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### **SUBMITTING “OTHER PAYER” INFORMATION ON PROFESSIONAL CLAIMS VIA THE MITS WEB PORTAL**

Considering Medicaid is the “payer of last resort”, providers must receive a payment or denial from other payers (i.e. Medicare or Commercial Insurance) prior to submitting claims to Ohio Medicaid and these claims must reflect the other payers’ payment and/or denial information. To assist providers when submitting claims that involve other payers, this document includes two examples and step-by-step instructions that will help providers denote other payer information on their claims.

**FIRST EXAMPLE:** This example reflects other payer information (e.g., adjustment reason codes, etc.) when it is entered at the claim/header level.

**SECOND EXAMPLE:** This example reflects other payer information (e.g., adjustment reason codes, etc.) when it is entered at the line/detail level.

#### **COMMON MISTAKES:**

- Providers mistakenly click the “add an item” button or press the enter key which creates a blank line. If this is done, providers must delete the blank line prior to submitting their claims.
- Providers don’t denote the other payers’ payer identifiers (IDs) in the electronic payer ID field. Providers can access the payer’s ID from the other payer’s electronic remittance advice or contact the other payer directly.
- For a single payer, providers mistakenly enter other payer information at the header and line level. Providers should enter other payer information at the header or line level (not both) for a single payer.
  - o Providers should refer to the other payer’s remittance advice to determine if other payer information should be entered at the header or line level.
  - o When the other payer adjudicates the claim at the line level they have broken down how each line was adjudicated. This is the most common way a professional claim is adjudicated.
  - o When the other payer adjudicates the claim at the header level they show how the entire claim was adjudicated, not “line by line”. Often times when a commercial insurance pays \$0.00, it is at the header level.
- When the other payer adjudicates the claim at the line level they have broken down how each line was adjudicated. This is the most common way a professional claim is adjudicated. When the other payer adjudicates the claim at the header level they show how the entire claim was adjudicated, not “line by line”. Often times when a commercial insurance pays \$0.00, it is at the header level.
- Providers don’t review their clients’ eligibility in MITS prior to submitting claims to determine if they are receiving services via a Medicare Managed Care plan (aka, Medicare Advantage Plan/HMO Medicare Risk) and assume that the Medicare Managed Care plan is a commercial payer. To avoid this mistake, providers should access their clients’ eligibility information via the MITS portal for the dates of service to be submitted on the claim.
- Providers mistakenly denote inaccurate adjustment reason code (ARC) amounts in the ARC amount fields. To avoid this problem, providers should access the ARC amounts from the other payers’ remittance advice and enter those ARC amounts in the appropriate fields.

## SUBMITTING “OTHER PAYER” INFORMATION AT THE HEADER LEVEL

Header - Other Payer \*\*\* No rows found \*\*\*

Select row above to update -or- click add an item button below.

delete add an item

Header - Other Payer Amounts and Adjustment Reason Codes

1. Click the “add an item” button in the Header - Other Payer panel.

Header - Other Payer

Last Name	First Name	MI	Date of Birth	Relationship	Gender	Policy ID	Paid Amount	Paid Date	Electronic Payer ID
A SMITH	JOHN	A	01/01/1950	FATHER	MALE		\$0.00	10/01/2017	01234

Select row above to update -or- click add an item button below.

delete add an item

\*Claim Filing Indicator: COMMERCIAL INSURANCE

\*Policy Holder Relationship to Insured: FATHER

\*Policy Holder Last Name: SMITH

\*Policy Holder First Name, MI: JOHN A

Policy Holder Date of Birth: 01/01/1950

Gender: MALE

\*Paid Amount: \$0.00

\*Paid Date: 10/01/2017

Allowed Amount: \$0.00

\*Insurance Carrier Name: BLUE CROSS BLUE SHIELD

\*Electronic Payer ID: 01234

Insured's Policy ID: 987654

\*Payer Sequence: PRIMARY

Medicare ICN:

Header - Other Payer Amounts and Adjustment Reason Codes

2. Complete the appropriate fields in the Header - Other Payer Panel.

3. Click the light blue line at the top of the Header - Other Payer Panel so the information populates in the line.

Header - Other Payer

Last Name	First Name	MI	Date of Birth	Relationship	Gender	Policy ID	Paid Amount	Paid Date	Electronic Payer ID
A SMITH	JOHN	A	01/01/1950	FATHER	MALE		\$0.00	10/01/2017	01234

Select row above to update -or- click add an item button below.

delete add an item

\*Claim Filing Indicator: COMMERCIAL INSURANCE

\*Policy Holder Relationship to Insured: FATHER

\*Policy Holder Last Name: SMITH

\*Policy Holder First Name, MI: JOHN A

Policy Holder Date of Birth: 01/01/1950

Gender: MALE

\*Paid Amount: \$0.00

\*Paid Date: 10/01/2017

Allowed Amount: \$0.00

\*Insurance Carrier Name: BLUE CROSS BLUE SHIELD

\*Electronic Payer ID: 01234

Insured's Policy ID: 987654

\*Payer Sequence: PRIMARY

Medicare ICN:

