

# MIT S WEB PORTAL BILLING GUIDE FOR PROFESSIONAL CLAIMS

*Revised 2011.12.21*

Fields marked with an asterisk (\*) require an entry.

Information entered into a field must be "recorded" before the system can use it. (In much the same way, information entered into a spreadsheet cell is accepted only after the <Enter> key is pressed.) Selecting a display row in a panel causes information to be recorded, as does moving the cursor out of a date field. Recording sometimes causes a momentary "graying out" of the entire screen.

Within a panel, press the 'add' button to enter new information. Select a display row to edit existing information. Select a display row and press the 'delete' button to remove the information for an existing line item. Select a display row and press the 'copy' button (if it is available) to base a new entry on the information for an existing line item. The selected display row is highlighted in light blue.

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

## Professional Claim: [Provider Identifier - PROVIDER NAME]

### BILLING INFORMATION

ICN (assigned and populated automatically when the claim is successfully submitted)

Claim Type (assigned and populated automatically from the provider's claim selection)

For professional claims, there are two possible claim types:  
M = Medical (such as would be submitted on a CMS 1500)  
B = Medicare cost-sharing (Medicare crossover), in which primary payment information for Medicare Part B or a Medicare Part C advantage plan is submitted

Provider ID (populated automatically from the provider's login)

This field shows the provider ID number that represents the billing or pay-to provider. This billing/pay-to provider ID number also appears in the Professional Claim header of this panel along with the provider's name.

**Professional Claim: [Provider Identifier - PROVIDER NAME]**

**\*Medicaid Billing Number**

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

Note: For a recipient who is a Qualified Medicare Beneficiary (QMB) on the date(s) of service, Medicare coverage is primary, and the Medicaid benefit is limited to Medicare cost-sharing (payment only of coinsurance and deductible).

**\*Date of Birth**

The date of birth must match the birth date on file for the recipient's Medicaid Billing Number entered in the previous field. Make sure that both the recipient's Medicaid Billing Number and date of birth are entered correctly; if they do not correspond, you will not be able to proceed.

Last Name (populated automatically when both a Medicaid billing number and date of birth are successfully entered)

First Name, MI (populated automatically when both a Medicaid billing number and date of birth are successfully entered)

**\*Patient Account #**

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

**Medical Record #**

Enter a medical record number assigned by the provider, if applicable. This optional field is meant to assist providers in maintaining medical records.

Hospice, Home Health Services, Private Duty Nursing, and ODJFS-Administered Waiver: This information is not necessary. Leave the field blank.

**Referring Provider #**

If a physician authorized a referral or an order for the service or supply, enter the NPI of the referring or ordering physician. The NPI is the only acceptable identifier in this field.

**Professional Claim: [Provider Identifier - PROVIDER NAME]**

○ Hospice, Home Health Services, Private Duty Nursing, and ODJFS-Administered Waiver: This information is not necessary. Leave the field blank.

**\*Medicare Assignment**

<Blank>
ASSIGNED
ASSIGNMENT ACCEPTED
NOT ASSIGNED [default]
PAT REFUSES TO ASSIGN

○ When assignment of Medicare benefits is accepted, both the practitioner and the patient agree to have Medicare pay the practitioner directly, and the practitioner also agrees to accept the Medicare-approved amount as payment in full. The difference between what Medicare approves and what Medicare pays is the cost-sharing amount and is usually covered by Medicaid.

**Patient Amount Paid**

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

○ Hospice: For a recipient receiving hospice room and board in a long-term care facility (procedure code T2046), enter the amount of the recipient's patient liability for the entire month that is to be applied toward the room and board. This patient liability amount is determined by the County Department of Job and Family Services.

