Oregon Health Plan
Provider Web Portal

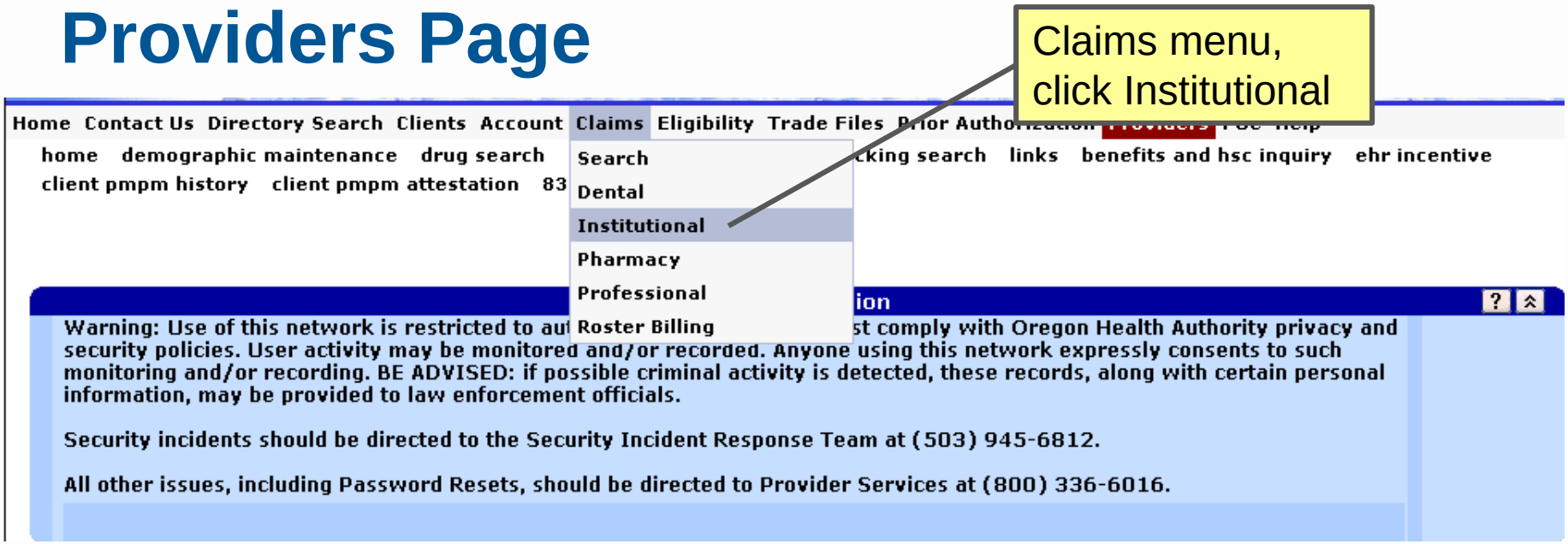
Institutional Claim

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

