



COB and TPL Claim Submission Webinar Training FAQs

Webinar Training Date: Morning of August 30, 2011

Release Date: September 16, 2011

**Please Note: Responses are current as of 9/16/2011, and are subject to updates.*

Question Number	Attendee Questions/Comments	Answer
1	<p>Question 1</p> <p>I need more assistance with the CAS and ARC codes. When a patient has Medicare and a commercial insurance, will you please post an example on the website?</p>	<p>Answer 1</p> <p>The examples provided in the Coordination of Benefits (COB) Training Webinar slides are available on the main MITS webpage at http://jfs.ohio.gov/mits/.</p> <p>The Ohio Department of Job and Family Services (ODJFS) plans to create additional examples to post after all the answers to the questions for all the COB Training Webinar sessions have been posted.</p>
2	<p>Question 2</p> <p>Where do you go to do a refund online?</p>	<p>Answer 2</p> <p>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.</p>

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3	<p>Question 3</p> <p>How do we file tertiary claims through the MITS Web Portal?</p>	<p>Answer 3</p> <p>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.</p> <ol style="list-style-type: none"> 1. Complete all the 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. <i>(Note: Information entered in the 'Other Payer' panel pertains to the entire claim.)</i> 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. <p>OR</p> <ol style="list-style-type: none"> 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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- 4b1. At the bottom of the panel, click the link for the 'Other Payer - Detail' panel.
- 4b2. 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.
- 4b3. Click the link for the 'Other Payer Amounts and Adjustment Reason Codes - Detail' panel.
- 4b4. Enter COB information (CAS Code Group, Amount, and ARC) received from the second payer for the line item.
- 4b5. Go to step 4b and repeat this process for each line item adjudicated by the second payer.
- 5. Go to step 2 and repeat this process for each additional payer.

ODJFS will be posting special instructions and examples for multiple-payer COB claims.

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4	<p>Question 4</p> <p>How do I find the carrier code?</p>	<p>Answer 4</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. 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"> • Look at the individual's Medicare or insurance card (not the Medicaid card). • Check the Explanation of Benefits (EOB) issued by the other payer. • Examine the Electronic Remittance Advice (ERA) issued by the other payer. • Contact the other payer, either by phone or through the payer's provider services website.

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Question 5

Why would you submit the charges to Medicaid if there is no balance to the patient (as in the CPT 99050 example given during the presentation)?

Answer 5

Providers should submit any paid third-party liability (TPL) claim to ODJFS as it was submitted to the prior payer, unless ODJFS has different billing rules governing claims for the service. For example, ODJFS may require different procedure code modifiers, a different claim form, or a CPT procedure code instead of a HCPCS level II procedure code. Lines denied by the third-party payer (TPP) will be considered for payment during the processing of the COB claim.

Denied claims and denied details from Medicare are handled through a different process. Providers should submit any paid Medicare claim, including denied lines, to ODJFS as it was submitted to Medicare. After ODJFS processes the crossover claim, the provider may submit denied lines to ODJFS. See Question 7.

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6	<p>Question 6</p> <p>Do we have to bill primary insurance first to get the Adjustment Reason Code (ARC), or do we just go to the website and find a code?</p>	<p>Answer 6</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 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): http://jfs.ohio.gov/OHP/providers/pdf/Answer_Key_12.pdf</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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7	<p>Question7</p> <p>How would you submit a charge that is not covered by Medicare but is covered by Medicaid?. For Medicare ARC code PR204, do you enter the amount paid as zero? We have tried this approach, but it does not work.</p>	<p>Answer 7</p> <p>In this case, the CAS Group Code is PR, the ARC is 204, and the amount associated with the ARC is the billed charge. The amount paid by Medicare is zero. Note that if the cost-sharing amount (deductible, copayment, or co-insurance) is zero, then Medicaid will deny the claim. Medicaid has no cost-sharing responsibility for 'CO-Contractual Obligations' amounts nor for 'PR-Patient Responsibility' amounts of \$0.00.</p> <p>Denied claims and denied details from Medicare are handled through a different process. If Medicaid covers the denied service but Medicare does not, then the denied service may be submitted as a regular (Medicaid primary) claim.</p>
8	<p>Question 8</p> <p>How will you know what the allowed amount is?</p>	<p>Answer 8</p> <p>ODJFS calculates the allowed amount from other information reported in the COB panels. When version 5010 of the X12 HIPAA Transaction and Code Set Standards is implemented, all payers will need to calculate the information themselves.</p>

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9	<p>Question 9</p> <p>In the 'Medicare Assignment' field in the main panel, why is the default 'Not assigned'? For Medicaid, shouldn't the default be 'Assigned'?</p>	<p>Answer 9</p> <p>Many of the default settings were pre-determined by the system design. You are correct that for ODJFS, 'Assigned' is currently the default for this field. ODJFS will determine whether some of the defaults can be changed to more commonly used values.</p>
10	<p>Question 10</p> <p>'Release of Information' and 'Signature Source' appear to be required fields. Why weren't they addressed?</p>	<p>Answer 10</p> <p>The COB trainings were intended to focus on the COB-specific fields on the main claim/header panel and the 'Detail' panel.</p> <p>'Release of Information' is a required field. 'Signature Source' is not required. Most providers have their patients complete and sign paperwork concerning the release of information and keep these documents on file.</p>
11	<p>Question 11</p> <p>I still need more specific information on TPL claims, specifically amounts paid by commercial insurance.</p>	<p>Answer 11</p> <p>ODJFS plans to develop additional tools to assist providers. Continue to check the MITS website for updates.</p>

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12	<p>Question 12</p> <p>When is an insurance EOB attachment required? It appears that the Medicare EOB attachment is not required, correct?</p>	<p>Answer 12</p> <p>EOB attachments are not required for TPL claims (either paid or denied) or for Medicare paid claims. In fact, adding attachments when they are not necessary delays the adjudication and payment of the claim.</p> <p>Denied claims and denied details from Medicare are handled through a different process. The process for seeking primary payment by Medicaid for services denied by Medicare requires the submission of attachments.</p>
13	<p>Question 13</p> <p>When an item is never covered by a third-party payer (TPP), how can a payment date and paid amount be entered?</p>	<p>Answer 13</p> <p>See the response to Question 6.</p>

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14	<p>Question 14</p> <p>Please explain how to successfully upload attachments through the MITS Web Portal.</p>	<p>Answer 14</p> <p>To submit an electronic attachment, follow these steps:</p> <ol style="list-style-type: none"> 1. On the 'Attachments' panel, make a selection from the 'Type of Document' drop-down list. 2. Select 'Upload' from the 'Transmission Type' drop-down list. 3. When the 'Browse' button appears, click it to select a document to upload from your computer. 4. Click the 'Upload Attachment' button. <p>An attachment must be in one of ten electronic formats: .bmp, .doc, .gif, .jpg, .mdi, .pdf, .ppt, .tiff, .txt, or .xls. Each attachment must be no greater than fifty megabytes (50MB) in size, and there is a maximum of ten attachments per claim submission. ODJFS is in the process of preparing an explanatory document with screen prints.</p>