

Medicaid on the Web

**Oklahoma Medicaid Management Information System (OKMMIS)
Provider Training Manual**

Version 2.1





Document Control

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1 Web Basics

1.1 Overview

Fundamental instructions for the SoonerCare Secure Site usage are listed below. Understanding basic usage of Web site elements will help users make the most of the SoonerCare Secure Site. Windows Internet Explorer versions 6, 7 or 8 must be used.

1.2 Terms to Know

- Left click – The action of clicking the left button on the mouse to activate a function.
- Cursor tool – This is the  icon, which mimics movement of the mouse to select page elements.



The screenshot shows a web browser window displaying the Oklahoma Health Care Authority (OHCA) Professional Claim form. The browser title is "Professional Claim - Microsoft Internet Explorer provided by HP - Let's Do Amazing!". The URL is "https://www.ohcaprovider.com/oklahoma/Claims/hcf/Form.shtml". The page has a green header with the OHCA logo and navigation tabs: Main, Claims, Eligibility, Pricing, Prior Auth, Trade Files, Account, Mailbox, Help, and Log Off. The form is titled "Professional Claim" and includes sections for Billing Information, Service Information, Charges, and Detail Information. A table with columns for Item, Procedure, Modifiers, Units, Charges, Status, and Allowed Amount is visible. A "Submit" button is at the bottom. Orange callouts point to various UI elements: the address bar, the navigation menu, a dropdown menu, a field, a scroll bar, a dropdown field, a down arrow, a button, and a checkbox.

Address Field – Characters entered in this field make up an address specific to a Web page or screen, as it is also referred to. For example, entering www.okhca.org in this field and pressing the enter key will open the OHCA homepage.

Menu Bar – Links within each tab, when accessed, will open the related screen. To access a topic, place the Cursor tool on the desired Menu Bar option and left click the selection. This opens the screen.

Drop-Down Menu – Some Menu Bar selections have a sub-section of menu choices. To open a screen, move the Cursor tool to the desired selection and left click.

Field –To enter information here, place the Cursor tool on the field and left click. Start typing when cursor appears in the field.

Scroll Bar – This allows the user to move the screen to view desired parts of the document. Place the Cursor tool on the bar, left click and hold the button, and move the mouse to scroll.

Drop-Down Field – Left click the down arrow to display selections. Choose by moving Cursor tool on the desired selection and left click. The field will populate with that selection.

Down Arrow – Place Cursor tool on the arrow and left click to open the expanded document.

Button – Place Cursor tool on the button and click to activate the function.

Check Box – Place Cursor tool on the box and left click so check mark populates the box.



Delete Button – This button is used to delete entered data. Place the Cursor tool on the delete button and left click to activate.

Add Link – This allows the user to add entries into the adjacent field. With data entered, place the Cursor tool on the Add link and left click to activate.

Scroll Buttons – These buttons appear when more than one selection has been made and are used to view those selections. Place the Cursor tool on either the up or down Scroll button, press and hold down the left button on the mouse. This will activate the scrolling action. Release the mouse button to stop scrolling.



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2 Initial Access to SoonerCare Secure Site

2.1 Overview

The following sections contain detailed instructions for initial access to the SoonerCare Secure Site.

2.2 General Submission Notes

The following are general submission notes to aid in the use of the SoonerCare Secure Site.

- Required fields are marked with an * in this document and on the Web.
- All dates should be entered in MMDDYY format.
- Dollars and cents should be entered with a decimal point.
- Buttons are distinguished in this document by bold text.
- Pop-up blocker software must be turned off or set to allow pop-ups on this website to access the Agreement page and other important pop-up pages on this website.

2.3 Getting to the Web site

Use the following steps to get on the SoonerCare Secure Site.

1. Type www.okhca.org into the **Address** field
2. Under the **Providers** Heading, click the OHCA Secure Site link.
3. Click the SoonerCare Secure Site link.

2.4 Initial Login – Provider Level

Use the following steps for initial login at the provider level on the SoonerCare Secure Site.



1. Under 'First Time Here' enter the Provider ID number in the **Log on ID*** field.
(Do not include the service location alphabet letter, e.g. 123456789.)

2. Enter the nine character PIN in the **PIN*** field.

Note: PIN is case sensitive.

3. Click the **Log On** button at the bottom of the screen.

4. An 'Oklahoman Confidentiality Agreement' page will appear. Read the data. At the bottom of the page are two buttons – **Agree** and **Reject**. If you accept the agreement, click the **Agree** button and proceed. Otherwise, click on **Reject**.



Note: Pop-up blocker software must be turned off or set to 'allow pop-ups' on this Web site in order to access the Agreement page and other important pop-up pages.

5. User will be redirected to the Account Maintenance screen.
6. Enter a user name in the **User Name*** field.
(Must begin with a letter of the alphabet and consist of 6 to 12 characters.)

Note: This field is case sensitive.

7. Enter a password in the **New Password*** field.
(Must begin and end with a letter of the alphabet, consist 6 to 8 characters total and contain no fewer than two numeric characters.)

Note: This field is case sensitive.