**Professional Claim: [Provider Identifier - PROVIDER NAME]**

**SERVICE INFORMATION**

\*Release of Information

<Blank>
INFORMATION ON FILE
INFORMED CONSENT TO RELEASE BY FEDERAL STATUTES
LIMITED OR RESTRICTED ABILITY TO RELEASE DATA
NOT ALLOWED TO RELEASE DATA [default]
ON FILE
SIGNED STMT PERMITTING RELEASE

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

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

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

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

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

Signature Source

<Blank> [default]
AUTH FOR HCFA-1500 BLOCK 12
AUTH FOR HCFA-1500 BLOCK 13
GENERATED BY PROVIDER
SIGNED AUTHORIZATION ON FILE
SIGNED HCFA-1500 ON FILE

- "HCFA-1500" means the CMS 1500 form.
- In lieu of signing an actual claim form, an individual may sign a statement to be retained by the provider. If the person is unable to sign, a representative may sign on her or his behalf. The signature authorizes the release of medical information necessary to process the claim.
- Hospice, Home Health Services, Private Duty Nursing, and ODJFS-Administered Waiver: This information is not necessary. Leave the field blank.

**Professional Claim: [Provider Identifier - PROVIDER NAME]**

Accident Related To

<Blank> [default]
ANOTHER PARTY RESPONSIBLE
AUTO ACCIDENT
EMPLOYMENT
OTHER ACCIDENT

- If the service or supply is related to an accident, choose the category most appropriate to the circumstances.
- Hospice, Home Health Services, Private Duty Nursing, and ODJFS-Administered Waiver: This information is not necessary. Leave the field blank.

Accident State

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

- If the service or supply is related to an automobile accident, identify the state or territory in which the accident occurred.
- Hospice, Home Health Services, Private Duty Nursing, and ODJFS-Administered Waiver: This information is not necessary. Leave the field blank.

Accident Country

- If the service or supply is related to an automobile accident, identify the country in which the accident occurred.
- Hospice, Home Health Services, Private Duty Nursing, and ODJFS-Administered Waiver: This information is not necessary. Leave the field blank.

Accident Date

- If the service or supply is related to an automobile accident, enter the date on which the accident occurred.
- Hospice, Home Health Services, Private Duty Nursing, and ODJFS-Administered Waiver: This information is not necessary. Leave the field blank.

**Professional Claim: [Provider Identifier - PROVIDER NAME]**

EPSDT Screening/Family Planning

<Blank> [default]
NEW SERVICES REQUESTED
PATIENT NOT REFERRED
PATIENT REFUSED REFERRAL
UNDER TREATMENT

- If an Early and Periodic Screening, Diagnosis, and Treatment (EPSDT, known as Healthchek) service was provided, then indicate the circumstances or outcome: Select 'PATIENT NOT REFERRED' if the service did not result in a referral. Select 'PATIENT REFUSED REFERRAL' if a referral was offered but the individual declined it. Select 'NEW SERVICES REQUESTED' if the screening provider has either scheduled the individual for another appointment or referred the individual to another provider for diagnostic or corrective treatment of at least one health problem identified during a Healthchek screening. Do not use this indicator for dental treatment referrals. Select 'UNDER TREATMENT' if the individual is currently being diagnosed or treated for a health problem by the provider as a result of a Healthchek referral.
- Hospice, Home Health Services, Private Duty Nursing, and ODJFS-Administered Waiver: This information is not necessary. Leave the field blank.

Prior Authorization #

- Complete this field only if prior authorization is required and has been approved by ODJFS for a service or supply listed on the claim. Use the ODJFS prior authorization number assigned for the service or supply.
- Private Duty Nursing, and ODJFS-Administered Waiver: A PA number is required for (1) ODJFS-administered home modification and supplemental adaptive/assistive devices, and (2) for private duty nursing provided to recipients who either are not enrolled on a waiver or are enrolled on an ODA- or DODD-administered waiver.
- Home Health Services and Hospice: No prior authorization is required.

Hospital Discharge Date

- Home Health Services and Private Duty Nursing: Enter the date of discharge when submitting a claim for increased post-hospital services provided after a qualifying hospital stay.

**Professional Claim: [Provider Identifier - PROVIDER NAME]**

Last Menstrual Period

- Enter the beginning date of the menstrual period if the service or supply is related to a pregnancy.
- Hospice, Home Health Services, Private Duty Nursing, and ODJFS-Administered Waiver: This information is not necessary. Leave the field blank.

**TOTAL CHARGES**

Total Charges (populated automatically when the claim is successfully submitted)

- This field displays the sum of all line item charges submitted.

