COB and TPL Claim Submission Webinar Training FAQs

Webinar Training Date: Afternoon of August 30, 2011

Release Date: September 16, 2011

*Please note: Responses are current as of 9/16/2011, and are subject to updates.
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<td>1</td>
<td><strong>Question 1</strong>&lt;br&gt;Do I need to void claims that were denied? And if so, how do I do it? Also, how do I fix the problem of a claim that was paid on the basis of incorrect third-party liability (TPL) information?</td>
<td><strong>Answer 1</strong>&lt;br&gt;Denied claims cannot be adjusted or voided. The provider can always resubmit the claim through the MITS Web Portal by (1) creating a new claim or (2) retrieving the denied claim by its ICN (which can be found with the 'Search' function), correcting the claim, and clicking the 're-submit' button.&lt;br&gt;&lt;br&gt;If a paid claim has incorrect TPL information, either (1) void the claim and resubmit a new claim with the correct information, or (2) adjust the claim by making the appropriate corrections. The second option is not available if the original claim was adjudicated before the MITS Go-Live date (08/02/2011).</td>
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|                 | Do we submit tertiary claims in the same way as claims with COB? | When there are two or more payers (in addition to Medicaid), the process is basically the same as for one payer. All the required COB information must be reported for each payer.  
1. Complete all COB panels for the primary payer.  
2. Return to the 'Other Payer' panel and click 'add'. A new 'Other Payer' row will be created and blank fields will be displayed. (Note: Information entered in the 'Other Payer' panel pertains to the entire claim.)  
3. Complete the fields for the second payer. Select 'Secondary' as the payer sequence.  
4a. If the second payer adjudicated the claim only at the claim/header level, go to the bottom of the 'Other Payer' panel and click the link for the 'Other Payer Amounts and Adjustment Codes' panel. Then enter COB information (CAS Code Group, Amount, and ARC) in the 'Other Payer Amounts and Adjustment Codes' panel.  
OR  
4b. If the second payer adjudicated the claim at the detail/line level, go to the 'Detail' panel immediately below and select the row representing a detail (line item) adjudicated by the second payer. (Remember: The same payer may adjudicate more than one line item, and more than one payer may adjudicate the same line item.) |
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<td>4b1.</td>
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<td>At the bottom of the panel, click the link for the 'Other Payer - Detail' panel.</td>
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<td>4b2.</td>
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<td>In the 'Other Payer - Detail' panel, click the drop-down list for the 'Carrier Code' field and select the payer ID for the second payer (which was entered in the 'Other Payer' panel in step 3). Enter the payment date and the amount paid for the line item.</td>
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<td>4b3.</td>
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<td>Click the link for the 'Other Payer Amounts and Adjustment Reason Codes - Detail' panel.</td>
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<td>4b4.</td>
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<td>Enter COB information (CAS Code Group, Amount, and ARC) received from the second payer for the line item.</td>
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<td>4b5.</td>
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<td>Go to step 4b and repeat this process for each line item adjudicated by the second payer.</td>
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<td>5.</td>
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<td>Go to step 2 and repeat this process for each additional payer.</td>
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ODJFS will be posting special instructions and examples for multiple-payer COB claims.
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<td>What should happen when a claim submitted through the MITS Web Portal is suspended? Is there follow-up needed by us or by Medicaid?</td>
<td>The suspension of a claim is not limited to MITS Web Portal submissions. A claim may be suspended for various reasons, most commonly because (1) the services on the claim require manual pricing, (2) the services require the review of attachments (e.g., required Hysterectomy, Sterilization, Abortion forms), or (3) information on the claim must be manually reviewed before the claim is denied or paid. No additional action is necessary unless you did not submit a required attachment. Claims waiting for attachments will stay in suspense for a period of time and then will be denied if the attachment does not come in. Attachments may be mailed or uploaded.</td>
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<td>The new system rejected a claim for lack of diagnosis and diagnosis pointer. We are not sure why. What is the DX pointer?</td>
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|                 |                             | At least one diagnosis code (reported at the header level) will be required on most professional claims. Codes entered on claims must include the number of digits specified by the *International Classification of Diseases, Ninth Edition* (ICD-9). System edits and audits (validity checks) will be applied to these codes. If diagnosis codes are used on a claim, then every line item (detail) listed on the 'Detail' panel must point to at least one diagnosis code listed on the 'Diagnosis' panel.  
- In the 'Diagnosis' panel, specify the sequence of the diagnoses in decreasing order of importance (1 = most important).  
- In the 'Detail' panel, associate each line item with the applicable diagnoses by selecting the sequence numbers from the 'Diagnosis Code Pointer' field drop-down lists. If you get an error message about diagnosis or diagnosis pointers after clicking the 'submit' button, just fix what is missing and resubmit the claim. |
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<td><strong>Question 5</strong>&lt;br&gt;I am a hospice provider submitting claims for room and board reimbursement. I would like to know the procedure for submitting a claim when the third-party payer (TPP) does not cover room and board.</td>
<td><strong>Answer 5</strong>&lt;br&gt;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 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 <em>The Answer Key #12</em>, 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>.&lt;br&gt;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.</td>
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<td>I get a denial something like &quot;need complete Medicare detail&quot;, but the whole 'Other Payer' section is filled out and I see no hyperlink. What am I missing?</td>
<td>See the slides from the Webinar COB presentation. The link to add the information at the detail level is located at the bottom of the 'Detail' panel. When the 'Other Payer Detail' panel opens, make sure that you highlight the detail (row) for which you are adding information. Make sure to not submit the same ARCs at the header and the detail levels. You can delete a row by highlighting it and clicking the 'delete' button.</td>
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We employ hospital-based physicians. We have a NPI for our hospital billing and a NPI for our professional side. How do you change the number for the professional billing?

