



COB and TPL Claim Submission Webinar Training FAQs

Webinar Training Date: Morning of August 29, 2011

Release Date: September 12, 2011

**Please Note: Responses are current as of 9/12/2011, and are subject to updates.*

Question Number	Attendee Questions/Comments	Answer
1	Question 1 On the detail line, does the rendering provider have to be completed?	Answer 1 No. If the rendering provider National Provider Identifier (NPI) was entered on the claim/header panel, a rendering provider NPI does not need to be submitted at the detail level. Whether or not a rendering provider NPI is required on the claim in addition to the billing provider NPI (at either the claim level or the detail level) is dependent on the provider type assigned to the billing provider and the services being billed on the claim. A rendering provider NPI does not need to be submitted anywhere on a professional claim if the billing provider is an “entity” provider and is a valid rendering provider type for the procedure codes submitted on the claim. <i>Note: If the billing provider is a professional group provider (type 21) or a dental group provider (type 31), a rendering provider NPI must be entered on the claim either at the claim/header level or on each detail/line.</i>

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2	<p>Question 2</p> <p>Where is the option for Medicare Part C?</p>	<p>Answer 2</p> <p>On the 'Other Payer' panel, select 'HMO Medicare Risk' from the drop-down list for the 'Claim filing indicator' field.</p>
3	<p>Question 3</p> <p>Is the Payer Identification (ID) code the same as the Capario code? Or the CPID?</p>	<p>Answer 3</p> <p>The Payer ID code is whatever code a payer uses to identify itself uniquely on payment-related documents. It may or may not be the same code used by Capario (a private healthcare IT company). You can locate the Payer ID code in several ways:</p> <ul style="list-style-type: none"> ● Look at the individual's Medicare or insurance card (not the Medicaid card). ● Check the Explanation of Benefits (EOB) issued by the payer. ● Examine the Electronic Remittance Advice (ERA) issued by the payer. ● Contact the other payer, either by phone or through the payer's provider services website.

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4	<p>Question 4</p> <p>What happens if a commercial plan does not have a carrier code because it does not send ERAs or accept electronic claims?</p>	<p>Answer 4</p> <p>The Ohio Department of Job and Family Services (ODJFS) is not aware of any commercial health care plan that does not accept electronic claims. Every payer must be able to accept HIPAA-compliant electronic transactions.</p>
5	<p>Question 5</p> <p>If an item is not actually billed to Medicare, what is the paid date?</p>	<p>Answer 5</p> <p>Only services that have been submitted to and adjudicated by Medicare may be submitted to ODJFS as Medicare crossover claims. The paid date field applies to both paid and denied items; on a paid crossover claim it simply denotes the date on which Medicare paid the claim.</p> <p><i>Note: Claims that have been denied by Medicare are not Medicare crossover claims. There is a different billing process for the submission of denied Medicare claims.</i></p> <p>Claims that have been denied by a commercial third-party payer (TPP), as well as claims that have not been submitted to and adjudicated by a commercial TPP because an exception specified in Rule 5101:3-1-08 of the Ohio Administrative Code applies, do require Adjustment Reason Codes (ARCs) to explain why the commercial TPP did not pay the claim. The system will use this information to determine whether the claim should be paid or denied.</p>

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6	<p>Question 6</p> <p>How is a Medicare psychiatric reduction to be submitted through MITS as a crossover claim?</p>	<p>Answer 6</p> <p>ARC 122 should be used to report Medicare psychiatric reduction amounts.</p>
7	<p>Question 7</p> <p>We are a Rural Health Clinic (RHC). How do we do wraparound billing when we only have 1 code?</p>	<p>Answer 7</p> <p>Slides pertaining to RHC/Federally Qualified Health Center (FQHC) wraparound payments were not included in the COB presentation. ODJFS will make sure to include slides specifically for the submission of wraparound payment claims.</p> <p>RHC and FQHC providers must submit all the services codes billed to the Medicaid Managed Care plan on all wrap around claims. In addition, providers must bill T1015 with the appropriate modifier on the first detail on the claim. See the end of this Q&A document for instructions on submitting simple RHC/FQHC wraparound claims (i.e., claims with only one T1015+U-modifier combination and for which a Medicaid MCP was the only other payer). ODJFS is developing instructions for wraparound claims that have more than one T1015+U-modifier combination on the claim or claims that involve one (or more) commercial payer(s) in addition to the Medicaid MCP.</p>

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8	<p>Question 8</p> <p>Where do you find Adjustment Reason Codes?</p>	<p>Answer 8</p> <p>A complete list of Adjustment Reason Codes is available on the website of the Washington Publishing Company, http://www.wpc-edi.com. Select the 'On-Line Code List Lookup' link.</p>
9	<p>Question 9</p> <p>So even if a claim is paid at zero by Medicare, we must enter an amount in the ARC area?</p>	<p>Answer 9</p> <p>If a claim is completely denied by Medicare, the claim must be submitted as a problem claim and not submitted as a Crossover claim. This is the same process as before.</p> <p>The example used in the presentation was a paid claim that had one line denied by Medicare. For a paid claim, you must report all the procedures originally billed on the claim adjudicated by Medicare. For the claim to balance correctly, ARCs must be submitted for each detail for which Medicare did not pay 100% of the billed charge.</p>

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10	<p>Question 10</p> <p>How should an FQHC or RHC submit a claim for supplemental payment (wraparound claim) through the MITS Web Portal?</p>	<p>Answer 10</p> <p>Follow these steps:</p> <ol style="list-style-type: none"> 1. Complete the main claim (header) panel just as you would for any other claim. 2. Complete the 'Detail' panel. <ol style="list-style-type: none"> a. For the first line item (detail), report procedure code T1015 with the appropriate U-modifier. In the 'Charges' field, enter the Prospective Payment System (PPS) rate amount established for the service at the particular facility. b. Report each procedure code submitted to the Medicaid MCP as an additional line item (detail); leave the default value of \$0.00 in the 'Charges' field. <p>Complete the 'Other Payer' panel and 'Other Payer Adjustment Reason Codes' panel as explained in <i>The Answer Key #2</i>, an information sheet on wraparound claims: http://jfs.ohio.gov/OHP/providers/pdf/Answer_Key_02.pdf</p>