



THE ANSWER KEY

A COMPENDIUM OF SOLUTIONS TO PROBLEMS ENCOUNTERED BY PROVIDERS IN SUBMITTING MEDICAID CLAIMS

Note: All information was current at the time of publication but is subject to change.

Coordination of Benefits, Part 1: Claim-Level Information, Detail-Level Information, and Adjustments

Coordination of benefits (COB) is the process of determining (1) which health plan or insurance policy will pay first when a Medicaid-eligible individual is covered by multiple health care insurers and (2) what payment obligations each party has when more than one plan or policy covers the same services. When a Medicaid-eligible individual also has health care coverage through another insurer, Medicaid rules require that providers must attempt to collect payment from that insurer before submitting a claim to Medicaid. There are two types of COB claims:

1. **Third-party liability (TPL) claims** involve a third-party payer other than Medicare, such as a private insurance company, TRICARE, or workers' compensation.
2. **Medicare crossover claims** are claims that have been adjudicated and paid by Medicare and have then been submitted to the Ohio Department of Job and Family Services (ODJFS) for payment of Medicare cost-sharing amounts such as deductibles and coinsurance. The term 'Medicare' includes Medicare Part C Advantage Plans, as well as traditional Medicare coverage. **Claims denied by Medicare are not Medicare crossover claims.** A claim submitted to Medicare that is automatically routed to ODJFS is an **automatic crossover claim**. A claim submitted directly to ODJFS by a provider is a **provider-submitted crossover claim**.

Note: A Medicare claim for an individual enrolled in a Medicare Advantage Plan will never automatically cross over; the provider must submit a claim to ODJFS for payment of Medicare cost-sharing amounts.

Medicaid payment amounts under MITS may be different from amounts that were paid before implementation of the new system. This difference is a result of enhanced and expanded COB claims-processing in MITS, as well as the enforcement of existing requirements that prior-payment information be provided at the appropriate level of detail. MITS has the ability to coordinate benefits at the line/detail level or at the header/claim level as applicable (for example, according to the particular claim type) to ensure that Medicaid is paying the appropriate amount.

Header/Claim Level vs. Line/Detail Level

On a COB claim, dollar figures are reported for the following data elements (as applicable): allowed/approved amount, payment amount, deductible amount, co-payment amount, and coinsurance amount.

A COB claim is considered to be adjudicated "at the header or claim level" if only one set of these figures is reported for the entire claim. It is considered to be adjudicated "at the line or detail level" if, in addition to the header-level COB information, figures are reported for individual line items. How a particular COB claim was adjudicated by the primary payer is shown on the explanation of benefits (EOB), remittance advice (RA), or 835 transaction report issued by the primary payer.

In general, if a claim is adjudicated by another payer at the line/detail level, then the provider must include line-/detail-level information on the COB claim it submits to ODJFS. There is one exception to this requirement: A provider may submit an institutional COB claim through the MITS Web Portal with only header-/claim-level information, even if the claim was adjudicated by the primary payer at the line/detail level. The Web Portal is not currently set up to accept line-/detail-level COB information on institutional claims.

Medicare Part C and Private Insurance HMOs

Some Medicaid-eligible individuals participate in a health maintenance organization (HMO) through Medicare or another third-party insurer. Most providers in an HMO network submit claims to the HMO and are paid by the HMO on a fee-for-service basis. Some network providers, however, are paid under a "per member per month" capitation arrangement and do not have claims adjudicated by the HMO. For Medicaid COB claims, these providers therefore do not have such required information as the date of payment, the allowed/approved amount, and the payment amount. In this situation, ODJFS allows the following entries:

Date of payment = Date of service
Allowed/approved amount = Billed charge
Payment amount = \$0

On such claims, providers must also report at least one CAS Group Code, Adjustment Reason Code (ARC), and ARC-associated amount.

Claim Adjustments

Claim adjustments are no longer accepted in paper format. All adjustments to COB claims must be submitted through the MITS Web Portal or by EDI transaction. A refund owed to ODJFS for overpayment must be handled as a voided claim or an adjustment; payment of refunds by check is no longer accepted. Form JFS 06768, "Claims Credit Reversal," is no longer used.

In rare instances, if a provider has been consistently unable to submit an adjustment through the Web Portal or by EDI, ODJFS may decide to accept it on paper, either form JFS 06766 (hospitals) or JFS 06767 (other providers).

For more information, see the MITS Information Supplemental Release on Coordination of Benefits:

http://www.jfs.ohio.gov/mits/Supplemental_Policy_Release-Coordination_of_Benefits.pdf