Number, Plan Name, Plan ID, Adjustment Reason Code, Adjustment Group Code, and Adjustment Amount.
- 4. Medicare Information:** A table with columns for Medicare Paid Date, Coinsurance Amount, Deductible Amount, and Medicare Paid Amount.
- 5. Detail:** A detailed view of a claim item, including Item, Revenue Code, HCPCS/Rates, Units, Charges, Non Covered Charges, Status, Modifiers, Units Of Measurement, Status, Allowed Amount, CoPay Amount, Medicare Paid Date, Deductible Amount, Coinsurance Amount, Medicare Paid Amount, TPL Amount, and Plan Payment Amount.
- 6. Hard-Copy Attachments:** A section for adding or deleting hard-copy attachments, with fields for Control Number, Transmission, Report Type, and Description.
- 7. Claim Status Information:** A section showing the current Claim Status (Not Submitted yet).
- 8. Outpatient APC:** A section for Outpatient APC information.

Institutional Claim (Header)

Billing Information

ICN

Provider ID 1376854091 NPI

1 Client ID* MJ301G5A [Search]

Never required

Last Name CWMM

First Name, MI PATTEE

Date of Birth 01/15/1975

Patient Account #

Medical Record #

6 Attending Phys [Search]

Taxonomy

Zip+4

Referring Phys [Search]

Facility Number 1699937912 [Search]

Taxonomy

Zip+4

Other Physician

Taxonomy

Zip+4

Insurance Denied

Required only if TPL is listed on client eligibility; does not include Medicare

Mailbox and Filename

Mailbox #

File Name

Service Information

2 Claim Type* O - OUTPATIENT CLAIMS

3 Type Of Bill* 131 [Search]

4 From Date* 10/01/2015

5 To Date* 10/01/2015

Patient Status [Search]

Admit Source [Search]

Admission Type [Search]

Admission Date

Admission Hour

Discharge Time

Charges

Total Charges \$0.00

Required only for inpatient claims

Required for inpatient claims when the client has discharged

Required fields:

1. Client ID
2. Claim Type
3. Type of Bill
4. From Date
5. To Date

6. * Hospital and long-term care claims require Attending physician NPI; may be OHP-enrolled or not

Additional Sections

Diagnosis Condition Payer Procedure Occurrence/Span Value

1 2 3 4 5 6

Sections:

1. Diagnosis
2. Condition
3. Payer
4. Procedure
5. Occurrence/
Span
6. Value

Click the title to
open the section

Diagnosis

Sequence	Diagnosis	Description	ICD Version	Present on Admission
A 1	M71811	Other specified bursopathies, right shoulder	10	

Type data below for new record.

2 Sequence* 1 3 Diagnosis* M71811 [Search]

Present on Admission Description Other specified bursopathie

ICD Version* 10

add 1

For each diagnosis:

1. Click add
2. Enter sequence
3. Enter diagnosis

Enter diagnosis code without the decimal

Sequence:
1 for first;
2 for second;
3 for third; etc.

Indicates the ICD version (9 or 10); ICD-10 is required as of 10/01/2015

Required for inpatient claims *only*

Present on Admission indicators:

- Y – Diagnosis was present upon admission
- N – Diagnosis was not present upon admission
- U – Documentation insufficient to determine
- W – Clinically undetermined

Condition

For each condition:

1. Click add
2. Enter sequence
3. Enter condition

Condition section is *only* required when applicable

Condition

*** No rows found ***

Select row above to update -or- click Add button

Sequence 2 Condition 3 [Search]

add 1

Payer

The screenshot shows a software interface for adding a payer. The interface includes a table with the following columns: Sequence, Payer, Prior Payment, and Estimated Amount Due. A yellow box highlights the 'add' button. A pink box highlights the Payer field. The text '*** No rows found' is visible at the top right of the table area. The text 'Select row above to update -or-' is visible above the table. The text 'Date' is visible to the right of the 'add' button.

Payer section is *only* required when client has other coverage (Medicare and/or TPL)

For each payer:

1. Click add
2. Enter sequence
3. Choose payer from drop-down menu
4. Enter prior payment received from payer
5. Enter estimated amount due after prior payment

Procedure

Procedure

*** No rows found ***

Select row above to update -or- click

Sequence	<input type="text"/>		
ICD Procedure	<input type="text"/> [Search]	Procedure Date	<input type="text"/>

delete add

For each procedure:

1. Click add
2. Enter sequence
3. Enter ICD procedure and date

Occurrence/Span

Occurrence/Span *** No rows

Select row above to update

Sequence	<input type="text"/>	From Date	<input type="text"/>
Occurrence Code	<input type="text"/> Search]	To Date	<input type="text"/>

For each occurrence/span:

1. Click add
2. Enter sequence
3. Enter occurrence code
4. Enter dates of the occurrence

delete add

Value

Value	
*** No rows found	
Select row above to update -or-	
Sequence	<input type="text"/>
Value	<input type="text"/>
Search]	Amount <input type="text"/>
<input type="button" value="delete"/> <input type="button" value="add"/>	

- For each value:
1. Click add
 2. Enter sequence
 3. Enter value code
 4. Enter amount