8. Confirm the password by retyping it in the **Confirm Password*** field.
9. Enter the contact name in the **Contact Name*** field.
10. Enter an e-mail address in the **E-Mail** field.
11. Enter phone number in the **Phone Number*** field. *(Example: 000-000-0000)*
12. Click the **Submit** button.
13. If all data is entered correctly, a pop-up notice will appear telling you that your data has been successfully saved. Click the **OK** button.
14. After clicking **OK**, the mailbox will appear.

After setting up your user name and password, future login attempts will be completed in the registered user log on by entering the user name in the **User Name*** field and password in the **Password*** field.



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3 Creating and Managing Clerks

3.1 Overview

This section will cover how to create and manage clerk access on the SoonerCare Secure Site. The following actions will be covered:

- Creating a Clerk
- Initial Logon for Clerk Level
- Editing Roles of an Existing Clerk
- Granting Access to an Existing Clerk
- Revoking Access of a Clerk

3.2 Creating a Clerk

Use the following steps for creating a clerk on the SoonerCare Secure Site.

Note: Must be logged on at the Provider level.

1. Click the **Account** tab from main page and choose **Maintenance**.
2. Click the **Create New Clerk** button. A clerk creation screen will appear where the new clerk's information will be entered.
3. In the **User Name*** field create a *temporary* name (i.e. CLK12345).
4. In the **Contact Name*** field enter the clerk's full name.
5. In the **Password*** field enter a *temporary* password (i.e. CLK12345).

Note: The clerk will replace the generic user name and password with desired selections when logging on the first time.

6. Select roles to be added to clerk's list from the menu field located right of the buttons.

Note: Hold down the Ctrl key to select multiple roles.

7. Click the **Grant Role** button when the desired roles are highlighted in the field.
8. Click the **Add All Roles** button, if clerk needs access to all the roles on this list.
9. To delete a role from the list, highlight the role to remove and click the **Cancel Role** button.



10. Click the **Create Clerk** button.
11. Click the **Save** button on the Account page.
12. Select the **Cancel** button to exit the clerk creation process.

Verify that the username and contact name are in the Provider Associations box.

3.3 Initial Logon for Clerk Level

The following are the steps to use for initial logon at the clerk level.

1. Open the SoonerCare Secure Site.
2. Under "Log on to OHCA's SoonerCare Secure Website", enter the *Temporary* user name in the **User Name*** field.
3. Enter the *Temporary* password in the **Password*** field.
4. Click **Log On** under this area.
5. An 'Oklahoman Confidentiality Agreement' page will appear. Read the data. At the bottom of the page are two buttons – **Agree** and **Reject**. If you accept the agreement, click the **Agree** button and proceed. Otherwise, click on **Reject**.
6. The **Account Maintenance** screen will appear.
7. Enter a user name in the **User Name *** field.
(Must begin with a letter and consist of six of 12 characters.)

Note: This field is case sensitive and must be different from *temporary* User Name.

8. Enter a password in the **New Password*** field.
(Passwords must have 6-8 characters total. The password must begin and end with an alpha character and have two numerical characters. The numerical characters cannot be on the beginning or end of the password. Example: te23mp. Multiple clerks can use the same password.)

Note: This field is case sensitive and has to be different from *temporary* Password.

9. Confirm the password by retyping it in the **Confirm Password*** field.
10. Enter an email address in the **E-mail** field.
11. Enter phone number in the **Phone Number*** field.
12. Fill in the two **Secret Questions and Answers** fields.



Note: Answers are Case Sensitive.

13. Click the **Submit** button.
14. If all data is entered correctly, a box will appear telling you that your data has been successfully saved. Click the **OK** button.
15. After clicking **OK**, the mailbox will appear.

3.4 Editing Roles of an Existing Clerk

The following are the steps to use in editing roles of an existing clerk.

Note: Must be logged on at the Provider level.

1. To change roles in an existing clerk's account, click the **Account** tab, choose **Maintenance** and highlight the desired clerk.
2. Click the **Edit Clerk Roles** button. A small window will appear.
3. Use the same process as described in Section 3.2 – Creating A Clerk to add and remove roles as desired.
4. Click the **Update Clerk** button when selections are complete.
5. Click the **Save** button on the Account page.

3.5 Granting Access to an Existing Clerk

The following are the steps to use in granting access to an existing clerk. This process must be followed for each provider account the clerk needs access to. Please note, clerk accounts only need to be created once.

Note: Must be logged on at the Provider level.

1. From the Provider Main page, click on **Account** and choose **Maintenance**.
2. Key the user name of the clerk to be granted access in the **User Name** field.

Note: This field is case sensitive

3. Click the **Grant Access To** button.
4. A box will pop-up stating you are giving access to an existing clerk, click **OK**.
5. Click the **Edit Clerk Roles** button to add roles the clerk will have access to.



6. Click the **Update Clerk** button when all selections are made.
7. Click the **Save** button on the Account page.

3.6 **Revoking Access of a Clerk**

If a clerk no longer needs access to your provider account, access needs to be disabled. The following are the steps to use in revoking access of a clerk.

1. Log in as the provider and click the **Account** tab and choose **Maintenance**.
2. Highlight the user name in the Provider Associations box and click the **Revoke Permissions** button.
3. A pop-up will appear to ask “Are you sure you want to revoke permissions?”. Click **OK**.
4. Click the **Save** button on the Account page.



