OREGON HEALTH AUTHORITY

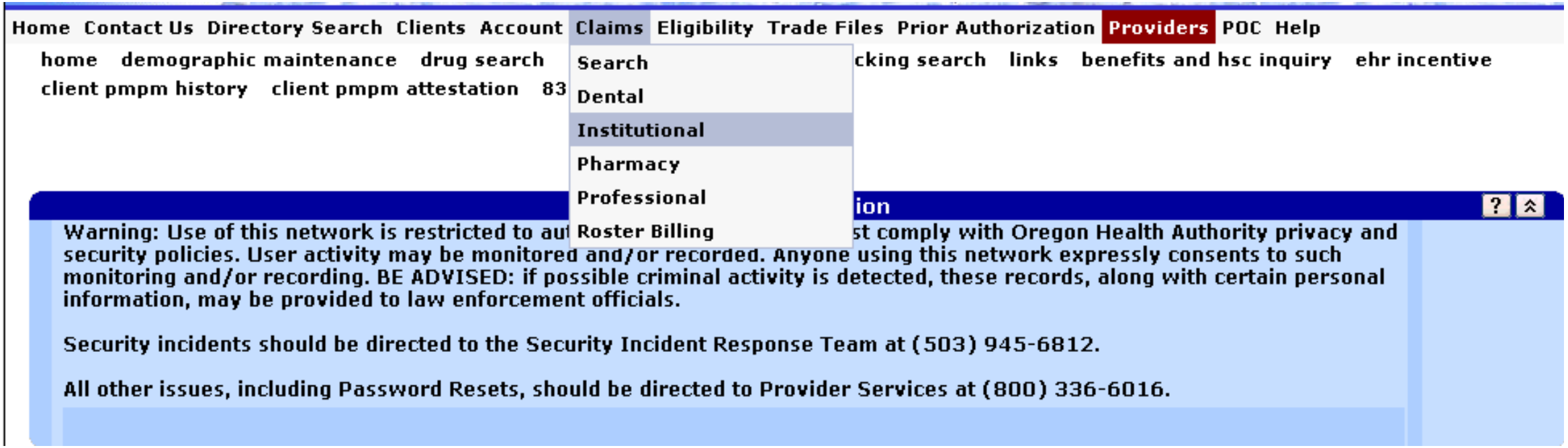
September 2024

MMIS Provider Portal Institutional Claim

Find program-specific instructions in supplemental guides for each program

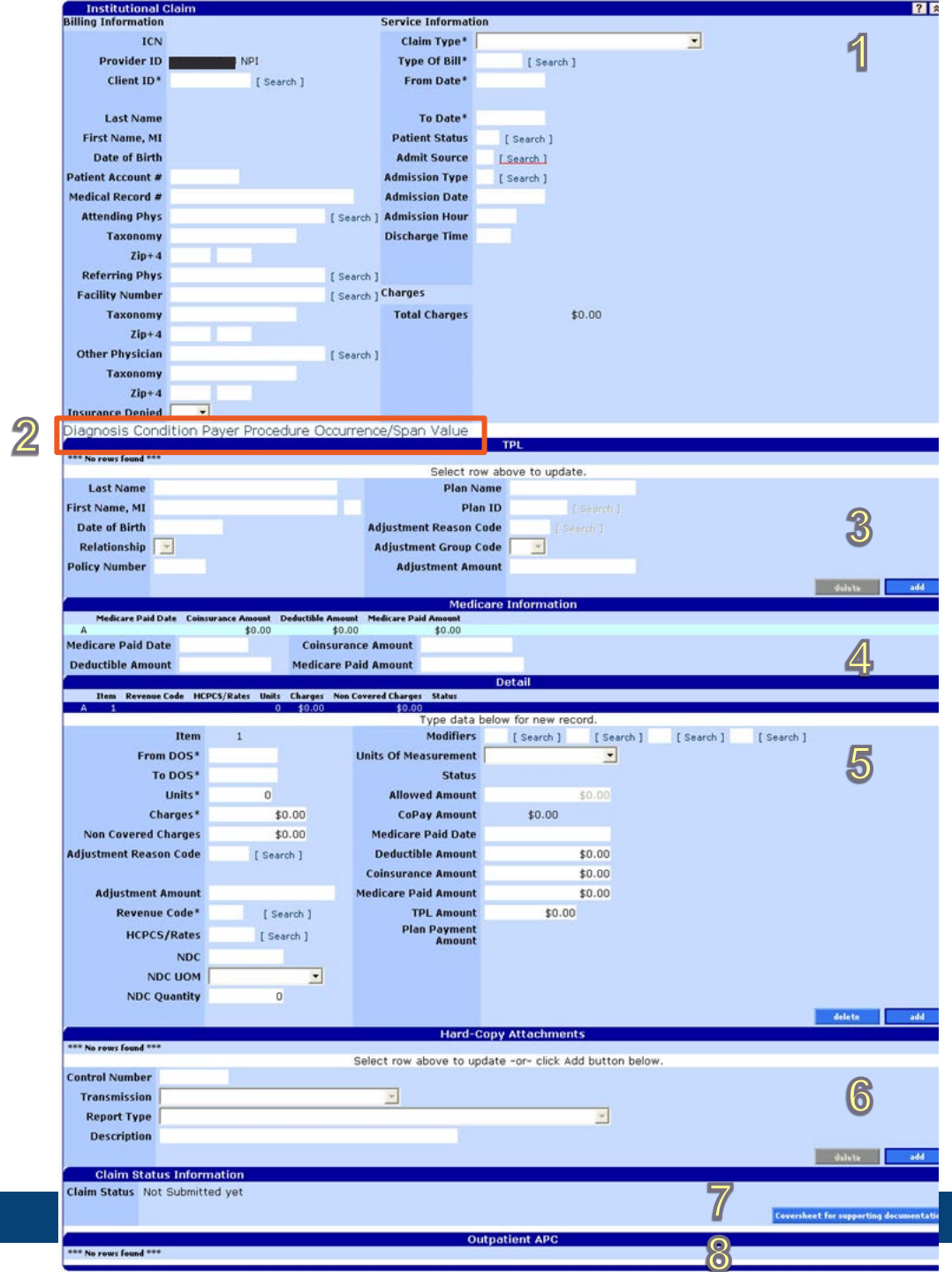
Go to https://www.or-medicaid.gov

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



Institutional claim sections

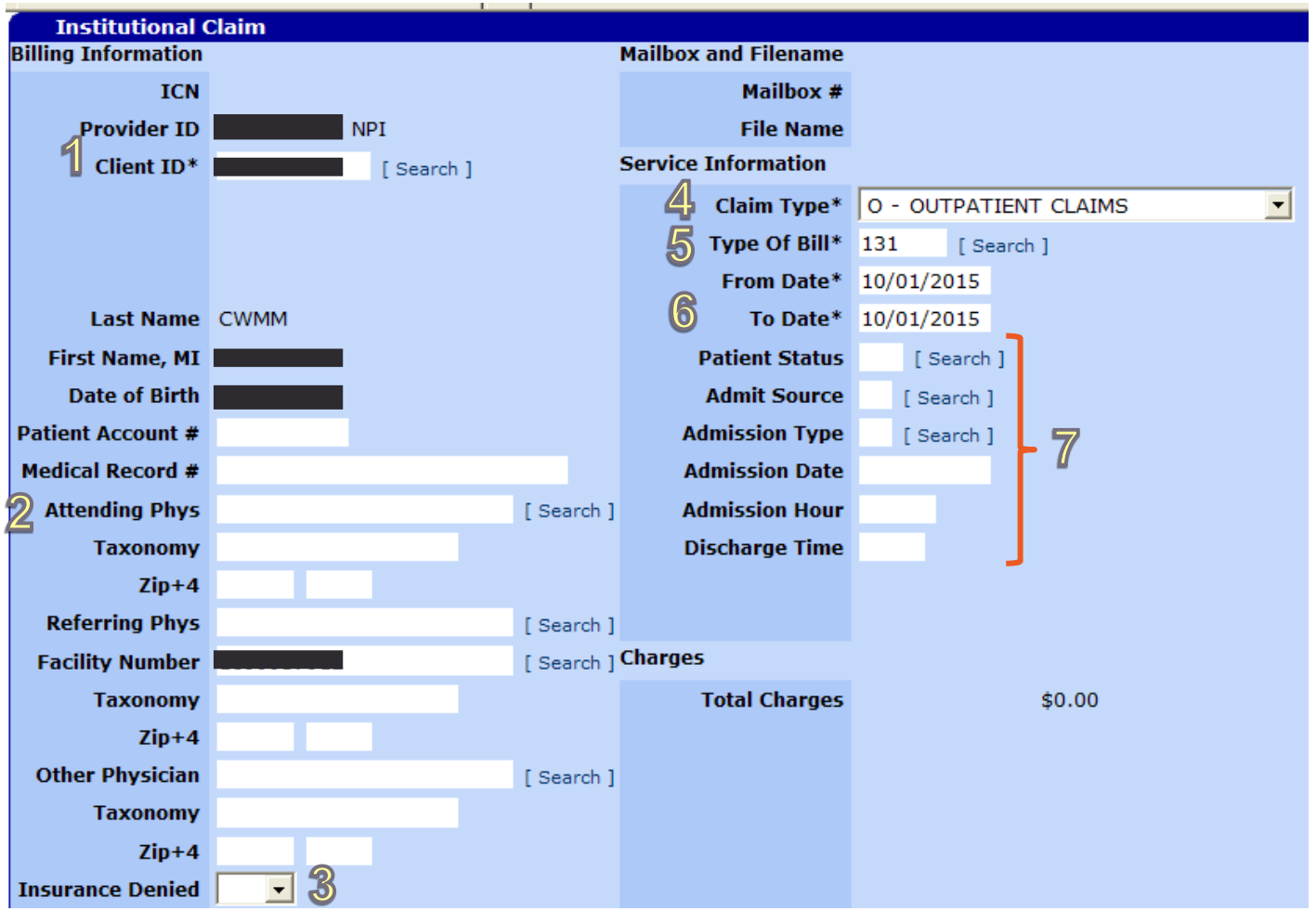
1. Institutional Claim (header)