Oregon Health Authority

June 2017

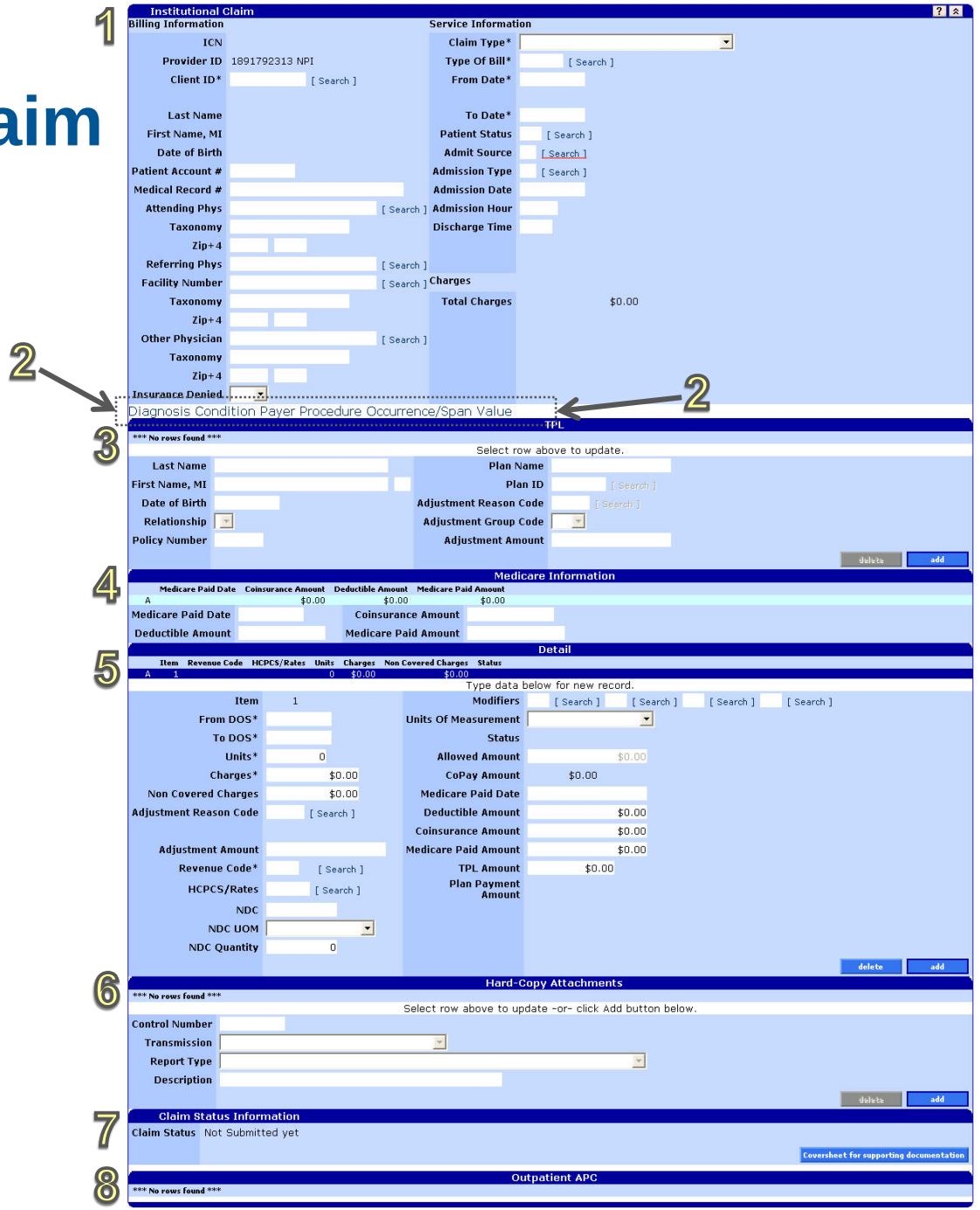
Providers Page