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

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

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

- This field displays the sum of the paid amounts reported in the 'Other Payer' panel. This TPL amount is applied toward the total claim payment.
- When an FQHC or RHC submits a claim to Medicaid for supplementary ("wraparound") payment for a service or supply provided to an enrollee of a Managed Care Plan (MCP), the payment made by the MCP is treated as though it were a TPL amount and will be displayed in this field.

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

- This amount will be reduced by any TPL payment amounts, including MCP payments to FQHCs and RHCs.

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

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

**Professional Claim: [Provider Identifier - PROVIDER NAME]**

Note Reference Code

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

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

Notes

- When a Medicaid School Program (MSP) claim is submitted, a Note Reference Code of 'CER' must be selected for the 'Note Reference Code' field, and a 10-character attestation code must be entered in this field to show whether or not the claim is certified by the executive officer of the MSP provider or his/her designee in accordance with rule 5101:3-35-04 of the Ohio Administrative Code.  
Format: ATTEST YES or ATTEST NAY  
(There must be a space after the word 'ATTEST'.)
- When a claim is submitted more than 365 days after the date of service because of either a hearing decision or a delay in a recipient's eligibility determination by the County Department of Job and Family Services (CDJFS), enter the appropriate reason code. The claim must be submitted within 180 days after the hearing decision or eligibility determination date.  
Hearing decision format: APPEALS XXXXXXXX CCYYMMDD  
(XXXXXXX is the hearing number and CCYYMMDD is the date on the hearing decision letter.)  
Eligibility determination format: DECISION CCYYMMDD  
(CCYYMMDD is the date on the eligibility determination notice from the CDJFS.)
- When a Medicaid co-payment exclusion applies, as described in rule 5101:3-1-09 of the Ohio Administrative Code, select 'ADD' in the 'Note Reference Code' field and enter a 10-character exclusion reason code in this field.  
Format for emergency exclusion: COPAY EMER  
Format for hospice exclusion: COPAY HSPC  
Format for pregnancy exclusion: COPAY PREG  
(There must be a space after the word 'COPAY'.)

## Diagnosis

Enter each diagnosis code to the highest level of specificity. Omit the decimal point. For each diagnosis code, select a sequence indicator (e.g., '1' for the principal or primary diagnosis). In the 'Detail' panel, diagnosis pointers are used to specify which diagnoses apply to a particular line item.

### \*Sequence

### \*Diagnosis Code

- Home Health Services, Private Duty Nursing, and ODJFS-Administered Waiver: A diagnosis is optional on claims with any of the following procedure codes:  
G0151, G0152, G0153, G0154, G0156,  
H0045,  
S0215, S5101, S5102, S5125, S5160, S5161, S5165, S5170,  
T1000, T1002, T1003, T1019, T2029.  
But if one or more diagnoses are specified, then each claim line in the 'Detail' panel must point to (be associated with) at least one diagnosis.
- Hospice: At least one terminal diagnosis is required.
- Transportation: For ground or air ambulance service, a diagnosis is optional. For wheelchair van service, do not specify a diagnosis, and omit diagnosis code pointers in the 'Detail' panel.

**Other Payer**

Press the 'add' button to specify that another source, such as commercial insurance or Medicare, is the primary payer for the recipient. FQHCs and RHCs use 'Other Payer' panels to report MCP payments when submitting a claim for FQHC/RHC supplemental payments.

Note: Information for each payer (other than Medicaid) must be entered separately. For example, if a recipient has both Medicare and commercial insurance, then create a different entry for each carrier. This panel does not need to be completed when Medicaid is the primary payer and there is no other payer.

**\*Claim Filing Indicator**

<Blank> [default]
AUTOMOBILE MEDICAL
BLUE CROSS/BLUE SHIELD
CENTRAL CERTIFICATION
CHAMPUS
COMMERCIAL INSURANCE CO.
DISABILITY
EXCLUSIVE PROVIDER ORGANIZATION (EPO)
HEALTH MAINTENANCE ORGANIZATION
HMO MEDICARE RISK
INDEMNITY INSURANCE
LIABILITY
LIABILITY MEDICAL
MEDICAID
MEDICARE PART B
OTHER FEDERAL PROGRAM
OTHER NON-FEDERAL PROGRAMS
POINT OF SERVICE (POS)
PREFERRED PROVIDER ORGANIZATION (PPO)
SELF-PAY
TITLE V
UNKNOWN
VETERAN ADMINISTRATION PLAN
WORKERS' COMPENSATION HEALTH CLAIM