Header - Other Payer Amounts and Adjustment Reason Codes

4. Click the “Header-Other Payer Amounts and Adjustment Reason Codes” button.

## HEADER LEVEL – CONTINUED

Header - Other Payer Amounts and Adjustment Reason Codes

\*\*\* No rows found \*\*\*

Select row above to update -or- click add an item button below.

delete **add an item**

5. Click the “add an item” button.

Header - Other Payer Amounts and Adjustment Reason Codes

Electronic Payer ID	CAS Group Code	ARC	Amount
A 01234	PR-Patient Responsibility	1	\$150.00
A 01234	CO-Contractual Obligations	45	\$50.00

Select row above to update -or- click add an item button below.

delete **add an item**

\*Electronic Payer ID 01234  
\*CAS Group Code PR-Patient Responsibility  
\*ARC 1  
\*Amount \$150.00

Payer Header Level Adjustment Reason Codes (ARC) and Amounts

6. Enter the appropriate Electronic Payer ID, CAS (Claim Adjustment Segment) Group Code, ARC, and ARC Amount information.

7. Click the light blue line at the top of the Header - Other Payer Amounts and Adjustment Reason Codes panel so the information populates in the line.

8. Repeat steps 5, 6, and 7 until all of the Electronic Payer IDs, CAS Group Codes, ARCs, and ARC amounts have been completed.

In this example, there is one Electronic Payer ID and two sets of CAS Group Codes, ARCs, and ARC amounts.

9. To add information for an additional payer repeat steps 1 thru 8.

## SUBMITTING “OTHER PAYER” INFORMATION AT THE LINE LEVEL

Header - Other Payer

\*\*\* No rows found \*\*\*

Select row above to update -or- click add an item button below.

delete **add an item**

Header - Other Payer Amounts and Adjustment Reason Codes

1. Click the “add an item” button in the Header - Other Payer panel.

Header - Other Payer

Last Name	First Name	MI	Date of Birth	Relationship	Gender	Policy ID	Paid Amount	Paid Date	Electronic Payer ID
A	SMITH	JEFFREY	01/01/1980	SELF	MALE	987654	\$0.00	10/01/2017	43210

Select row above to update -or- click add an item button below.

delete **add an item**

\*Claim Filing Indicator HMO, MEDICARE RISK

\*Policy Holder Relationship to Insured SELF

\*Policy Holder Last Name SMITH

\*Policy Holder First Name, MI JEFFREY

Policy Holder Date of Birth 01/01/1980

Gender MALE

\*Paid Amount \$0.00

\*Paid Date 10/01/2017

Allowed Amount \$0.00

\*Insurance Carrier Name HUMANA MEDICARE

\*Electronic Payer ID 43210

Insured's Policy ID 456789

\*Payer Sequence PRIMARY

Medicare ICN

Header - Other Payer Amounts and Adjustment Reason Codes

2. Complete the appropriate fields in the Header - Other Payer Panel.

3. Click the light blue line at the top of the Header - Other Payer panel so the information populates in the line.

4. Repeat steps 1, 2, and 3 until all Other Payers have been added.

## LINE LEVEL – CONTINUED

Item	FDOS	Units	Charges	Medicaid Allowed Amount	Status	Place of Service	Procedure Code	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Final EAPG
A 1	10/01/2017	0.00	\$0.00	\$0.00								

Select row above to update -or- click add an item button below.

delete **add an item** copy

Item 1

\*From DOS 10/01/2017 To DOS 10/01/2017

\*Units 1.00 \*Charges \$50.00

Medicaid Allowed Amount \$0.00

Rendering Provider 1234567890

Submitted EAPG Initial EAPG Status

\*Place Of Service 12 [ Search ] \*Procedure Code A5500 [ Search ]

Emergency [ v ]

Referred EPSDT Service/ Family Planning [ v ]

Diagnosis Code Pointer 01 [ v ] [ v ] [ v ] [ v ]

Modifiers LT [ Search ] [ Search ] [ Search ] [ Search ]

Final EAPG Pay Action

NDC Detail - Other Payer Additional Provider Information

5. In the Detail panel complete the appropriate fields for the detail/line.

6. Click the light blue line at the top of the Detail panel so the information populates in the line.

7. If you need to enter additional codes, click the “add an item” button and complete the appropriate fields for each additional code. After the information is entered in each line, click the light blue bar at the top of the Detail panel so the information populates in the bar.

