



Medicaid Information  
Technology System

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## **COB and TPL Claim Submission Webinar Training FAQs**

*Webinar Training Date: Afternoon of August 29, 2011*

**Release Date: September 12, 2011**

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

Question Number	Attendee Questions/Comments	Answer
1	<p>Question 1</p> <p>For Part C crossover claims — which usually do not have line-item coinsurance and deductible amounts — could we indicate the coinsurance and deductible at the header level?</p>	<p>Answer 1</p> <p>No, all professional crossover claims must be submitted with adjustment amounts and adjustment reason codes (ARCs) at the detail level. The system is not designed to receive Coordination of Benefits (COB) information on professional crossover claims only at the header level.</p>
2	<p>Question 2</p> <p>Where do you get the carrier codes from?</p>	<p>Answer 2</p> <p>The information that must be entered in the 'Carrier Code' field is simply the Payer Identification (ID) code of the Medicare plan or insurance company. It is not the carrier code on the Medicaid card, the individual's Medicaid number, or any other number. Each payer defines its own Payer ID code. The Ohio Department of Job and Family Services (ODJFS) does not maintain a list of Payer ID codes, so the best source for this information is the payer itself. You can locate the Payer ID code in several ways:</p> <ul style="list-style-type: none"> <li>● Look at the individual's Medicare or insurance card (not the Medicaid card).</li> <li>● Check the Explanation of Benefits (EOB) issued by the other payer.</li> <li>● Examine the Electronic Remittance Advice (ERA) issued by the other payer.</li> <li>● Contact the other payer, either by phone or through the payer's provider services website.</li> </ul>

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3	<p>Question 3</p> <p>Why do we need to bill room and board to the other insurance listed on the eligibility screen when we know that the insurance does not cover room and board and that the individual is a hospice patient? The hospice needs to bill the room and board to Medicaid and pay the facility.</p>	<p>Answer 3</p> <p>Many insurance plans include some institutional or medical coverage for at least some (usually short-term, skilled) inpatient stays in a Long Term Care Facility (LTCF). In addition, MITS is designed to apply third-party liability (TPL) edits on claims for LTCF services. But the system does not post TPL edits when the recipient has an insurance policy that covers only specialized services. For example, dental insurance plans will not cause a TPL edit to post for a medical visit.</p> <p>Rule 5101:3-1-08 of the Ohio Administrative Code (OAC), on a situation-by-situation basis, allows a provider to send a COB claim to ODJFS without its having been adjudicated first by the other payer of record. On such a claim, the provider rather than the insurance carrier/other payer must supply the CAS Code Group and Adjustment Reason Code (ARC). Providers must make sure they keep records to show that they complied with the provisions of this rule. For more information, see <i>The Answer Key #12</i>, an information sheet for providers on how to submit to Medicaid COB claims that are always denied by third-party payers (TPPs):  <a href="http://jfs.ohio.gov/OHP/providers/pdf/Answer_Key_12.pdf">http://jfs.ohio.gov/OHP/providers/pdf/Answer_Key_12.pdf</a></p> <p>ODJFS will continue to monitor how the new system processes COB claims, it will take into account suggestions submitted by providers and it will make improvements on the design of the COB cost-avoidance editing, when appropriate. Comments regarding hospice room and board services and home care services are already being reviewed.</p>

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4	<p>Question 4</p> <p>How about if the commercial insurance does not cover the service and the agency needs to bill Medicaid? How do we show that no payment was made on the claim?</p>	<p>Answer 4</p> <p>The TPL example in the presentation shows how to submit a COB claim when at least one of the line items has been denied by the commercial payer on a paid claim.</p> <p>For a denied claim, the provider must send COB information at the detail level if the payer (1) paid zero for the denied line items, (2) provided the reason for the denials by detail, (3) reported the payments for the paid line items at the detail level and (4) provided the adjustment reasons (i.e., why 100% of the billed charges were not paid) at the detail level.</p> <p>If the claim was denied at the header level, the provider must send COB information at the header level, including the ARC provided by the payer. The provider may also follow the process explained in Answer 3, if the process is applicable.</p> <p>The provider must submit payer-supplied Adjustment Reason Codes (ARCs) to ODJFS. If the payer did not furnish an ARC, then the provider must report the most appropriate ARC that corresponds to the denial message (e.g., explanation on the EOB) issued by the payer.</p>