 Never select 'MEDICAID'. (It appears on this list because it is included in the 5010 version of the 837 transaction.)  
 For Medicare Part B, select 'MEDICARE PART B'.  
 For a Medicare Advantage Plan, also known as Medicare Part C, select 'HMO MEDICARE RISK'.  
 For third-party insurance other than Medicare, select 'COMMERCIAL INSURANCE CO.'.  
 For FQHC or RHC supplemental payments for MCP enrollees, select 'HEALTH MAINTENANCE ORGANIZATION'.

**Other Payer**

○ Transportation: Wheelchair van services (procedure codes A0130, S0209, and T2001) are never covered by Medicare, regardless of trip origin or destination or any other factor. On claims exclusively for wheelchair van services, omit all Medicare-related information. On claims for ambulance services, include Medicare-related information for dually-eligible individuals.

**\*Policy Holder Relationship to Insured**

<Blank> [default]
CADAVER
DONOR
CHILD
CHILD WHERE INSURED HAS NO FIN RESP
DEPENDENT OF A MINOR DEPENDENT
EMANCIPATED MINOR
EMPLOYEE
FATHER
FOSTER CHILD
GRANDCHILD
GRANDPARENT
HANDICAPPED DEPENDENT
INJURED PLAINTIFF
LIFE PARTNER
MOTHER
NEPHEW OR NIECE
ORGAN DONOR
OTHER RELATIONSHIP
SELF
SIGNIFICANT OTHER
SPONSORED DEPENDENT
SPOUSE
STEPCHILD
UNKNOWN
WARD

○ If the policy holder or subscriber is the recipient, select 'SELF'.

**\*Policy Holder Last Name**

○ If the 'Policy Holder Relationship to Insured' is specified as 'SELF', this field will be automatically populated. Otherwise, enter the information.

**\*Policy Holder First Name, MI**

○ If the 'Policy Holder Relationship to Insured' is specified as 'SELF', this field will be automatically populated. Otherwise, enter the information.

**Other Payer**

Policy Holder Date of Birth

If the 'Policy Holder Relationship to Insured' is specified as 'SELF', this field will be automatically populated. Otherwise, enter the information.

Gender

<Blank> [default]
FEMALE
MALE
UNKNOWN

\*Paid Amount

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

\*Paid Date

Enter the date on which the carrier processed the claim.

Allowed Amount

Do not enter anything in this field. The amount allowed by the particular insurance carrier will be calculated automatically from the adjustment amounts and Adjustment Reason Codes reported.

\*Insurance Carrier Name

\*Carrier Code

Enter the Payer Identification (ID) code of the Medicare plan or insurance company. Do not enter the carrier code listed on the individual's Medicaid card. The Payer ID code may be obtained from the individual's Medicare or private insurance card, an explanation of benefits (EOB) or electronic remittance advice (ERA) issued by the payer, or the payer itself. Each payer defines its own Payer ID code. ODJFS does not maintain a list of Payer ID codes.

Insured's Policy ID

**Other Payer**

\*Payer Sequence

<Blank> [default]
PRIMARY
SECONDARY
TERTIARY

- Indicate the role of the payer in processing the claim. For example, if a recipient's Medicare pays only after the recipient's commercial insurance, select 'PRIMARY' for the commercial insurance entry and 'SECONDARY' for the Medicare entry.

Medicare ICN

- For claims processed by Medicare as the primary payer (either traditional Medicare Part B or a Medicare Advantage Plan aka Medicare Part C), enter the Medicare ICN assigned by the Medicare carrier for the service on the Medicare Explanation of Benefits, remittance advice, or 835 Health Care Claim Payment/Advice transaction.

**Other Payer Amounts and Adjustment Reason Codes (Select Detail Above)**

Select the 'Other Payer Amounts and Adjustment Reason Codes' link at the bottom of the 'Other Payer' panel to enter claim-level monetary amounts and Claim Adjustment Reason Codes (CARCs, or ARCs for short) for a particular payer.