2. Additional sections menu
3. TPL: Third-Party Liability
4. Medicare Information
5. Detail
6. Hard-Copy Attachments
7. Claim Status Information
8. Outpatient APC



Institutional Claim (header): 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)



Additional sections:

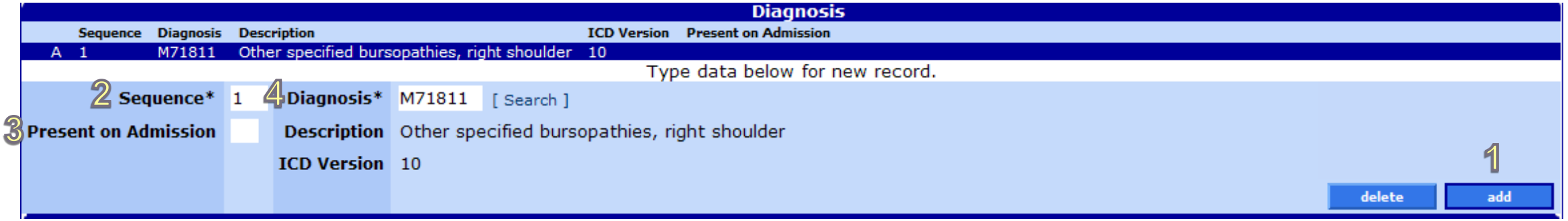
1. Diagnosis
2. Condition
3. Payer
4. Procedure
5. Occurrence/Span
6. Value

Click the section name to open the section

Diagnosis

For each diagnosis:

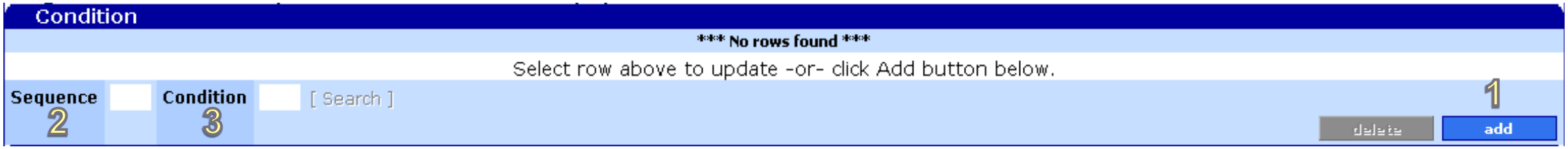
1. Click **add**
2. Enter the sequence (e.g., 1 for primary diagnosis)
3. Enter Present on Admission indicator (for inpatient claims):
   - Y: Diagnosis present on admission
   - N: Diagnosis not present on admission
   - U: Documentation insufficient to determine
   - W: Clinically undetermined
4. Enter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