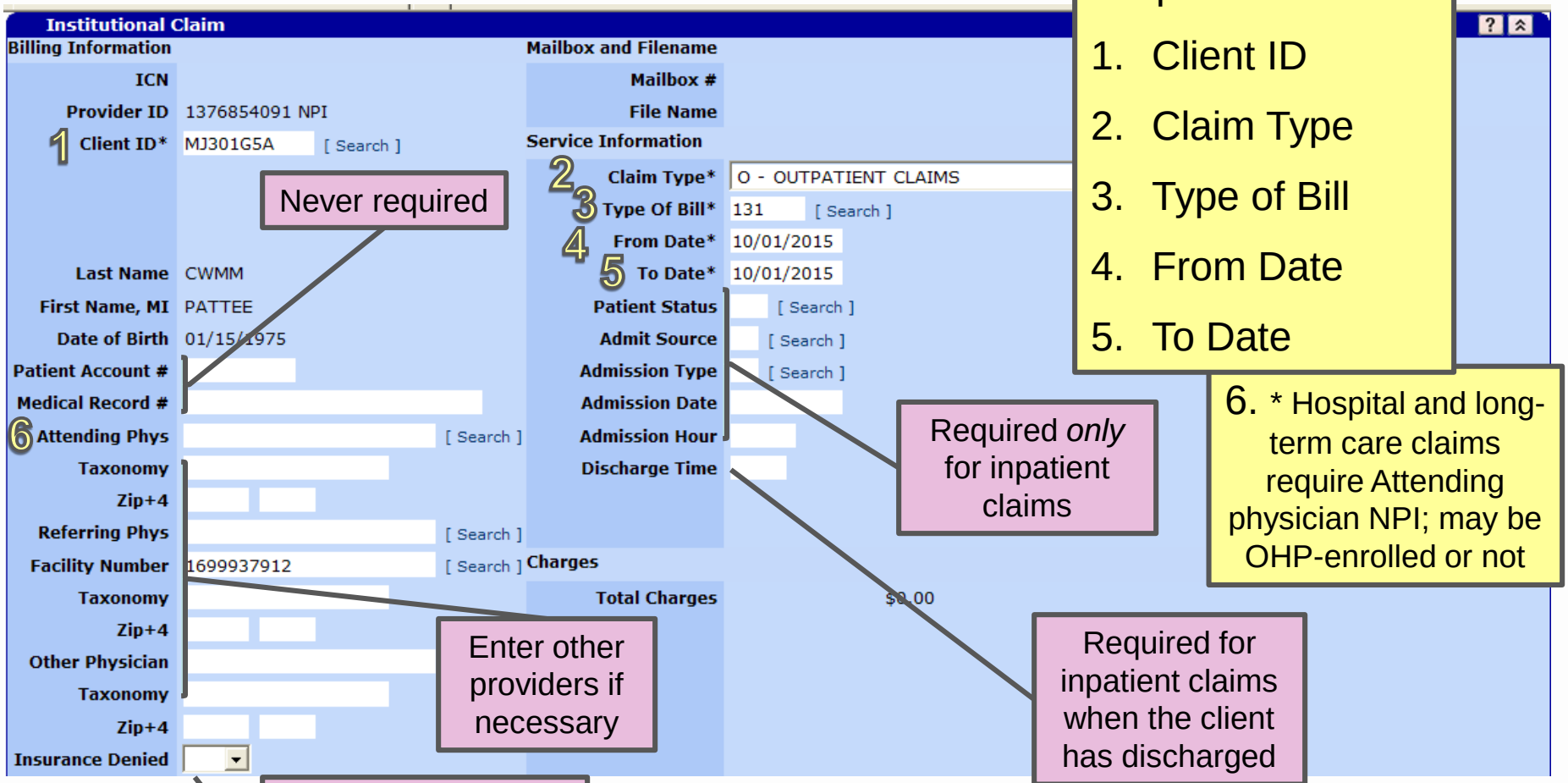
Institutional Claim

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



Institutional Claim (Header)