Note: The 'Other Payer' panel displays the non-Medicaid payers associated with a particular claim. The 'Other Payer Amounts and Adjustment Reason Codes' panel displays the payment amounts and ARCs associated with a particular payer.

Be sure to enter all claim-level monetary amounts and ARCs for the payer.

**\*CAS Group Code**

<Blank> [default]
CO-Contractual Obligations
CR-Correction and Reversals
OA-Other adjustments
PI-Payer Initiated Reductions
PR-Patient Responsibility

Select the Claim Adjustment Segment (CAS) Group Code received from the carrier on the explanation of benefits, remittance advice, or 835 transaction.

**Payer Line Level Amounts and Adjustment Reason Codes (ARC)**

**\*Amount**

Enter the amount, in dollars, corresponding to a particular claim-level ARC received from the carrier on the explanation of benefits, remittance advice, or 835 transaction.

**ARC**

Enter the claim-level ARC (for which there is a corresponding dollar amount) received from the carrier on the explanation of benefits, remittance advice, or 835 transaction.

## Detail

In the 'Detail' panel, each service or supply is represented as a line item. Each line is numbered in the order in which it is entered. Display rows are arranged in descending order; later line items are displayed above earlier line items.

Note: Some information for a line item may be entered separately in the 'NDC (Detail Item #)' and 'Other Payer Detail' panels. Be sure to select the correct line before entering information into these panels. The selected line is shown in the headers, such as 'NDC (Detail Item 2)'; the default value is item 1.

Item (populated automatically)

- Home Health Services, Private Duty Nursing, and ODJFS-Administered Waiver: Claims must be submitted chronologically, in the order of the visits. The sequence of the claim lines must also match the sequence of the visits; otherwise, the claim may be denied.

\*From DOS

- Enter the date on which the service or supply was provided. A separate line is required for each date of service. Multiple-date spans are not permitted, even if other payers accept them.

To DOS (populated automatically)

- Because multiple-date spans are not permitted, the content of the 'From DOS' field is automatically copied to this field.

\*Units

- Enter the number of units appropriate to the service or supply.
- Transportation: For each line item other than mileage, enter 1.

\*Charges

- Enter the usual and customary charge for the service or supply.

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

- This field shows the amount payable for the service or supply before any TPL or Medicare payment is deducted.

## Detail

## Rendering Provider

- A rendering provider ID (in the form of a National Provider Identifier, or NPI) is required only when an entity such as a group practice, an ambulatory surgery center (ASC), or a hospice is submitting a claim for professional fees on behalf of an affiliated physician or individual practitioner. Use form JFS 06777, "Group Practice Provider Information", to update and maintain member affiliations.
- A separate rendering provider ID is not required for an ASC submitting a claim for a facility service, nor for a hospice submitting a claim for a hospice service, nor for other providers (fee-for-service clinics, cost-based clinics including FQHCs and RHCs, independent laboratories, home health service providers, private duty nursing providers, ODJFS-administered waiver providers, etc.). These providers should leave this field blank.

## Status (populated automatically when the claim is successfully submitted)



## \*Place Of Service

- Hospice, Home Health Services, Private Duty Nursing, and ODJFS-Administered Waiver: Enter (or use the [Search] function to select) the code that best describes the place of service. Do not use old code 09, which now means "prison" and will cause denial of the claim.
- Independent Laboratory: Use 81.
- Transportation: For ground ambulance, use 41. For air ambulance, use 42. For wheelchair van, use 99.

## Procedure Code

- Hospice, Home Health Services, Private Duty Nursing, and ODJFS-Administered Waiver: Procedure codes for home health nursing service (G0154), home health aide service (G0156), or therapy service (G0151, G0152, G0153) that are provided on the same day may be reported on the same claim.

**Detail**

Emergency

<Blank> [default]
No
Yes

- Completion of this field is optional, but you may select either 'No' to indicate that the service or supply provided was not emergency-related or 'Yes' to indicate that the service or supply provided was emergency-related.
- Hospice, Home Health Services, Private Duty Nursing, and ODJFS-Administered Waiver: This information is not applicable. Leave the field blank.