4 General SoonerCare Secure Site Elements

4.1 Overview

This section will cover the general elements and how to use those features. The following elements will be covered:

- Allow a Third Party to Receive 835 Remittance Advice
- Global Messages
- Eligibility Inquiry
- Pricing

4.2 Allow Third Party to Receive 835 Remittance Advice

Use the following steps if the user needs to allow a third party (billing agent or other provider) to receive 835 Remittance Advice on their behalf.

Note: If a third party is authorized to receive electronic remittance advice (835) on a provider's behalf, that provider will no longer receive a remittance advice (via paper or electronically) directly from OHCA. For more information on designating a third party to receive 835 files, call the EDI Help Desk at (405) 416-6801 or (800) 522-0114 *option 2, 2*.

1. Log on and navigate to the account maintenance section by clicking on the **Account** tab at the top of the page.
2. Key the user name of the third party to be granted access in the **User Name** field.
3. Click the check box for **Designate User to Receive RA's**.
4. Click the **Grant Access To** button.
5. Click the **Save** button.

4.3 Global Messages

Global messages are an easy, secure way for OHCA to inform providers of the latest news, changes or upcoming events.

After logging in, any new global messages will appear. After reading each message, click the **Read** check box. This will move the message to the mailbox for future reference until it is expired and purged by the system. After reading all messages click the **Next** button.



4.4 Eligibility Inquiry

The following are the steps to use to inquire on a member's eligibility.

1. Click the **Eligibility** tab.
2. Select one of the four criteria to search by from the drop-down. The four options are MEMBER ID, SSN and Date of Birth, NAME and Date of Birth or by CASE NUMBER.
Each option will require that a date-of-service (DOS) range of up to 13 months also be entered. The Calendar option to the right of each date field may be used for a fast selection of the date.
3. Click the **Search** button.

Status A indicates the electronic request for eligibility was accepted by Oklahoma Medicaid and does not reflect the eligibility of the member. The eligibility and benefit programs for the member will appear below the status.

4.5 Pricing

The Pricing feature allows providers to look up detailed information on Procedure codes, Drug codes and DRG codes, such as the allowed amount, billing restrictions and prior authorization requirements.

Note: Pricing results are based on the provider specialty, date of service selected, benefit package selected and/or modifier combination.

The following are the steps to use to search pricing on the SoonerCare Secure Site.

1. Click on **Pricing** Tab at the top. A disclaimer page will appear, if you agree to all terms of the agreement click on **'I Accept'** to go to the next page. If you do not agree, click **'I Do Not Accept'** – if you do not accept you will be redirected to the home page.
2. Click the applicable radio button next to **Procedure**, **Drug** or **DRG** code.
3. Click the **Benefit Package*** dropdown button and select the **Benefit**.
(This automatically defaults to Oklahoma Title XIX.)
4. Enter the **Date of Service** in the MM/DD/CCYY format or use the pop-up calendar option.
5. Enter **Modifiers** and/or **Age** for more accurate results.
6. Click **Search**.
7. Click the link provided to view pricing results.

Note: The message "No records found for combination" indicates that the procedure code is not covered for the program selected.



4.5.1 Pricing Example

Procedure 90806: Title 19

Provider Type: Physician

Provider Specialty: Family Practitioner

Pricing and limitations for date of service 12/10/2009:

- Allowed Amount: \$85.46
- No PA Required
- Maximum Units: 1
- Age Restriction: 0 – 999
- Gender: Both
- Attachment is Not Required
- Not a Lifetime Procedure
- Not restricted to any Diagnosis
- Restricted to certain Specialty
- Ambulatory Surgical Facility Fee: \$0.00
- Ambulatory Payment Classification Fee: \$0.00
- Discounted: NA



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5 Claims

5.1 Overview

This section will cover general claim topics and how to submit, void and copy claims on the SoonerCare Secure Site. The following will be covered:

- Claim Submission – Professional
- Claim Submission – Professional Crossover
- Claim Submission – Institutional
- Claim Submission – Institutional Crossover
- Claim Submission – Pharmacy (Including Compounds)
- Claim Submission – Dental
- Dental History Inquiry
- Hardcopy Attachment
- Claim Inquiry
- Resubmit a Claim – Denied Claims Only
- Void a Claim – Paid Claims Only
- Copy a Claim – Paid Claims Only and Resubmit

5.2 Claim Submission – Professional

The following are the steps to use in submitting a professional claim.

To begin, from the provider main page, click the **Claim Submission** link to open the Claims screen then click the **Professional** link. Another option is to click the **Claims** tab to open the drop-down and select **Submit Professional**.

Note: To efficiently fill out the claim and avoid problems, use the **Tab** key to move from field to field. Do **not** use the Return or Enter key.

Billing Information Section

1. The billing information, including NPI, should auto-populate. Confirm the information is correct. If incorrect, log out and access the correct provider.