Never required

Required *only* for inpatient claims

Enter other providers if necessary

Required for inpatient claims when the client has discharged

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

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

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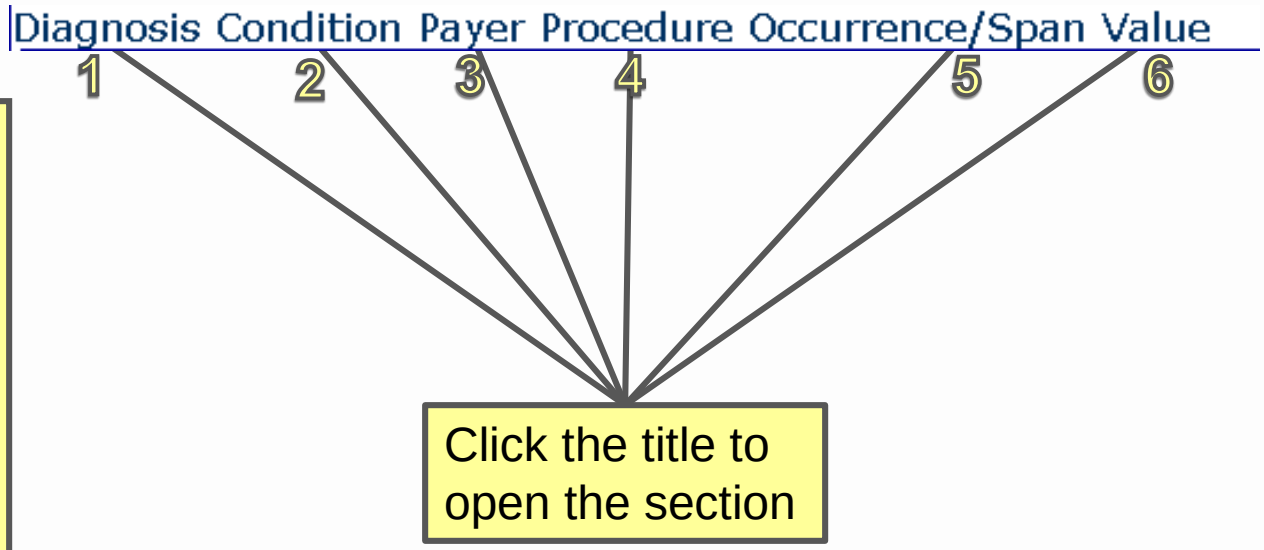
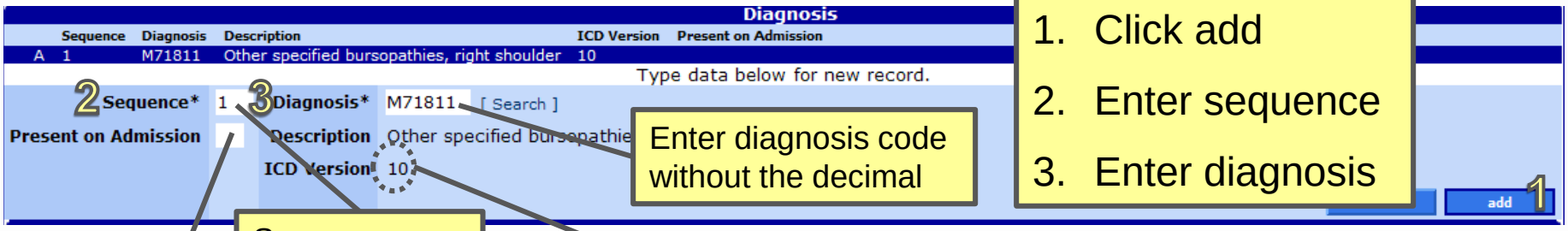
Additional Sections



Sections:

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

Diagnosis



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:

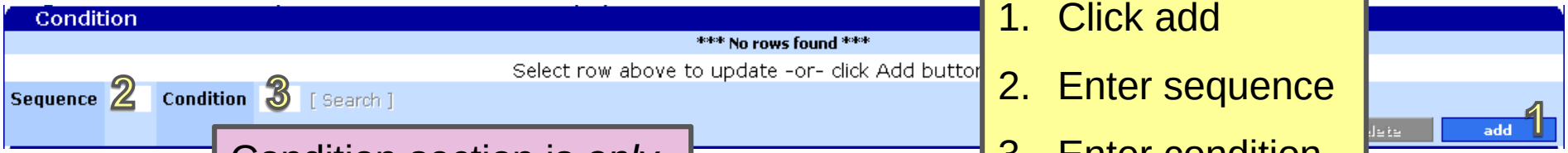
Y – Diagnosis was present upon admission

N – Diagnosis was not present upon admission

U – Documentation insufficient to determine

W – Clinically undetermined

Condition

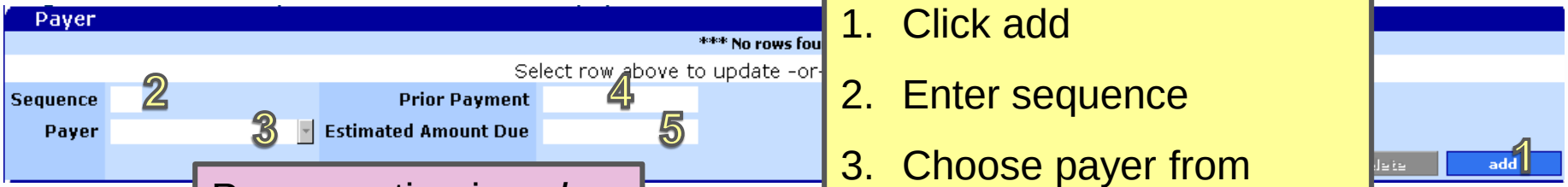


Condition section is *only* required when applicable

For each condition:

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

Payer



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

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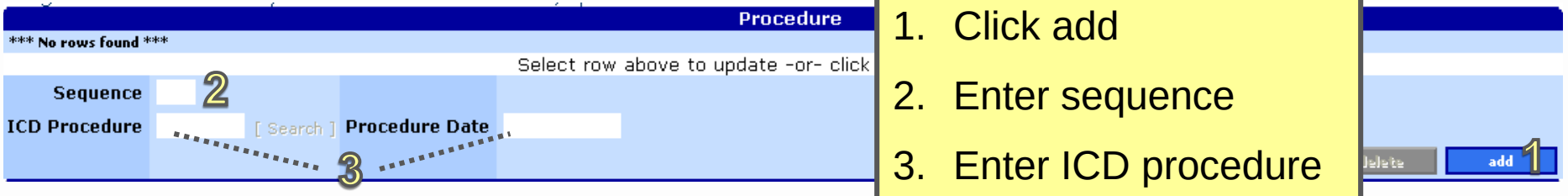
Procedure



For each procedure:

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

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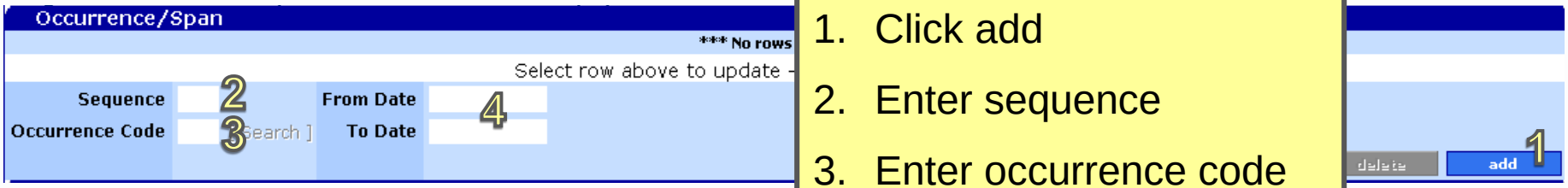
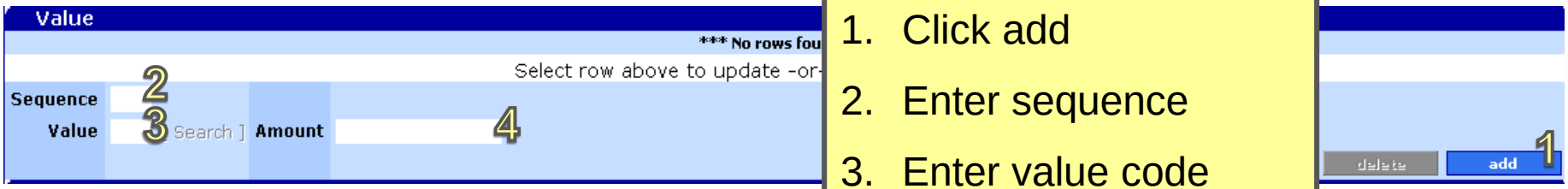
Occurrence/Span



For each occurrence/span:

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

Value



For each value:

1. Click add
2. Enter sequence
3. Enter value code
4. Enter amount

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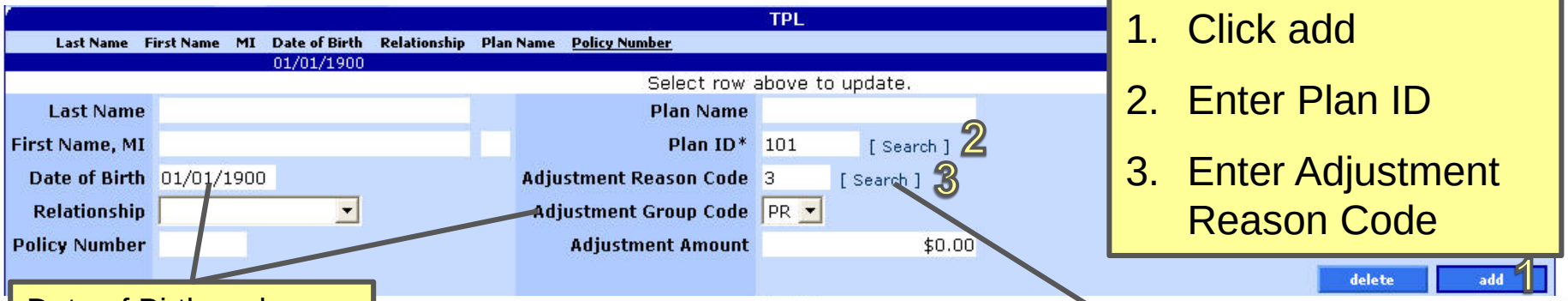
TPL