EPSDT Screening/Family Planning

<Blank> [default]
EPSDT SCREENING
FAMILY PLANNING

- Completion of this field is required if the claim meets one of two criteria: If the service or supply was provided as a result of an EPSDT referral, then select 'EPSDT SCREENING'. Also select the appropriate entry in the 'EPSDT Screening/Family Planning' field of the primary panel. If the service or supply is related to family planning, then select 'FAMILY PLANNING'.
- Hospice, Home Health Services, Private Duty Nursing, and ODJFS-Administered Waiver: This information is not applicable. Leave the field blank.

Diagnosis Code Pointer [4]

<Blank> [default]
1 through 8

- At least one diagnosis code pointer is required for most services and supplies; up to four pointers may be specified. Select the sequence number of each diagnosis (listed in the 'Diagnosis' panel) that is associated with the supply or service.
- Hospice, Home Health Services, Private Duty Nursing, and ODJFS-Administered Waiver: A diagnosis is optional. But if one or more diagnoses are specified in the 'Diagnosis' panel, then each line item must point to (be associated with) at least one diagnosis.
- Transportation: For ground or air ambulance service, a diagnosis is optional. But if a diagnosis has been specified in the 'Diagnosis' panel, then each line item must point to (be associated with) at least one diagnosis. For wheelchair van service, omit diagnosis code pointers.

## Detail

## Modifiers [4]

- When applicable, enter each two-character procedure code modifier associated with the supply or service; up to four modifiers may be specified.  
Note: Modifiers are not shown in the display rows near the top of the panel. Select a display row to see the modifiers that have been entered in the data fields.
- Home Health Services, Private Duty Nursing, and ODJFS-Administered Waiver: The following modifiers are used with the procedure codes listed.
  - HQ.....G0151, G0152, G0153, G0154, G0156, S5125, T1000, T1002, T1003, or T1019 delivered in a group setting
  - U1.....G1054, T1000, or T1002 for a consumer receiving infusion therapy
  - U2.....G0151, G0152, G0153, G0154, G0156, S5125, T1000, T1002, T1003, or T1019 for a second visit to a consumer on the same date of service
  - U3.....G0151, G0152, G0153, G0154, G0156, S5125, T1000, T1002, T1003, or T1019 for a third or successive visit to a consumer on the same date of service
  - U4.....T1000, T1002, T1003, or T1019 for a single visit > 12 and ≤ 16 hours in length
  - U5.....G0151, G0152, G0153, G0154, G0156 for increased home health services for children > 14 hours a week
  - U8.....S5125 in lieu of intermittent nursing or for units of home care attendant services provided for personal care tasks (HCAS/PC) [OAC rules 5101:3-46-06.1 and 5101:3-50-06.1]
- Transportation: The [Search] function is unreliable; search results reveal omissions, inconsistencies, inaccuracies, and other errors. For each service, enter the necessary point-of-transport modifier (which specifies the trip origin and destination) and any appropriate pricing or informational modifier.

**NDC (Detail Item #)**

Select the 'NDC' link at the bottom of the 'Detail' panel to open the 'NDC (Detail Item #)' panel.

Before entering information for a line item in the 'NDC (Detail Item #)' panel, select the display row for the line in the 'Detail' panel. The header in the 'NDC (Detail Item #)' panel will change according to the selection—'NDC (Detail Item 1)', 'NDC (Detail Item 2)', and so on.

**\*NDC**

A National Drug Code (NDC) is an 11-digit number that specifically identifies the manufacturer, product, and package size. It is made up of three segments of five digits, four digits, and two digits respectively. On a drug package, the printed NDC often includes separators such as hyphens or dashes (e.g., 55555-4444-22). Omit separators when entering an NDC. If the NDC printed on a drug package consists of only 10 digits, then add a leading zero to the appropriate segment.

Drug Name (populated automatically when the NDC is successfully entered)

**\*Unit of Measure**

<Blank> [default]
F2-International Unit
GR-Gram
ML-Milliliter
UN-Unit

Prescription Number

**\*Drug Unit Price**

**\*Unit Quantity Submitted**

## Other Payer Detail (Detail Item #)

If another payer has been entered in the 'Other Payer' panel, then select the 'Other Payer – Detail' link at the bottom of the 'Detail' panel to open the 'Other Payer Detail (Detail Item #)' panel.