2. Enter the Member ID in the **Member ID*** field.
3. If applicable, enter the **Member Count**. (DMHSAS providers only, based on Member ID.)
4. The patient account number (provider's internal ID) will be captured and appear on the remittance advice if entered into the **Patient Account #** field. (Optional field)
5. If the claim being billed requires a referral from the PCP, enter the PCP's NPI in the **Referring NPI** field.

Service Information Section

6. The **Claim Type** drop-down is automatically set to Professional.
(For steps on submitting a Professional Crossover claim, refer to Section 5.3.)
7. The **From Date*** field is auto-populated from the details section, please ignore.
8. The **To Date*** field is auto-populated from the details section, please ignore.
9. If applicable, enter the expected delivery date into the **Expected Delivery Date** field.
(Pregnancy related services only.)
10. If claim is related to an accident, select the accident type in the **Accident Related To** drop-down. (Options are: None, Employment, Auto or Other.)
11. Enter the diagnosis code in the **Principle** field.
 - a. Enter any additional diagnosis codes in "Other" boxes which populate after the initial diagnosis is entered.

Note: Enter the diagnosis code(s) without decimals.

Charges Section

12. The **Total Charges** field will automatically populate from the details section. Do not enter charges here.
13. If applicable, enter the third party liability paid amount in the **TPL Amount** field.
 - a. If the third party liability carrier denied coverage, click the down arrow in the **Carrier Denied** field, highlight and click **Yes**.
14. If claim is related to laboratory services (non-CLIA waved), enter the facility CLIA number in the **CLIA Number** field.



Detail Information Section

15. The **Item** field (line number) is auto-populated. Do not enter data here.
16. Enter the date(s) of service in the **From DOS** and **To DOS** fields.
17. Select the place of service code by clicking on the down arrow in the **POS*** field then highlight and click the appropriate code.
18. Enter the procedure code in the **Procedure*** field.
19. If applicable, enter modifier codes in the **Modifiers** fields.
(2 modifiers per box.)
20. If applicable, enter the diagnosis cross-reference in the **Diag. Cross-Ref** field.

Note: If the claim has diagnosis codes, enter the numeric codes 1, 2, 3 or 4, in order of importance corresponding with the diagnosis code(s) entered. Do not use commas or dashes.

21. Enter number of units billed in the **Units*** field.
22. Enter the dollar amount of charges in the **Charges*** field. This action will automatically populate the **Total Charges** field.
(Total charges = Number of Units x Charge per Unit)
23. If applicable, enter the NDC (National Drug Code) in the **NDC*** field.
(NDC is an 11 digit number that must be in the format 00000-0000-00.)
24. If applicable, enter the quantity in the **NDC Quantity*** field.

Note: When changing from liters to ml and mg to grams, measurements must be rounded to the nearest 10th.

25. If applicable, enter the UOM (unit of measure) in the **UOM*** field.
26. If applicable, enter a DMH contract source code in the **DMH Contract Source** field.
27. Enter the rendering provider's NPI in the **Rendering NPI*** field.
(The rendering provider is the person or entity who actually rendered the service and is not necessarily a physician.)
28. If applicable (e.g. Teaching Physician), enter the contract code in the **Contract Code** field.
29. If the rendering provider is tied to more than 1 group, either the **Taxonomy** or **Zip+4** must be entered in the corresponding box.



30. If additional items are to be billed on this submission, click the **Add** button next to the line item window and repeat process.

31. When finished, click the **Submit** button.

5.3 Claim Submission – Professional Crossover

The following are the steps to use in submitting a professional crossover claim.

Please allow ample time for Medicare to crossover claims directly to Medicaid before filing crossovers on the SoonerCare Secure Site. The Medicare information that is needed for this claim type should be taken directly from the Medicare EOMB.

To begin, on the provider main page, click the **Claim Submission** link to open the Claims screen then click the **Professional** link. Another option is to click on the **Claims** tab to open the drop-down and select **Submit Professional**.

Note: To efficiently fill out the claim and avoid problems, use the **Tab** key to move from field to field. Do **not** use the Return or Enter key.

Service Information Section

1. Click the **Claim Type** drop-down and choose **Crossover – Professional**.
(The Crossover Details section should now be visible)

Crossover Details Section

2. Enter the Medicare Allowed Amount in the **Allowed Medicare Amount*** field.
3. If applicable, enter the Deductible in the **Deductible** field.
4. If applicable, enter the Co-Insurance Amount in the **Co-Insurance Amount** field.
5. If applicable, enter the Psychiatric Services Amount in the **Psychiatric Services Amount*** field.
6. Enter the Medicare Payment Amount in the **Medicare Payment Amount*** field.
7. Enter the Medicare Payment Date in the **Medicare Payment Date*** field.

The remainder of the claim should be completed as a Professional claim.



5.4 Claim Submission – Institutional

The following are the steps to use in submitting an institutional claim.

To begin, on the Provider Main Page, click the **Claim Submission** link to open the Claims screen and click the **Institutional** link here. Another option is to click the **Claims** tab to open the drop-down and select **Submit Institutional**.

Note: To efficiently fill out the claim and avoid problems, use the **Tab** key to move from field to field. Do **not** use the Return or Enter key.