The billing number for hospital-based physicians will be either the provider number of the hospital (provider type 01) or the provider number of a physician professional group (provider type 21) with the EIN of the hospital. Some hospitals have more than one professional group number for different specialty practices. Each hospital can choose the option that best fits its business. When the provider type for the billing number is 01(hospital) or 21 (professional group), the claim must have a rendering NPI that is assigned to the individual physician who performed the services. Each rendering provider must be listed as a member of the billing provider's professional group.

Contact the ODJFS Provider Enrollment unit to change the billing provider number or to associate additional rendering provider numbers with the billing provider number.
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<td>When a commercial insurance company denies a claim as the primary payer, which CAS Group Code and ARC would we use?</td>
<td>There is no single ARC for services that are denied or are non-covered by commercial insurance or Medicare. The provider must send the ARC and CAS Group Code that were furnished by the payer. If no ARC is specified, the provider must select the ARC that best represents the reason given by the payer for the denial or non-coverage. For more information, see <em>The Answer Key #12</em>, 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></td>
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<td><strong>Question 9</strong></td>
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<td>If Medicare pays only 3 out of 4 lines on a claim, do you have to send all 4 lines to Medicaid? Or just the ones that Medicare processed and paid?</td>
<td>Providers should submit all the details adjudicated on a paid Medicare claim regardless of whether the details were paid or denied. Denied claims and denied details from Medicare are handled through a different process. Any detail denied by Medicare will be denied by Medicaid on the crossover claim. After the crossover claim has been processed and paid by Medicaid, the provider may submit the denied lines to Medicaid as the primary payer. ODJFS is developing additional information on the process for denied Medicare services.</td>
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<td>If Medicaid denies a line item as a duplicate, how do you resubmit that line item if it is not in fact a duplicate?</td>
<td>For the primary duplicate edits, a second claim for the same procedure code with same primary modifier(s), billed for the same date of service by the same provider, will generally be denied as a duplicate. Additionally, ClaimCheck duplication edits impose limits on the number of times a procedure may be billed for a date of service or in combination with other procedure codes. Some audits also send out duplicate error messages. For most procedures, reporting multiple units for the detail (line item) prevents duplication errors. For surgeries subject to multiple surgery (MS) pricing, use the site modifiers; multiple units are not allowed for MS codes. For home care visits, use the U1, U2, and U3 modifiers appropriately. If a line item on claim B is denied as a duplicate of a paid line item on claim A but in fact is not a duplicate, then either (1) claim A must be voided and a new claim must be submitted or (2) claim A must be adjusted. ODJFS is still researching duplication problems that have been reported by providers to determine whether processing corrections are required.</td>
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<td><strong>Question 11</strong>&lt;br&gt;I am a hospice provider billing for hospice services. How do I submit a claim for Hospice when Medicare is listed as primary payer but the patient has only Medicare Part B (which does not cover hospice services)?</td>