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

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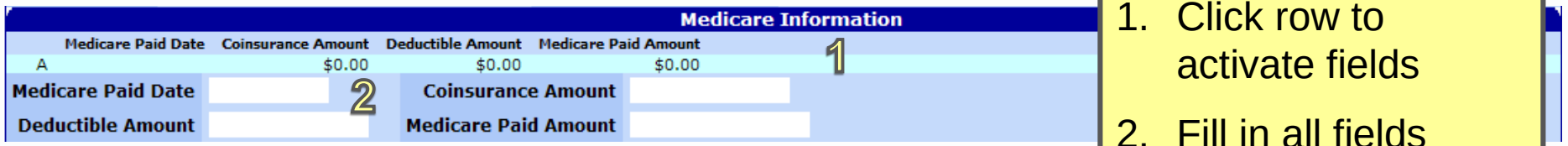
Medicare Information



For each third-party:

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

Medicare section required *only* when client has Medicare coverage

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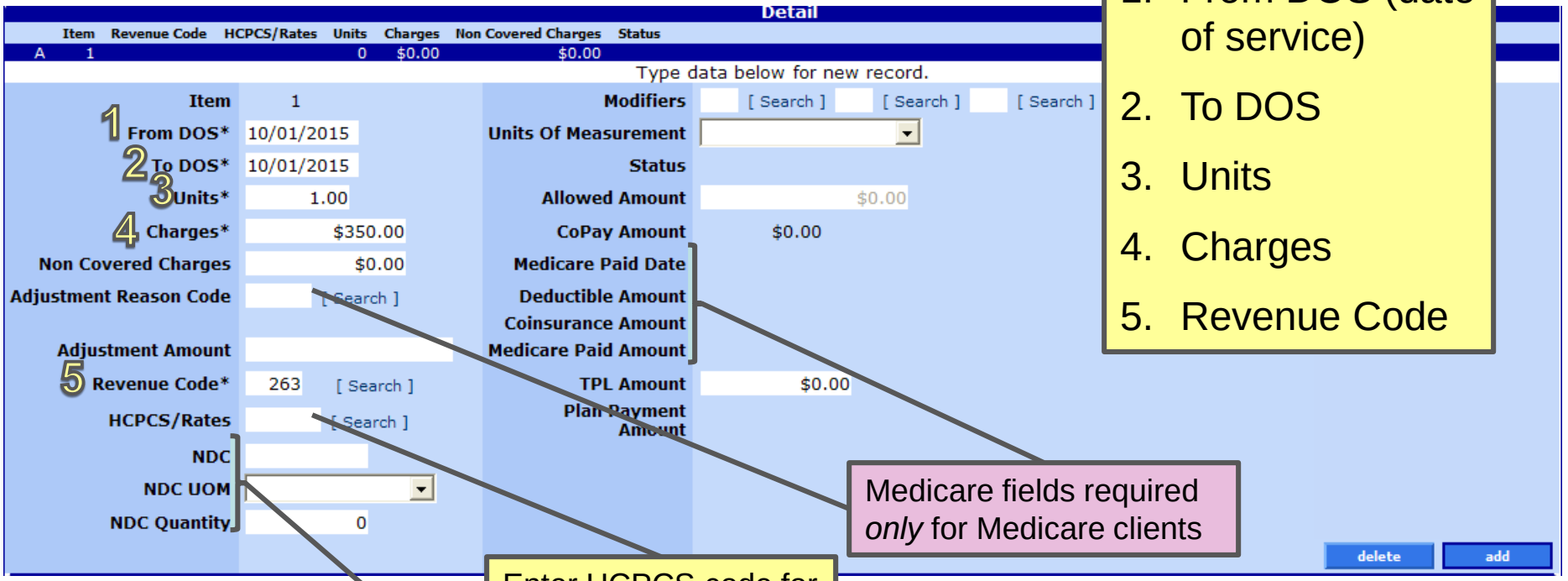
Detail