Billing Information Section

1. The Provider NPI should auto-populate. Confirm the information is correct. If incorrect, log out and access the correct provider.
2. Enter the Member ID in the **Member ID*** field.
3. The patient account number (provider's internal ID) will be captured and appear on the remittance advice if entered into the **Patient Account #** field. (Optional field)
4. Enter the attending physician's NPI in the **Attending Physician NPI*** field.
5. If the service was for a SoonerCare Choice member, enter the referring provider's NPI into the **Referring Physician NPI** field.
6. If applicable, enter the **Facility NPI** number.
7. If applicable, enter any other physician NPI in the **Other Physician NPI** field.
8. Select yes or no in the **Insurance Denied** drop-down.
9. Select the appropriate type of claim in the **Claim Type*** drop-down.

Service Information Section

10. Enter the three-digit Bill Code number in the **Type of Bill*** field.
 - First digit identifies Type of Facility.
 - Second digit identifies Level of Care.
 - Third digit identifies Frequency.

See UB04 Uniform Codes www.nubc.org.

11. Enter the beginning date of service in the **From Date*** field.



12. Enter the end date of service in the **Thru Date*** field.
13. Enter the number of eligible days in the **Covered Days*** field.
(This field is also applicable to Long Term Care. This is required on all **Inpatient** and **Nursing Facility** claims.)
14. Select the patient's current status in the **Patient Status** drop-down.
15. Select the type of admission in the **Admission Type** drop-down.
16. Enter the date of admission in the **Admission Date** field.
17. Using military time convention, enter the admission time in the **Admission Hour** field.
18. Using military time convention, enter discharge time in the **Discharge Time** field.

Charges Section

19. The **Total Charges** field is automatically populated and manual input is not required.

Billing Codes Section

20. Select the appropriate diagnosis type in the **Diagnosis Code*** drop-down.
21. Enter the diagnosis code(s).

Note: Do not use a decimal when entering the diagnosis code.

22. If applicable, when submitting an inpatient claim, select the **Point of Admission (POA)** code for each diagnosis code entered from the drop-down.
23. Enter the appropriate four-digit ICD-9-CM procedure code in **Procedure Code** field.
 - a. If required, enter the date in the **Date** field within the **Procedure Code** field.

Note: See the volume 3 ICD-9-CM manual.

24. If applicable, click the drop-down arrow and highlight the appropriate condition code in the **Condition Code** field.
25. If applicable, click the drop-down arrow and highlight the appropriate value code affecting this claim in the **Value Code** field; enter a dollar amount (including decimal point).
26. If applicable, select the appropriate occurrence code in the **Occurrence/Span Code** drop-down. Enter the dates in the **From** and **Thru** fields.
27. If applicable, select the appropriate payer code in the **Payer Code** drop-down.



28. If applicable, enter the dollar amount (including decimal point) in the **Prior Payment** field.
(The amount that has been received from a previous third party payer.)

29. Do not enter data in the **Estimated Due** field.

Detail Information Section

30. The **Item** field (line number) is auto-populated. Do not enter data here.

31. Enter the date in which the service started and ended in the **FDOS*** and **TDOS*** fields, respectively.

Note: Separate individual dates of service by line here. The FDOS and TDOF will populate with dates keyed in the Service Information Section but may need to be changed if billing for individual dates of service.

32. Enter the three-digit Revenue Code in the **Revenue Code*** field.

33. If applicable, enter the five-digit HCPCS code in the **HCPCS/Rates** field.

34. If applicable, enter the Modifiers in the **Modifiers** field.
(2 modifiers per box.)

35. If applicable, enter an NDC (National Drug Code) in the **NDC*** field.
(NDC is an 11 digit number that must be in the format 00000-0000-00.)

36. If applicable, enter the Quantity in the **NDC Quantity*** field.

Note: When changing from liters to ml and mg to grams, measurements must be rounded to the nearest 10th.

37. If applicable, enter the NDC UOM (unit of measure) in the **UOM*** field.

38. Enter the number of units billed at the detail level in **Units*** field.

39. Enter the amount billed in the **Charges** field.
(Total charges = Number of Units x Charge per Unit)

40. The **Allowed Amount** field is auto-populated. Do not enter data here.

41. The **Units Allowed** field is auto-populated. Do not enter data here.

42. The **Paid Amount** field is auto-populated. Do not enter data here.
(The amount of funds paid to an entity.)

43. If additional items are to be billed on this submission, click the **Add** button next to the line item window and repeat process in the Detail Information Section.



44. Click the **Submit** button when finished.

5.5 Claim Submission – Institutional Crossover

The following are the steps to use in submitting an institutional crossover claim.

Please allow ample time for Medicare to crossover claims directly to Medicaid before filing crossovers on the SoonerCare Secure Site. The Medicare information that is needed for this claim type should be taken directly from the Medicare EOMB.

To begin, on the provider main page, click the **Claim Submission** link to open the Claims screen then click the **Institutional** link. Another option is to click the **Claims** tab to open the drop-down and select **Submit Institutional**.

Note: To efficiently fill out the claim and avoid problems, use the **Tab** key to move from field to field. Do **not** use the Return or Enter key.

