



OREGON
HEALTH
AUTHORITY

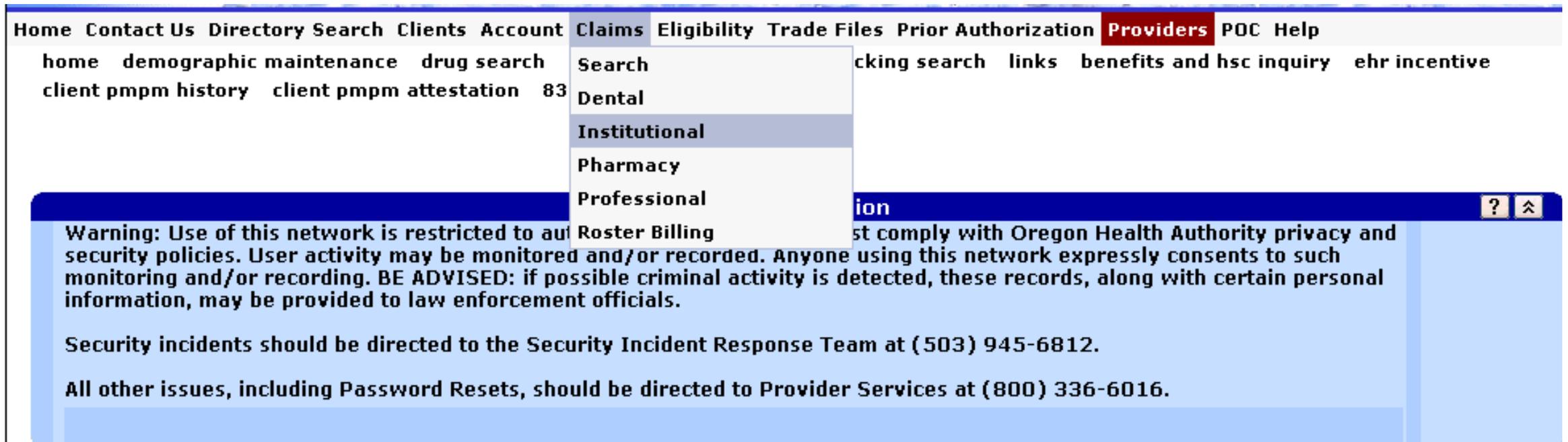
September 2024

MMIS Provider Portal Institutional Claim

**Find program-specific instructions in
supplemental guides for each program**

Go to <https://www.or-medicaid.gov>

- Click **Account > Secure Site**
- After login, click **Claims > Institutional**



The screenshot shows the top navigation bar of the Oregon Medicaid website. The menu items are: Home, Contact Us, Directory, Search, Clients, Account, Claims, Eligibility, Trade Files, Prior Authorization, Providers, POC, and Help. The 'Providers' item is highlighted in red. Below the navigation bar, there is a search bar and several links: home, demographic maintenance, drug search, client pmpm history, client pmpm attestation, 83, Search, Billing search, links, benefits and hsc inquiry, and ehr incentive. A dropdown menu is open under the 'Claims' item, showing the following options: Search, Dental, Institutional (highlighted), Pharmacy, Professional, and Roster Billing. Below the navigation bar, there is a blue banner with a warning message: "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, 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." In the top right corner of the banner, there are two icons: a question mark and an upward arrow.

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 displays a web-based form for an institutional claim, divided into several sections. The sections are numbered 1 through 8, corresponding to the list on the left. Section 1 is the 'Institutional Claim' header, which includes 'Billing Information' (ICN, Provider ID, Client ID, Last Name, First Name, MI, Date of Birth, Patient Account #, Medical Record #, Attending Phys, Taxonomy, Zip+4, Referring Phys, Facility Number, Taxonomy, Zip+4, Other Physician, Taxonomy, Zip+4, Insurance Denied) 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). Section 2 is a menu for 'Diagnosis Condition Payer Procedure Occurrence/Span Value'. Section 3 is 'TPL' (Third-Party Liability) information, including Last Name, First Name, MI, Date of Birth, Relationship, Policy Number, Plan Name, Plan ID, Adjustment Reason Code, Adjustment Group Code, and Adjustment Amount. Section 4 is 'Medicare Information', showing Medicare Paid Date, Coinsurance Amount, Deductible Amount, and Medicare Paid Amount. Section 5 is 'Detail', a table with columns for Item, Revenue Code, HCPCS/Rates, Units, Charges, Non Covered Charges, and Status. Section 6 is 'Hard-Copy Attachments', including Control Number, Transmission, Report Type, and Description. Section 7 is 'Claim Status Information', showing Claim Status as 'Not Submitted yet'. Section 8 is 'Outpatient APC', which is currently empty. The form includes various search fields, dropdown menus, and buttons for 'delete' and 'add'.