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5	<p>Question 5</p> <p>If we submitted a claim but the claim was denied, how do we go back to re-submit the claim to get it paid?</p>	<p>Answer 5</p> <p>There are two ways you can re-submit the claim: (1) Re-enter the entire claim with the corrections. (2) Correct the denied claim.</p> <p>To correct a denied claim, go into the MITS Web Portal, select the 'Claims' menu, then select the 'Search' option. When the search panel opens, enter the ICN of the denied claim that you want to submit. Change the fields that need to be corrected or enter information in fields that were not completed in the original submission. Click 're-submit.'</p> <p>Please note that before each panel can accept the information you enter in the fields, you need to highlight the information row first. For panels that are accessed from a hyperlink within another panel, you also need to highlight the information row at the top of the panel.</p>
6	<p>Question 6</p> <p>Can we have a copy of the PowerPoint presentation?</p>	<p>Answer 6</p> <p>Yes. The presentation will be posted to the main MITS webpage, <a href="http://http://jfs.ohio.gov/mits/">http://http://jfs.ohio.gov/mits/</a>. Or you can download it by <a href="#">clicking here</a>.</p>

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7	<p>Question 7</p> <p>Where does the amount for coinsurance go (e.g., the amount we want Medicaid to pay)?</p>	<p>Answer 7</p> <p>For all Medicare crossover claims and for most professional claims with TPL, the coinsurance is submitted as an amount with ARC 02 and a CAS Code Group value of PR in the ‘Other Payer Amounts and Adjustment Reason Codes - Detail’ panel. This panel is accessed through the hyperlink on the ‘Other Payer Detail’ panel.</p> <p>If the coinsurance amount and the payment made by Medicare or another payer (TPL) does not equal the billed charge (and usually it does not), the provider will need to submit at least one additional ARC (e.g., 45) to explain the unpaid balance.</p> <p>For some professional claims with TPL, the coinsurance amount is entered at the claim/header level in the ‘Other Payer Amounts and Adjustment Reason Codes’ panel. The process is similar to entering information at the detail level.</p>
8	<p>Question 8</p> <p>This training was only for submitting COB claims through the Web Portal. For claims submitted through EDI, is the information the same?</p>	<p>Answer 8</p> <p>The information is exactly the same. It must be entered in the appropriate segments.</p>

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9	<p>Question 9</p> <p>We never had to worry about billing Medicaid nursing home room and board to a commercial insurance before for a hospice patient. It is the responsibility of hospice to pay this and get reimbursed by Medicaid. There needs to be some type of exception for these claims. It will take many months to wait to get a denial back from the commercial insurance, and then we run the risk of being past the timely filing limits; plus, we have already paid the facility for these days. They will not wait for us to get paid.</p>	<p>Answer 9</p> <p>See the answer to Question 3.</p>

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10	<p>Question 10</p> <p>How do we submit home health professional claims, which have no individual line items, at the detail level?</p>	<p>Answer 10</p> <p>ODJFS recognizes that Medicare and other payers may require home health services to be submitted on institutional claims rather than professional claims with revenue center codes rather than the G-codes ODJFS requires. If the other payer (commercial) adjudicated and paid the claim at the claim/header level, all the COB information is entered in the claim-/header-level 'Other Payer' panel and 'Other Payer Amounts and Adjustment Reason Codes' panel.</p> <p>ODJFS should not be receiving any professional or institutional Medicare crossover claims for home health or hospice services, because there is no Medicare cost-sharing on these claims.</p> <p>For more information, see the MITS Supplemental Information Release on Coordination of Benefits:  <a href="http://jfs.ohio.gov/mits/Supplemental_Policy_Release-Coordination_of_Benefits.pdf">http://jfs.ohio.gov/mits/Supplemental_Policy_Release-Coordination_of_Benefits.pdf</a></p> <p>Many other MITS-related resources — such as provider information releases, provider training material, publications, implementation notices and other communications — that more fully address topics of interest are available at the MITS website:  <a href="http://jfs.ohio.gov/mits/">http://jfs.ohio.gov/mits/</a></p>