Before entering information for a line item in the 'Other Payer Detail (Detail Item #)' panel, select the display row for the line in the 'Detail' panel. The header in the 'Other Payer Detail (Detail Item #)' panel will change according to the selection—'Other Payer Detail (Detail Item 1)', 'Other Payer Detail (Detail Item 2)', and so on.

### LINE LEVEL AMOUNTS AND ADJUSTMENT REASON CODES

#### \*Carrier Code

- The entries in the drop-down list are populated automatically from the 'Carrier Code' field in the 'Other Payer' panel.

#### \*Paid Date



#### \*Paid Amount

- Enter the amount paid by the particular insurance carrier for the line item.

**Other Payer Amounts and Adjustment Reason Codes – Detail (Select Detail Above)**

Select the 'Other Payer Amounts and Adjustment Reason Codes – Detail' link at the bottom of the 'Other Payer Detail (Detail Item #)' panel to enter line-level monetary amounts and Claim Adjustment Reason Codes (CARCs, or ARCs for short) for a particular payer.

**\*CAS Group Code**

<Blank> [default]
CO-Contractual Obligations
CR-Correction and Reversals
OA-Other adjustments
PI-Payer Initiated Reductions
PR-Patient Responsibility

 Select the Claim Adjustment Segment (CAS) Group Code received from the carrier on the explanation of benefits, remittance advice, or 835 transaction.

**Payer Line Level Amounts and Adjustment Reason Codes (ARC)**

**\*Amount**

 Enter the amount, in dollars, corresponding to a particular line-level ARC received from the carrier on the explanation of benefits, remittance advice, or 835 transaction.

**ARC**

 Enter the line-level ARC (for which there is a corresponding dollar amount) received from the carrier on the explanation of benefits, remittance advice, or 835 transaction.

**Attachments**

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

**\*Type of Document**

<Blank> [default]
ADMISSION SUMMARY
CERTIFICATION
COMPLETED REFERRAL FORM
DENTAL MODELS
DIAGNOSTIC REPORT
DISCHARGE SUMMARY
EXPLANATION OF BENEFITS
MODELS
NURSING NOTES
OPERATIVE NOTE
PHYSICAL THERAPY CERTIFICATION
PHYSICAL THERAPY NOTES
PHYSICIAN ORDER
PRESCRIPTION
PROSTHETICS OR ORTHOTIC CERTIFICATION
RADIOLOGY FILMS
RADIOLOGY REPORTS
REFERRAL FORM (OHIO 6653)
REPORT OF TESTS AND ANALYSIS REPORT
SUPPORT DATA FOR CLAIM

 An attachment is required for the adjudication of certain claims. When a required attachment is submitted with a claim, the claim will be suspended for review. An attachment that is not required will not be reviewed; the accompanying claim will be processed as though there were no attachment. The mere presence of an attachment will not cause a claim to be suspended for review. Therefore, submit an attachment only when an attachment is required.

**\*Transmission Type**

<Blank> [default]
MAIL
UPLOAD

 An attachment that is uploaded will automatically be linked to the claim by Internal Control Number (ICN). An 'upload' button will appear after the claim has been submitted. Only file types gif, tiff, bmp, jpg, ppt, doc, xls, pdf, txt, and mdi can be uploaded.

**Attachments**

- An attachment that is mailed to ODJFS after the claim is submitted through the portal must be accompanied by an EDMS cover page and sent to the appropriate mailing address. A button for printing a cover page and a button for displaying addresses will appear after the claim has been submitted.

## Supporting Data for Delayed Submission / Resubmission

### Previously Denied ICN or TCN

- If (1) this claim is a resubmission or correction of a claim that has been denied within the past 180 days for reasons other than lack of timely filing and (2) the interval between the date of service and the current submission date (today) is more than 365 days, then enter the Internal Control Number (ICN) or Transaction Control Number (TCN) of the previously denied claim.  
Documentation to support the use of this panel must be retained for audit purposes.

## Claim Status Information

Claim Status (populated automatically when the 'submit' button is pressed)

submit

cancel