Service Information Section

1. Click the **Claim Type** drop-down and choose the **Crossover** claim type.
(The Crossover Details section should now be visible).
2. If applicable, enter the Deductible in the **Deductible** field.
3. If applicable, enter the Co-Insurance in the **Co-Insurance** field.
4. If applicable, enter the Blood Deductible in the **Blood Deductible** field.
5. Enter the Medicare Payment Date in the **Medicare Payment Date*** field.
6. To enter the Medicare payment information choose Medicare from the **Add Payer Code** field in the Billing Codes Section. Enter the dollar amount (including decimals) in the **Prior Payment** field.
(This is the amount that has been received prior to this payment from the payer.)
7. Do not enter data in the **Estimated Due** field.

The remainder of the claim should be completed as an Institutional claim.

5.6 Claim Submission – Pharmacy (Including Compounds)

The following are the steps to use in submitting a pharmacy claim.

To begin, on the provider main page, click the **Claim Submission** link to open the Claims screen then click the **Pharmacy** link. Another option is to click the **Claims** tab to open the drop-down and select **Submit Pharmacy**.



Note: To efficiently fill out the claim and avoid problems, use the **Tab** key to move from field to field. Do **not** use the Return or Enter key.

Billing Information Section

1. The billing information, including NPI, should auto-populate. Confirm the information is correct. If incorrect, log out and access the correct provider.
2. Enter the Member ID in the **Member ID*** field.
3. Enter the Prescriber NPI in the **Prescriber NPI** field.
4. Enter the Prescriber Name in the **Prescriber Name** field that correlates to the Prescriber ID above.
5. If the claim is related to a pregnancy, click the **Pregnancy** checkbox.
(If the member was/is pregnant at the time the script was dispensed.)
6. If the claim is related to an emergency, click the **Emergency** checkbox.
(If the script was written due to an emergency condition.)
7. If the claim is related to a Nursing Facility, click the **Nursing Facility Indicator** checkbox.
(If the member was/is at a nursing facility at the time the script was dispensed.)
8. If the claim is related to an Insurance Denial, click **Insurance Denied Indicator** checkbox.
(If another insurance carrier denied the current prescription.)
9. The Rendering Provider NPI is auto-populated and should be the same as the information in the Billing Information Section.

Prescription Information

10. Indicate the claim type from the drop-down **Claim Type** field.
(Either pharmacy claim or a compound)
11. Enter the prescription number in the **Prescription #** field.
12. Enter the prescription date in the **Date Dispensed** field.
(Date the prescription was dispensed by the pharmacy.)
13. Enter the date prescribed in the **Date Prescribed** field.
(The date the prescription was prescribed by the physician.)
14. If applicable, enter the number of refills in the **New/Refill** field. If there are no refills, or it is a new script, enter 00.



15. Select the appropriate dispensing order in the **Dispense/Written** drop-down.
(Indicate if the script was Dispensed as Prescribed or Other Orders).
16. Enter the applicable PA # or Super PA for script in the **Prior Auth #** field. If no PA was obtained, leave the field blank.

Charges Section

17. Enter the total amount being billed for all scripts in this submission in the **Total Charges** field.
18. Enter the amount paid on this claim by another insurance carrier before Medicaid in the **TPL Amount** field. If no other insurance is involved or has paid on this claim, leave the field at 0.00.

DUR Overrides Section

19. If applicable, select the appropriate intervention used in dispensing of the prescription using the **Intervention** drop-down.
20. If applicable, select the appropriate intervention outcome using the **Outcome** drop-down.
21. If applicable, select the conflict code to be overridden using the **Conflict Code** drop-down.

Detail Information Section

22. Enter the applicable NDC for the prescription being billed in the **NDC** field.
23. Enter the quantity being dispensed in the **Quantity** field.
24. When finished, click the **Submit** button.

The Add and Remove buttons are only viewable if the claim type is set to Compound Drug. This enables the provider to add additional NDCs on the same claim.

5.7 Claim Submission – Dental

The following are the steps to use in submitting a dental claim.

Click the **Claim** button in the toolbar and select **Dental**, or click the **Claims** tab then highlight and click **Submit Dental**.

Note: To efficiently fill out the claim and avoid problems, use the **Tab** key to move from field to field. Do **not** use the Return or Enter key.



Billing Information Section

1. The Provider NPI should auto-populate. Confirm the information is correct. If incorrect, log out and access the correct provider.
2. Enter the Member ID in the **Member ID*** field.
3. The patient account number (provider's internal ID) will be captured and appear on the remittance advice if entered into the **Patient Account #** field. (Optional field)
4. Select yes or no in the **Insurance Denied** drop-down.

Service Information Section

5. If the claim is related to an emergency, click the **Emergency** checkbox.
6. If the claim is related to an accident, select accident type in the **Accident Related To** drop-down.
7. Select the place of service code by clicking on the down arrow in the **POS*** field then highlight and click the appropriate code.
8. Enter the rendering provider NPI in the **Rendering Provider NPI*** field.

Note: If the rendering provider NPI is linked to more than one SoonerCare ID then a nine-digit zip code or taxonomy code may be required

9. The **SC Rendering Provider** field is for non-medical providers only.

Claim Charges Section

10. The **Total Charges** is auto-populated from the charges entered at the detail level. Do not enter data here.
11. Enter the total amount that has been paid by private insurance in the **TPL Amount** field.