TPL

TPL						
Last Name	First Name	MI	Date of Birth	Relationship	Plan Name	Policy Number
			01/01/1900			
Select row above to update.						
Last Name				Plan Name		
First Name, MI				Plan ID*	101	[Search] ²
Date of Birth	01/01/1900			Adjustment Reason Code	3	[Search] ³
Relationship				Adjustment Group Code	PR	
Policy Number				Adjustment Amount		\$0.00
						delete add ¹

- For each third-party:
1. Click add
 2. Enter Plan ID
 3. Enter Adjustment Reason Code

Date of Birth and Adjustment Group Code are not required, but both auto-populate upon claim submission

TPL section required *only* when client has third-party insurance; does not include Medicare

Use Search links to search for appropriate ID or code

Medicare Information

Medicare Information			
Medicare Paid Date	Coinsurance Amount	Deductible Amount	Medicare Paid Amount
A	\$0.00	\$0.00	\$0.00
Medicare Paid Date	<input type="text"/>	Coinsurance Amount	<input type="text"/>
Deductible Amount	<input type="text"/>	Medicare Paid Amount	<input type="text"/>

For each third-party:

1. Click row to activate fields
2. Fill in all fields

Medicare section required *only* when client has Medicare coverage

Detail

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

Type data below for new record.

Item	1	Modifiers	[Search] [Search] [Search]
1 From DOS*	10/01/2015	Units Of Measurement	[Search]
2 To DOS*	10/01/2015	Status	
3 Units*	1.00	Allowed Amount	\$0.00
4 Charges*	\$350.00	CoPay Amount	\$0.00
Non Covered Charges	\$0.00	Medicare Paid Date	
Adjustment Reason Code	[Search]	Deductible Amount	
Adjustment Amount		Coinsurance Amount	
5 Revenue Code*	263 [Search]	Medicare Paid Amount	
HCPCS/Rates	[Search]	TPL Amount	\$0.00
NDC		Plan Payment Amount	
NDC UOM			
NDC Quantity	0		

- Required fields:
1. From DOS (date of service)
 2. To DOS
 3. Units
 4. Charges
 5. Revenue Code

Medicare fields required *only* for Medicare clients

Enter HCPCS code for outpatient services

NDC fields required *only* for physician-administered drugs; enter NDC in 11-digit format

Hard-Copy Attachments

This section is never required

Hard-Copy Attachments

*** No rows found ***

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

Control Number	<input type="text"/>
Transmission	<input type="text"/>
Report Type	<input type="text"/>
Description	<input type="text"/>

Claim Status Information

Claim Status Information	
Claim Status	Not Submitted yet
View supporting documentation	

Not Submitted yet claim; provider may

- Submit
- Cancel

submit

cancel

Submits the claim for processing

Clears changes made during this session

Claim Status PAID

PAID claim; provider may

- Cancel
- Adjust
- Void
- Copy claim

Claim Status Information	
Claim Status	PAID
Claim ICN	5012011705001
Paid Date	01/12/2012
Allowed Amount	\$90.00

Coversheet for supporting documentation

HIPAA Adjustment Reasons		
Detail Number	HIPAA Adjustment Reason Code	HIPAA Adjustment Reason Description
1	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).
2	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).

Clears changes made during this session

cancel adjust void copy claim

Adjusts the existing claim with changes made during this session

Cancel the existing claim; previous payments will be recouped

Duplicates the existing claim; status will change back to Not Submitted Yet

Claim Status DENIED

DENIED claim; provider may

- Re-submit
- Cancel

Claim Status Information	
Claim Status	DENIED
Claim ICN	2011335001239
Denied Date	12/01/2011
Allowed Amount	\$0.00

Coversheet for supporting documentation

HIPAA Adjustment Reasons		
Detail Number	HIPAA Adjustment Reason Code	HIPAA Adjustment Reason Description
0	95	Plan procedures not followed.
1	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).
1	24	Charges are covered under a capitation agreement/managed care plan.
2	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).
2	24	Charges are covered under a capitation agreement/managed care plan.

re-submit cancel

Submits a new claim with changes made during this session

Clears changes made during this session

*Claim status **SUSPENDED**: In some cases, a claim may suspend for internal review when our system is unable to determine if a claim should pay or deny. Providers may take *no* action on suspended claims. Claims are given a PAID or DENIED status after internal review. This process should never take longer than two weeks.



Outpatient APC

Outpatient APC				
Detail Number	Procedure Code	Payment APC	Procedure APC	APC Status Indicator
1	76805	00266	00266	S - Significant Procedure, Not Discounted when Multiple

Ambulatory Payment Classification (APC) is displayed if applicable to the claim; display shows the procedure, payment APC and and APC Status Indicator

Refer to Hospital Services program web page for current APC resources:
<http://www.oregon.gov/oha/HSD/OHP/Pages/Policy-Hospital.aspx>

Do You Need Further Assistance?

Provider Services Unit (PSU)

800-336-6016

dmap.providerservices@state.or.us

Medicaid Provider Training

Medicaid.Provider-Training@state.or.us