Ohio | Medicaid Information Technology System

#12
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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 2: Bypassing the TPP

Rule 5101:3-1-08 of the Ohio Administrative Code (OAC) sets forth the general requirement that providers must submit coordination of benefits (COB) claims to Medicare or to a third-party payer (TPP) before submitting them to Medicaid. If the file for a Medicaid-eligible individual shows that the person has coverage through Medicare or a TPP, then COB information must be reported on the claim submitted to Medicaid; otherwise, the claim will be denied (in MITS jargon, the claim will "post a TPL edit").

However, in paragraphs (D)(1)(d) and (D)(2), rule 5101:3-1-08 lists exceptions under which a provider may submit a COB claim directly to Medicaid without submitting it to a TPP. A provider may know in advance that a TPP will not pay a claim because, for example, the service was not a covered benefit under the TPP plan, the service was rendered before or after the dates of coverage, the billed charge was applied to the individual's cost-sharing amount, or the individual has reached a benefit maximum.

(The full text of this rule may be found on the Lawriter website, **http://codes.ohio.gov**. It is also available on the Ohio Department of Job and Family Services (ODJFS) eManuals website, **http://emanuals.odjfs.state.oh.us/emanuals**; within the 'Ohio Health Plans – Provider' collection, select the 'General Information for Medicaid Providers' manual.)

If all line items (details) on the claim satisfy at least one of these exceptions, then the claim may be submitted to ODJFS with only claim-/header-level information and without line-/detail-level COB information. Here are the basic steps to follow in submitting such a claim through the MITS Web Portal:

1. Complete the 'Other Payer' panel in the usual way, but enter the date of service (DOS) as the date of payment.
2. At the bottom of the 'Other Payer' panel, select the 'Other Payer Amounts and Adjustment Reason Codes' link.

3. In the 'Other Payer Amounts and Adjustment Reason Codes' panel, activate the CAS Code Group field drop-down list and select 'PR-Patient Responsibility'.

   Note: The provider must supply the CAS Code Group because the claim has not been adjudicated by a TPP. If a claim is submitted to a TPP, the TPP will specify a CAS Group Code for each unpaid portion of the claim. Medicaid has no cost-sharing responsibility for 'CO-Contractual Obligations' amounts nor for 'PR-Patient Responsibility' amounts of $0.00.
4. In the 'Amount' field (the first field to the right of the 'Amount / ARC' label), enter the total billed charge for the claim.
5. In the 'ARC' field, enter the ARC that most closely corresponds to the reason why the TPP would not pay the claim. For example, ARC 96, 'Non-covered charge(s)', could be reported if the particular service is not covered by the individual's TPP insurance plan. A complete list of Adjustment Reason Codes is available on the website of the Washington Publishing Company, **http://www.wpc-edi.com**; on the main page, select the 'On-Line Code List Lookup' link.

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