Condition

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

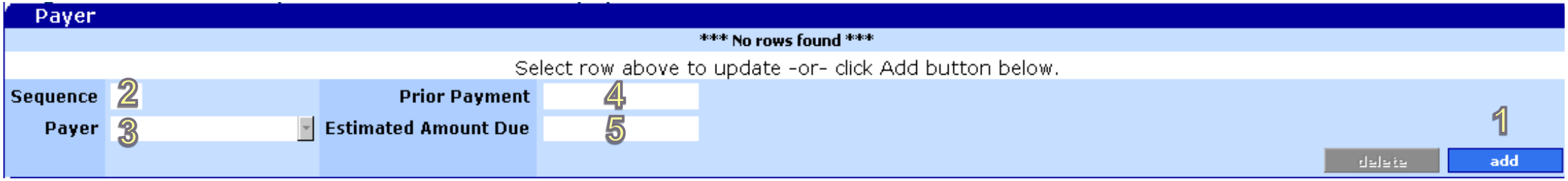
1. Click **add**
2. Enter sequence
3. Enter condition



Payer

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

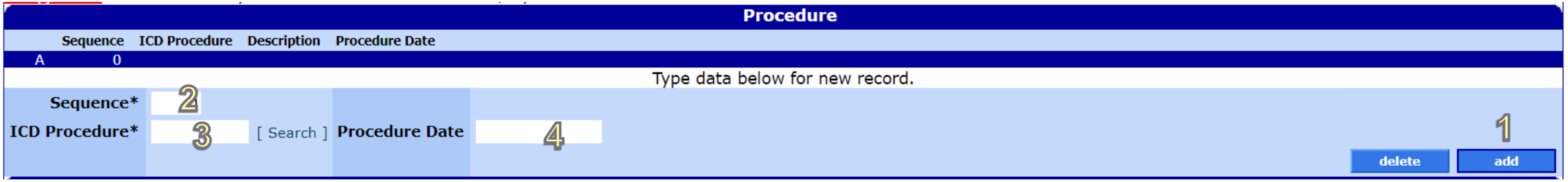
1. Click **add**
2. Enter sequence (e.g., 1 for primary payer)
3. Choose payer from drop-down menu
4. Enter prior payment received from payer
5. Enter estimated amount due after prior payment



Procedure

For hospital inpatient claims. For each procedure:

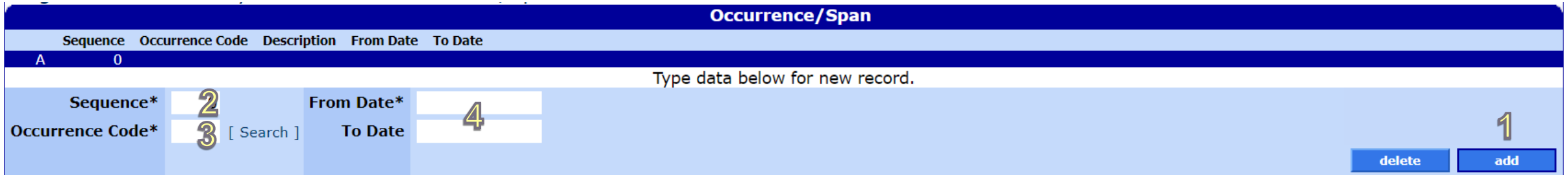
1. Click **add**
2. Enter sequence
3. Enter ICD-10 procedure code
4. Enter the procedure date