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

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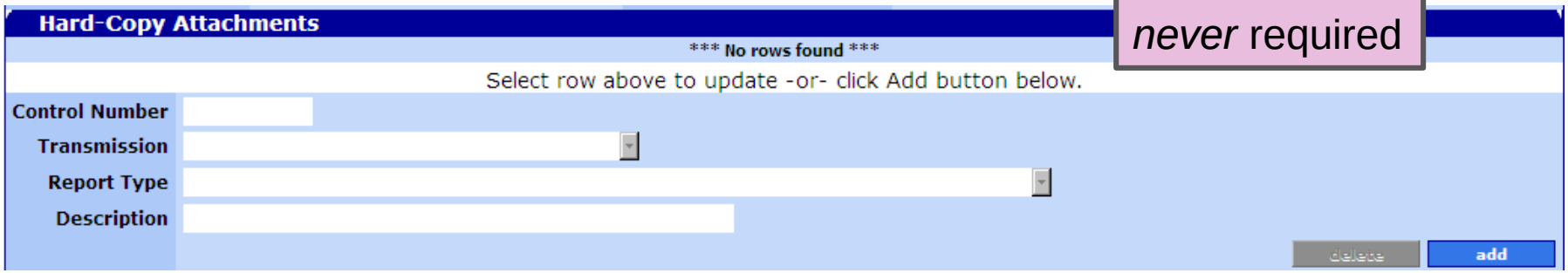
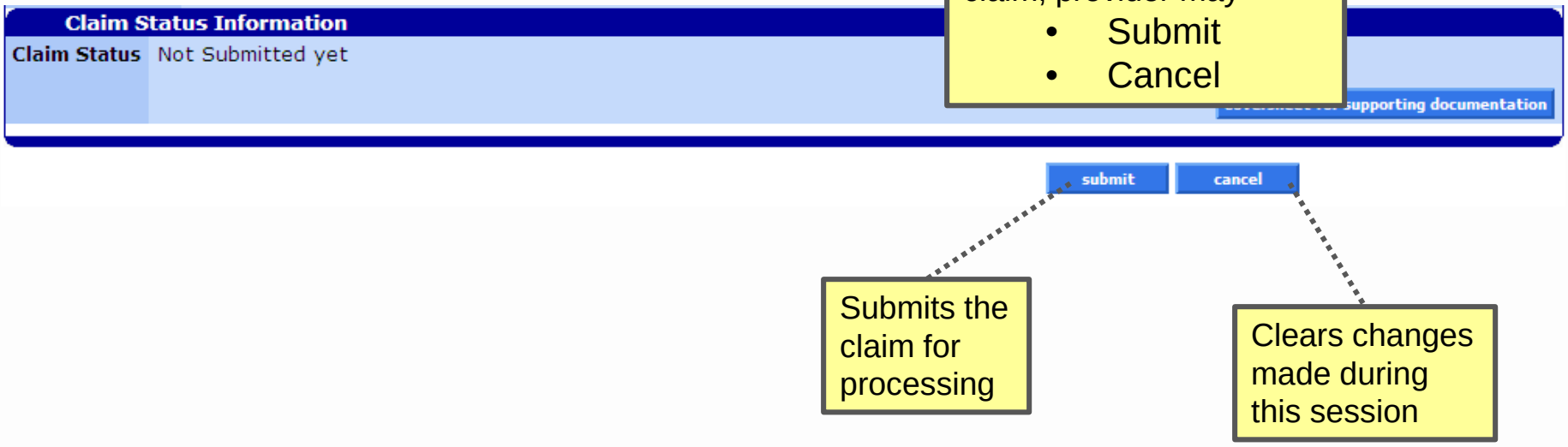
Hard-Copy Attachments