Detail Information Section

12. The **Item** field (line number) is auto-populated. Do not enter data here.
13. Enter the date of service in the **DOS*** field.
14. Enter the procedure code in the **Procedure*** field.
15. If the procedure is tooth specific, enter the tooth number in the **Tooth Number** field.
16. If the procedure is surface specific, enter the surface in the **Surface** field.



17. If applicable, choose the Quadrant from the available options in the **Prosthesis** field.
18. If applicable, enter modifier codes in the **Cavity Code** fields.
19. Enter the number of units billed in the **Units*** field.
20. Enter the total dollar amount of charges in the **Charges*** field for all units for this line of service.
(Total charges = Number of Units x Charge per Unit)
21. If additional items are to be billed on this submission, click the **Add** button next to the line item window and repeat process.
22. When finished, click the **Submit** button.

5.8 Dental History Inquiry

The following are the steps to use to inquiry on a member's dental history.

From the Provider Main Page, click the **Dental Inquiry Link** or click the **Claims** drop-down and choose **Dental Inquiry**. You will be directed to the Treatment History page.

1. Enter the member ID in the **Member ID*** field.
2. The **Date of Service*** field is auto populated with past 12 months. To select a different date span, use the drop-down option. (Options are Past 2 years, Past 3 years and Past 5 years.)
3. If applicable, choose a tooth number in the **Tooth Number** field.
4. If applicable, enter a Procedure Code in the **Procedure Code** field.

5.9 Hardcopy Attachment

Providers can indicate they are sending a claim attachment by using the Hard Copy Attachment window. The following steps are used to indicate a hard copy attachment to a claim.

1. On the claim submission screen, click the down arrow on the **Hard-Copy Attachments** bar. (Green bar located directly above the **Submit** button.)
2. Enter the attachment control number in the **Attachment Control Number** field.

Note: ACN is a unique number that the provider creates for the attachment. Avoid using alpha characters, dashes and spaces.

3. Select the Transmission Code in the **Transmission Code** drop-down.



4. Select the Report Type in the **Report Type** drop-down.
5. Enter a brief description of the attachment being sent in the **Description** field.
6. Once all information is entered, the link **Show** will be visible in the selection box. Click Show to view and print the **Attachment Cover Sheet**.
7. Click the **Submit** button when finished.

A claim submitted successfully with an attachment will have a status of “Suspended” and will have an ICN number beginning with ‘23’. (example: 2310678145603)

5.10 Claim Inquiry

The following are the steps to use to inquire on a claim.

Note: Only claims for the Provider ID that is logged in at the time of inquiry will populate.

1. Click the **Claim Inquiry**.
2. If known, the Internal Control Number (ICN) can be entered in the **ICN** field. (If the ICN is known, all other fields can be left blank.)

Note: Only that specific claim will show when searching by an ICN.

3. If known, the Member ID number can be entered in the **Member ID** field.
4. To narrow search results, the **Claim Status** field can be set to ‘Any Status,’ ‘Denied,’ ‘Paid,’ ‘Suspended’ or ‘Resubmit’.
5. If known, the patient account number can be entered in the **Patient Acct. #** field.
6. Date type can be selected from the **Date Type** radio buttons; either ‘Date of Service’ or ‘Warrant Date’ can be selected.
7. Enter the From Date of Service in the **From Date** field, and the Through Date of Service in the **Thru Date** field.
8. Click the **Search** button.

5.11 Resubmit a Claim – Denied Claims Only

The following are the steps to use to resubmit a denied claim.

1. Use steps 1-8 in Section 5.10 – Claim Inquiry to locate the denied claim.



2. Click the **ICN** link of the claim that needs correction.
3. Modify the field(s) containing the incorrect data.
4. Click the **Re-Submit** button when finished.

5.12 **Void a Claim – Paid Claims Only**

The following are the steps to use to void a paid claim.

The only claims that may be voided are claims in a paid status.

1. Use steps 1-8 in Section 5.10 – Claim Inquiry to locate the paid claim.
2. Click the **ICN** link of the claim to be voided.
3. Click the **Void** button.
4. A pop-up will show stating “ICN is null and void”.
(The voided claim will now have an ICN starting with ‘59’.)

This will create an account receivable for the amount previously paid. This amount will be deducted from a future warrant.

5.13 **Copy a Claim – Paid Claims Only and Resubmit**

The following are the steps to use to copy a paid claim and resubmit.

1. Use steps 1-8 in Section 5.10 – Claim Inquiry to locate the paid claim.
2. Click the **ICN** link of the claim to be copied.
3. Click on **Copy Claim**.
4. Make any changes needed to the applicable fields.
5. Click **Resubmit**.



6 Prior Authorization

6.1 Overview

This section will cover prior authorization requests on the SoonerCare Secure Site.

Submitting a prior authorization request on the SoonerCare Secure Site allows for the automatic generation of a prior authorization tracking number. The HCA-12A and HCA13A are still required for consideration of PA requests. This generated PA number should be added to the HCA-13A coversheet.