Occurrence/Span

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

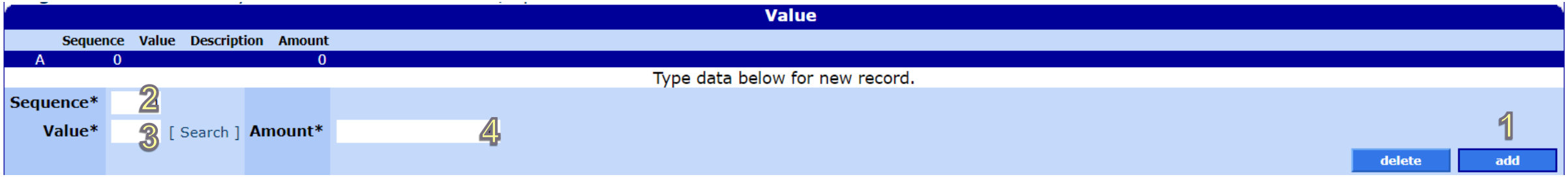
1. Click **add**
2. Enter sequence
3. Enter occurrence code
4. Enter From and To Dates of the occurrence



Value

For each value:

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

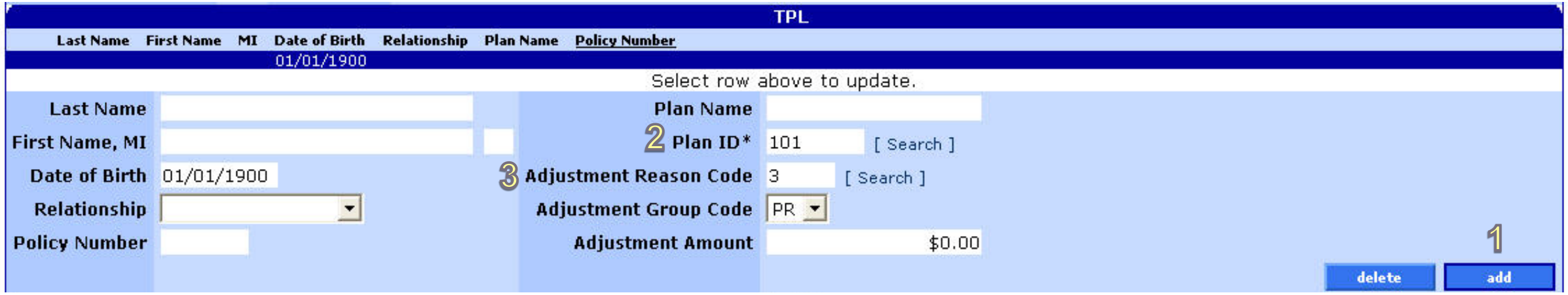


TPL

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

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

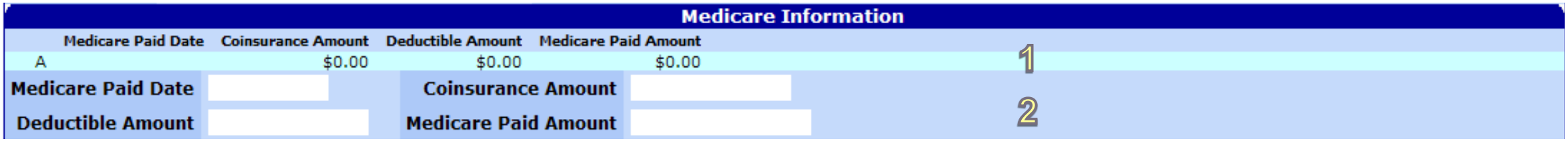
The Date of Birth and Adjustment Group Code fields are not required; they auto-populate upon claim submission



Medicare Information

If the client has Medicare coverage:

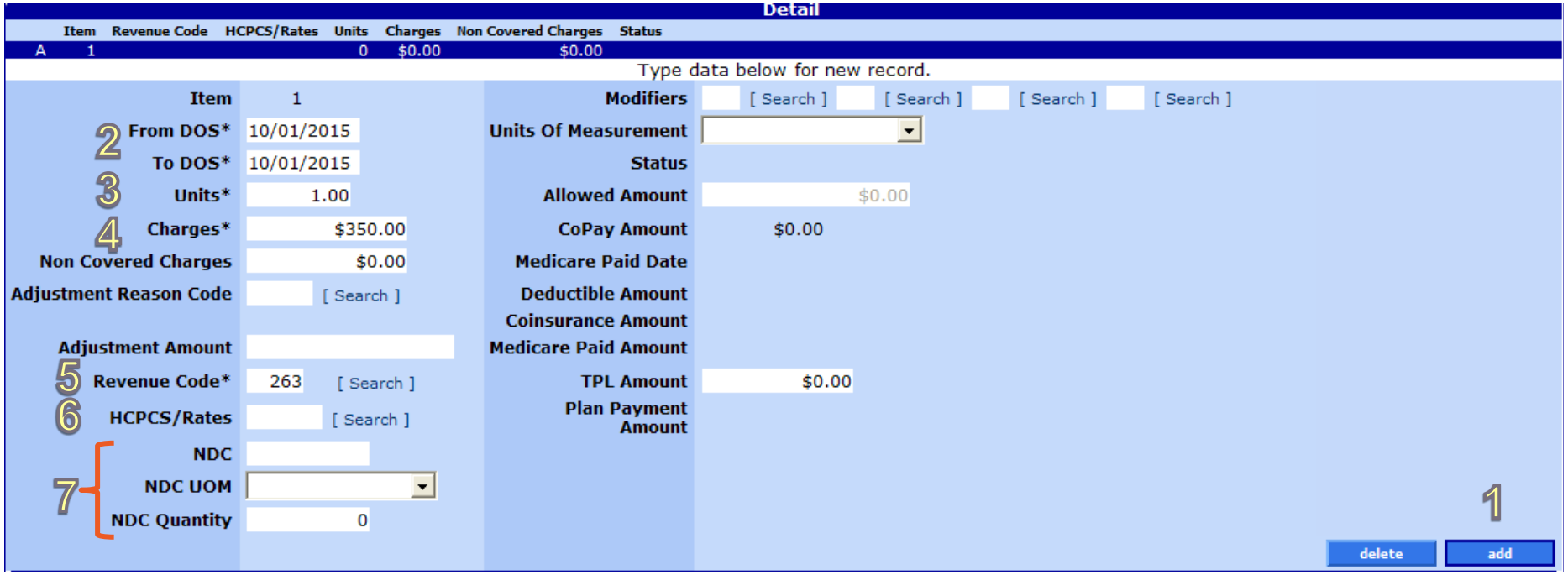
1. Click the row to activate fields
2. Fill in all fields



Detail

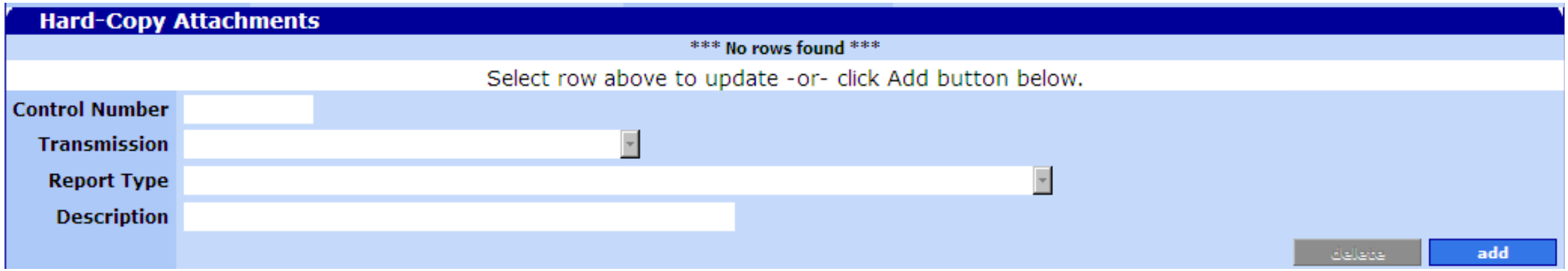
For each detail line:

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)



Hard-Copy Attachments

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



Claim Status Information

Before you submit the claim, you have two choices:

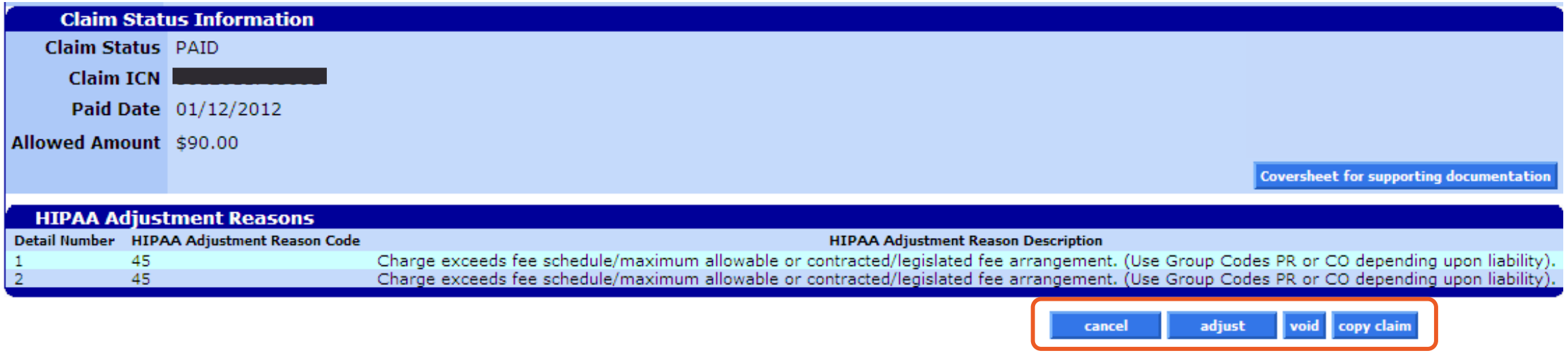
- Click **submit** to submit the claim for processing.
- Click **cancel** to clear information you have entered on the claim.

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

Claim Status: PAID

On paid claims, you can:

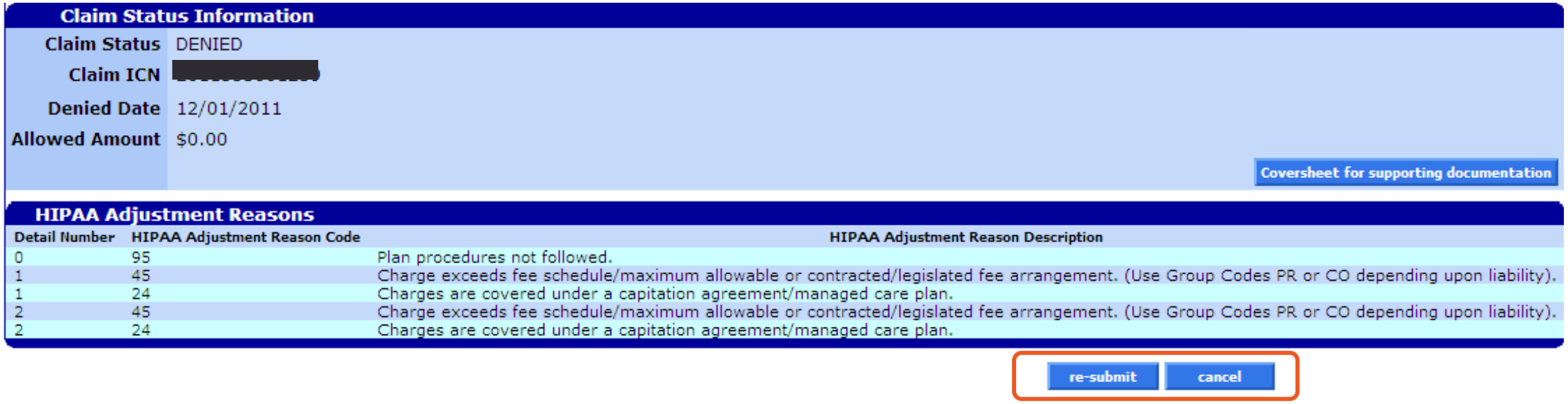
- Click **cancel** to clear changes made during this session
- Click **adjust** to adjust with changes made during this session
- Click **void** to cancel the claim. OHA will recover payments made on the claim.
- Click **copy claim.** This creates a new claim. It will have all the information entered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



Claim Status: 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: 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).
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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).
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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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