This section is *never* required



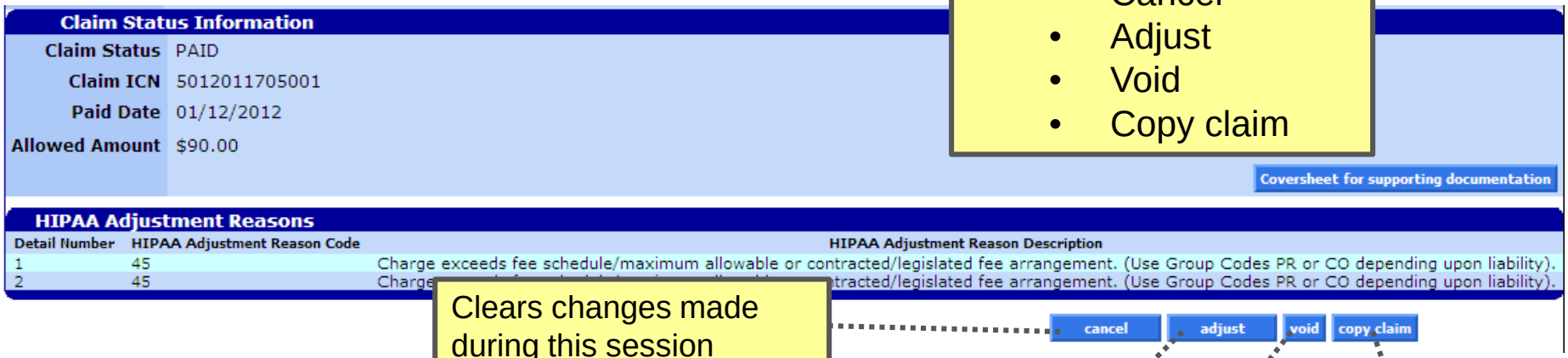
Claim Status Information

Not Submitted yet claim; provider may
- Submit
- Cancel



Claim Status PAID

PAID claim; provider may
- Cancel
- Adjust
- Void
- Copy claim



Clears changes made during this session

Adjusts the existing claim with changes made during this session

Cancels the existing claim; previous payments will be recouped

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

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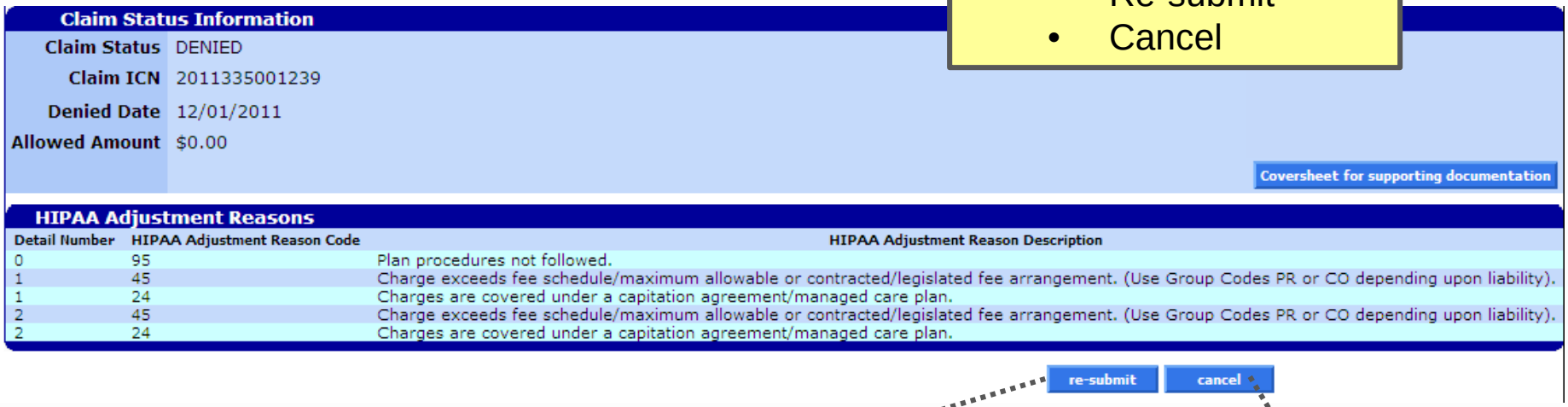
Claim Status DENIED

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.

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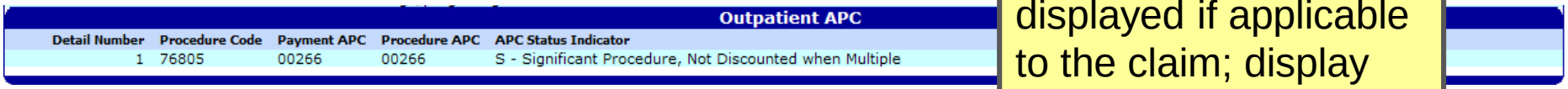
Outpatient APC



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