Institutional Claim (header): Required fields

Fields marked with an asterisk (*) are required on all claims

1. Client ID*
2. Attending Physician NPI (for hospital and long-term care claims)
3. Insurance Denied (for clients with TPL; does not include Medicare)
4. Claim Type*
5. Type of Bill*
6. From and To Dates*
7. Patient Status, Admission and Discharge fields (for inpatient claims)

The screenshot shows the 'Institutional Claim' form with the following sections and fields:

- Billing Information:**
 - ICN
 - Provider ID [redacted] NPI
 - 1 Client ID* [redacted] [Search]
 - Last Name CWMM
 - First Name, MI [redacted]
 - Date of Birth [redacted]
 - Patient Account # [redacted]
 - Medical Record # [redacted]
 - 2 Attending Phys [redacted] [Search]
 - Taxonomy [redacted]
 - Zip+4 [redacted]
 - Referring Phys [redacted] [Search]
 - Facility Number [redacted] [Search]
 - Taxonomy [redacted]
 - Zip+4 [redacted]
 - Other Physician [redacted] [Search]
 - Taxonomy [redacted]
 - Zip+4 [redacted]
 - Insurance Denied [dropdown] 3
- Mailbox and Filename:**
 - Mailbox #
 - File Name
- Service Information:**
 - 4 Claim Type* O - OUTPATIENT CLAIMS
 - 5 Type Of Bill* 131 [Search]
 - 6 From Date* 10/01/2015
 - 6 To Date* 10/01/2015
 - Patient Status [Search]
 - Admit Source [Search]
 - Admission Type [Search]
 - Admission Date [redacted]
 - Admission Hour [redacted]
 - Discharge Time [redacted]
 - 7 (bracketed group: Patient Status, Admit Source, Admission Type, Admission Date, Admission Hour, Discharge Time)
- Charges:**
 - Total Charges \$0.00

Additional sections:

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

Click the section name to open the section

1

2

3

4

5

6

[Diagnosis](#) [Condition](#) [Payer](#) [Procedure](#) [Occurrence/Span](#) [Value](#)

Diagnosis

For each diagnosis:

1. Click **add**
2. Enter the sequence (e.g., 1 for primary diagnosis)
3. Enter Present on Admission indicator (for inpatient claims):
 - Y: Diagnosis present on admission
 - N: Diagnosis not present on admission
 - U: Documentation insufficient to determine
 - W: Clinically undetermined
4. Enter the ICD-10 diagnosis code (do not use decimals)

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	4 Diagnosis*	M71811 [Search]
3 Present on Admission	<input type="checkbox"/>	Description	Other specified bursopathies, right shoulder
		ICD Version	10

1
delete add

Condition

This section is only required when applicable. For each condition:

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

Condition	
*** No rows found ***	
Select row above to update -or- click Add button below.	
Sequence <input type="text"/>	Condition <input type="text"/> [Search]
2	3
<input type="button" value="delete"/> <input type="button" value="add"/>	

Payer

This section is required only when the client has other coverage (TPL and/or Medicare). For each payer:

1. Click **add**
2. Enter sequence (e.g., 1 for primary payer)
3. Choose payer from drop-down menu
4. Enter prior payment received from payer
5. Enter estimated amount due after prior payment

Payer	
*** No rows found ***	
Select row above to update -or- click Add button below.	
Sequence 2	Prior Payment 4
Payer 3	Estimated Amount Due 5
<input type="button" value="delete"/> <input type="button" value="add"/>	

Procedure

For hospital inpatient claims. For each procedure:

1. Click **add**
2. Enter sequence
3. Enter ICD-10 procedure code
4. Enter the procedure date

Procedure			
Sequence	ICD Procedure	Description	Procedure Date
A	0		
Type data below for new record.			
Sequence*	<input type="text" value="2"/>		
ICD Procedure*	<input type="text" value="3"/> [Search]	Procedure Date	<input type="text" value="4"/>
			<input type="button" value="delete"/> <input type="button" value="add"/>

Occurrence/Span

For Skilled Nursing Facility (SNF) services, use this screen to enter the client's qualifying hospital stay. For each occurrence/span:

1. Click **add**
2. Enter sequence
3. Enter occurrence code
4. Enter From and To Dates of the occurrence

Occurrence/Span				
Sequence	Occurrence Code	Description	From Date	To Date
A	0			
Type data below for new record.				
Sequence*	<input type="text" value="2"/>		From Date*	<input type="text" value="4"/>
Occurrence Code*	<input type="text" value="3"/> [Search]		To Date	<input type="text"/>
				<input type="button" value="delete"/> <input type="button" value="add"/>

Value

For each value:

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

Value			
Sequence	Value	Description	Amount
A	0		0
Type data below for new record.			
Sequence*	<input type="text" value="2"/>		
Value*	<input type="text" value="3"/> [Search]	Amount*	<input type="text" value="4"/>
			<input type="button" value="delete"/> <input type="button" value="add"/>

TPL

For each third-party liability (TPL) resource (do not include Medicare):

1. Click **add**
2. Enter Plan ID
3. Enter Adjustment Reason Code

The Date of Birth and Adjustment Group Code fields are not required; they auto-populate upon claim submission

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				2 Plan ID*	101	[Search]
Date of Birth	01/01/1900			3 Adjustment Reason Code	3	[Search]
Relationship				Adjustment Group Code	PR	
Policy Number				Adjustment Amount		\$0.00
						1
						delete add

Medicare Information

If the client has Medicare coverage:

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

Medicare Information				
Medicare Paid Date	Coinsurance Amount	Deductible Amount	Medicare Paid Amount	
A	\$0.00	\$0.00	\$0.00	1
Medicare Paid Date	<input type="text"/>	Coinsurance Amount	<input type="text"/>	
Deductible Amount	<input type="text"/>	Medicare Paid Amount	<input type="text"/>	2

Detail

For each detail line:

1. Click **add**
2. Enter From and To DOS* (dates of service)
3. Enter Units*
4. Enter Charges*
5. Enter Revenue Code*
6. Enter HCPCS (for outpatient services)
7. Enter NDC information (for physician-administered drugs only)

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] [Search]		
2 From DOS*	10/01/2015	Units Of Measurement		[Select]		
3 To DOS*	10/01/2015	Status				
4 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				
6 HCPCS/Rates	[Search]	TPL Amount		\$0.00		
NDC	[Search]	Plan Payment Amount				
7 NDC UOM	[Select]					
7 NDC Quantity	0					
						1
						delete add

Hard-Copy Attachments

MMIS does not use information entered in this section. If you need to submit hardcopy attachments, please submit a paper claim.

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

Before you submit the claim, you have two choices:

- Click **submit** to submit the claim for processing.
- Click **cancel** to clear information you have entered on the claim.

Once you click **submit**, you will see one of three claim status options: Paid, Denied, or Suspended.



The screenshot shows a web interface for 'Claim Status Information'. The title bar is dark blue with white text. Below it, a light blue bar displays 'Claim Status Not Submitted yet'. On the right side of this bar is a button labeled 'Coversheet for supporting documentation'. Below the main content area, there are two blue buttons: 'submit' and 'cancel'. These two buttons are enclosed in a red rectangular box, indicating they are the primary actions to be taken.

Claim Status: PAID

On paid claims, you can:

- Click **cancel** to clear changes made during this session
- Click **adjust** to adjust with changes made during this session
- Click **void** to cancel the claim. OHA will recover payments made on the claim.
- Click **copy claim**. This creates a new claim. It will have all the information entered on the paid claim, with a status of “Not Submitted Yet.”

Claim Status Information		
Claim Status	PAID	
Claim ICN	[REDACTED]	
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).

[cancel](#) [adjust](#) [void](#) [copy claim](#)

Claim Status: DENIED

On denied claims, you can:

- Click **resubmit** to make changes to the claim and submit the changes during this session.
- Click **cancel** to clear changes made during this session.

Claim Status Information		
Claim Status	DENIED	
Claim ICN	[REDACTED]	
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

Claim Status: SUSPENDED

- You cannot take any action on a suspended claim.
 - OHA staff will give the claims a Paid or Denied status after internal review.
 - The review should not take longer than 30 days.

Claim Status Information		
Claim Status	SUSPENDED	
Claim ICN	[REDACTED]	
Allowed Amount	\$0.00	

HIPAA Adjustment Reasons		
Detail Number	HIPAA Adjustment Reason Code	HIPAA Adjustment Reason Description
0	223	Adjustment code for mandated federal, state or local law/regulation that is not already covered by another code and is mandated before a new code can be created.
0	206	National Provider Identifier - missing.
0	22	This care may be covered by another payer per coordination of benefits.
0	40	Charges do not meet qualifications for emergent/urgent care.
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).
3	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).
4	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).
5	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).
6	16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark
6	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).
7	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).
8	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).
9	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).
10	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).
11	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).
12	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).
13	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).
14	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).
15	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).

Outpatient APC

- This section displays on claims subject to Ambulatory Payment Classification (APC).
- It shows the procedure code, Payment APC and APC Status Indicator.

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

Outpatient APC

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

Need help?

Contact OHP Provider Services

800-336-6016 option 5

dmap.providerservices@oha.oregon.gov

Thank you

You can get this document in other languages, large print, braille or a format you prefer free of charge. Contact OHP Provider Services at dmap.providerservices@oha.oregon.gov or 800-336-6016 (voice). We accept all relay calls.

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