6.2 Prior Authorization (PA) Submission

The following fields are to be populated by the system or Medical Authorization Unit.

- **PA Number** – Will be populated automatically once the provider clicks the Submit button.
- **Requesting Provider** – Field is automatically populated with the provider ID that was used to log on. This can also be a group number.
- **Media Type** – Will always be Web.
- **Date Received** – The date the PA is submitted.
- **Update Received** – The date the PA Unit receives any updates.
- **Date Mailed** – The date the letter of PA status is mailed to the provider.
- **Analyst** – Person in the PA Unit that analyzes the PA.
- **Review Clerk** – Clerk which reviews the PA information.
- **Entry Clerk** – Clerk which entered the PA information into the system.
- **Fund** – Fund Code associated with the PA.
- **Managed Care** – PA Unit will choose 'No' because Managed Care is no longer an option.



6.3 Header Section

The following are the steps to complete the header section fields. These fields are to be entered by the provider.

1. Enter the Member ID in the **Member ID*** field.
(After entering, hit the tab key and the Date of Birth, Last Name, First Name and Middle Initial will automatically populate.)
2. Enter the NPI in the **NPI*** field. This field is required for medical providers.
(If applicable, the nine-digit zip code, contract code and taxonomy code must match exactly what is entered on the HCA-12A.)
 - a. For non-medical providers the **SoonerCare Servicing Provider** field should be populated with the Oklahoma Medicaid ID.
3. Enter the appropriate diagnosis code for the requested service (without decimals) in the **Diagnosis** field.
4. To select the provider type, click the **Assignment Code*** drop-down.
(The provider type of the servicing provider.)

6.4 Line Item Details

The following are the steps to complete the line item detail fields. These fields are to be entered by the provider.

1. The **Status** field gives the status of a PA. The PA will be in "Evaluation" status until the Medical Authorization Unit has conducted its review. After the review, the status will change to Approved or Denied. Do not enter data here.
2. To submit a PA with a procedure code, revenue code or NDC drug code, select the appropriate option in the **Service Type Code** drop-down.
3. Enter the appropriate procedure, revenue or NDC in the **Procedure/Revenue/NDC** field.

Note: Each procedure code must be entered on a separate line.

4. Enter any modifiers for the requested code in the **Modifiers** field.
5. The **Requested Effective Date and End Date*** (or date span) will auto-populate with today's date. If requested dates are different, the dates must be changed.
6. Enter the number of units in the **Units** field.
7. The requested **Dollar** amount for services can be left blank.



To add another procedure/revenue/NDC code, click on 'Add' button and complete the detail section for the new code.

6.5 Prior Authorization Inquiry

The following are the steps to complete a prior authorization inquiry.

From the Provider Main Page, click the **Prior Authorization** and choose **Status Inquiry** or click the **Prior Authorization** tab and choose **Inquiry**.

1. If known, enter the PA number in the **PA Number*** field.
(If the PA number is known, all other fields can be left blank.)
2. If known, enter the Member ID in the **Member ID*** field.
3. If known, enter the assignment code (optional) from the **Assignment Code*** drop-down to narrow the search results.
4. If known, enter the start date in the **Start Date** field or the date from the calendar pop-up.
5. Click the **Search** button.

6.6 Prior Authorization Notice

The following are the steps to use in viewing a prior authorization notice.

Note: Clicking the Search button with no other criteria will allow a user to view all available PA notices under the user's provider number.

1. From the **Prior Authorization** drop-down choose and click **Notice**.
2. Enter one of the following search criteria:
 - **Member ID** – Access recent PA notices submitted for a particular member.
 - **Last Name, First Name** – Access recent PA notices submitted for a particular member.
 - **Service Type** – Choose Procedure Code, Procedure Code Group, NDC or Revenue Code from the drop-down.
3. If a specific date span is needed, enter the From and Through Service Dates in the **From Date** and **Through Date** fields. The date fields are auto-populated with a 60-day span.

Note: The SoonerCare Secure Site holds a 60-day rolling PA Notice history. For example, if the PA request was entered into the system on 01/01/2012, the notice will not be available for online viewing after 03/02/2012.



4. Click the **Search** button.
5. Click the PA number link to view and print the **PA Notice Image**.



Appendix A Resources

A.1 Quick Reference Guide

The Quick Reference Guide is a great resource for providers. It provides OHCA and HPES contact information and other resource material.

The most recent version of the Quick Reference Guide can be found at:

<http://okhca.org/WorkArea/linkit.aspx?LinkIdIdentifier=id&ItemID=12336>

A.2 Eligibility Verification System Guide

The EVS Guide is an instructional guide on how to use EVS to check eligibility for a recipient.

The most recent version of the Quick Reference Guide can be found at:

<http://okhca.org/WorkArea/linkit.aspx?LinkIdIdentifier=id&ItemID=10705>

A.3 Provider Billing and Procedures Manual

The Provider Billing and Procedures Manual combines all the useful information for SoonerCare Providers. This manual covers topics such as SoonerCare programs, billing, EDI and many others.

The most recent version of the Quick Reference Guide can be found at:

<http://okhca.org/WorkArea/linkit.aspx?LinkIdIdentifier=id&ItemID=100>