<td><strong>Answer 11</strong>&lt;br&gt;ODJFS needs to make a change to the Medicare cost-avoidance edit so that it does not post for hospice procedure codes when an individual has Medicare Part B but not Part A. This change request will have a high priority, but ODJFS cannot give an exact date of correction. Until this problem is resolved, you may submit the claim as a problem claim with form JFS 06653 and a brief explanation of the problem, or you may wait on the correction.</td>
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<td><strong>Question 12</strong>&lt;br&gt;Modifier U3 is not being accepted in the portal. We cannot submit any Behavioral Health claims through MITS. We are an FQHC.</td>
<td><strong>Answer 12</strong>&lt;br&gt;The MITS Web Portal should not prevent Federally Qualified Health Center (FQHC) providers from using the modifier U3. Another error may have caused denial of the claim. If you received an error message indicating that the modifier is invalid, the provider is not eligible to provide the service, or the provider is not eligible for reimbursement, please check with the ODJFS Provider Enrollment Unit to determine whether there is a rate assigned to the FQHC for code T1015 with modifier U3. If not, Provider Enrollment staff members can work with appropriate ODJFS colleagues to determine the rate.</td>
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<td>Question 13</td>
<td>Answer 13</td>
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<td>When a commercial insurance company is the primary payer, what carrier code do you use?</td>
<td>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. ODJFS does not maintain a list of Payer ID codes, so the best source for this information is the payer itself.</td>
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<td>Question 14</td>
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<td>We are a FQHC. MITS is making us enter a $3.00 co-pay on wraparound dental claims. We never had to do that before. It's our understanding that the patient is not responsible for the $3.00 in this situation. How do we get around it in MITS?</td>
<td>The patient is not responsible for the $3.00 co-payment. The supplemental (&quot;wraparound&quot;) payment is the difference between the payment made by the Managed Care Plan (MCP) and what the payment would be to the FQHC under the Medicaid fee for service (FFS) program. MITS is designed to use the FFS payment logic, including the deduction of the co-payment, in determining the supplemental payment. Your question has initiated an investigation into whether the FFS co-payment deduction should be a factor in the supplemental payment amount. Watch for updates on this issue.</td>
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<td><strong>Question 15</strong>&lt;br&gt; We were receiving our payments as direct deposits. Why are we now getting checks, and how do we get back to direct deposit? Whom do we call or what do we do?</td>
<td><strong>Answer 15</strong>&lt;br&gt; ODJFS cannot explain why your direct deposit stopped. If direct deposit is still not working, please contact Ohio Shared Services:&lt;br&gt; <strong>Phone:</strong> 1 (877) OHIO-SS1 (1-877-644-6771) 1 (614) 338-4781&lt;br&gt; <strong>E-mail:</strong> <a href="mailto:vendor@ohio.gov">vendor@ohio.gov</a>&lt;br&gt; Or to access the form to request direct deposit payments, go to this ODJFS website for Medicaid providers: <a href="http://jfs.ohio.gov/OHP/provider.stm">http://jfs.ohio.gov/OHP/provider.stm</a></td>
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<td>16</td>
<td><strong>Question 16</strong>&lt;br&gt; We operate a FQHC. On claims involving National Drug Codes (NDCs), do we report the 340B Drug Pricing Program acquisition price or the usual and customary amount?</td>
<td><strong>Answer 16</strong>&lt;br&gt; The 340B acquisition price should be entered if the drug was purchased at that price; otherwise, the usual and customary price should be reported.</td>
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