Item	FDOS	Units	Charges	Medicaid Allowed Amount	Status	Place of Service	Procedure Code	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Final EAPG
A 1	10/01/2017	0.00	\$0.00	\$0.00								

Select row above to update -or- click add an item button below.

delete add an item copy

Item 1

\*From DOS 10/01/2017 To DOS 10/01/2017

\*Units 1.00 \*Charges \$50.00

Medicaid Allowed Amount \$0.00

Rendering Provider 1234567890

Submitted EAPG Initial EAPG Status

\*Place Of Service 12 [ Search ] \*Procedure Code A5500 [ Search ]

Emergency [ v ]

Referred EPSDT Service/ Family Planning [ v ]

Diagnosis Code Pointer 01 [ v ] [ v ] [ v ] [ v ]

Modifiers LT [ Search ] [ Search ] [ Search ] [ Search ]

Final EAPG Pay Action

NDC **Detail - Other Payer** Additional Provider Information

8. Click the “Detail - Other Payer” button at the bottom of the Detail panel.

## LINE LEVEL – CONTINUED

Detail - Other Payer

\*\*\* No rows found \*\*\*

Select row above to update -or- click add an item button below.

delete **add an item**

Detail - Other Payer Amounts and Adjustment Reason Codes

9. Click the “add an item” button in the Detail - Other Payer panel.

Detail - Other Payer

Detail Item #	Electronic Payer ID	Paid Date	Paid Amount
A 1	43210	10/01/2017	\$27.50

Select row above to update -or- click add an item button below.

delete add an item

LINE LEVEL ADJUSTMENT REASON CODES AND AMOUNTS

\*Detail Item 1

\*Electronic Payer ID 43210

\*Paid Date 10/01/2017

\*Paid Amount \$27.50

Allowed Amount \$0.00

Detail - Other Payer Amounts and Adjustment Reason Codes

10. Complete the Detail Item, Electronic Payer ID, Paid Date and Paid Amount fields. (MITS will automatically calculate the Allowed Amount)

11. Click the light blue line at the top of the Detail-Other Payer Panel so the information populates in the line.

12. Repeat steps 9, 10, and 11 until all Detail Item, Electronic Payer ID, Paid Date, and Paid Amount fields are completed for each line.

Detail - Other Payer

Detail Item #	Electronic Payer ID	Paid Date	Paid Amount
A 1	43210	10/01/2017	\$27.50

Select row above to update -or- click add an item button below.

delete add an item

LINE LEVEL ADJUSTMENT REASON CODES AND AMOUNTS

\*Detail Item 1

\*Electronic Payer ID 43210

\*Paid Date 10/01/2017

\*Paid Amount \$27.50

Allowed Amount \$0.00

**Detail - Other Payer Amounts and Adjustment Reason Codes**

13. Click the “Detail-Other Payer Amounts and Adjustment Reason Codes” Button.

## LINE LEVEL – CONTINUED

Detail - Other Payer Amounts and Adjustment Reason Codes  
\*\*\* No rows found \*\*\*  
Select row above to update -or- click add an item button below.  
delete add an item

14. Click the “add an item” button.

Detail - Other Payer Amounts and Adjustment Reason Codes  
Detail Item/Electronic Payer ID CAS Group Code ARC Amount  
A 1/43210 CO-Contractual Obligations 45 \$21.50  
A 1/43210 PR-Patient Responsibility 2 \$1.00  
Select row above to update -or- click add an item button below.  
delete add an item  
\*Detail Item/Electronic Payer ID 1/43210  
\*CAS Group Code CO-Contractual Obligations  
\*ARC 45  
\*Amount \$21.50

15. Enter the appropriate Electronic Payer ID, CAS Group Code, ARC, and ARC Amount.

16. Click the light blue line at the top of the panel so the information populates the line.

17. Repeat steps 14, 15, and 16 until all of the Electronic Payer ID, CAS Group Code, ARC, and ARC amounts have been completed for this line. In this example, there is one Electronic Payer ID and two sets of CAS Group codes, ARCs, and ARC amounts.

## HELPFUL HINTS FOR SUBMITTING CLAIMS WITH OTHER PAYER INFORMATION

Providers should access the ARCs and ARC amounts from the other payers' remittance advice notices and enter that information in the appropriate fields. If the ARCs and ARC amounts do not appear on the remittance advice notice, then providers will need to refer to the information noted below for example ARCs, the Washington Publishing Company website, and the ARC calculations.

### EXAMPLE ADJUSTMENT REASON CODES (ARCs):

- 1 - Deductible
- 2 - Coinsurance
- 3 - Co-payment
- 45 - Contractual Obligation/Write Off
- 96 - Non-Covered Services

Refer to the Washington Publishing Company's website for more ARCs (<http://www.x12.org/codes/claim-adjustment-reason-codes/>).

### CALCULATIONS:

#### Commercial Payer

- Paid Amount + ARC Amounts = Total Charges (**Claim/Header level only**)
  - If the commercial payer paid or denied the claim at the header level, submit the CAS Group Codes, ARC Amounts, and ARCs at the header level.
  - If the commercial payer paid or denied the claim at the line level, submit the CAS Group Codes, ARC Amounts, and ARCs at the line level.
- MITS will calculate the allowed amount.

#### Medicare Payer (Traditional/Managed Care)

- Paid Amounts + ARC Amounts = Line Item Charges (**Claim/Header Level Only**)
  - Submit the CAS Group Codes, ARC Amounts, and ARCs at the line level.
- MITS will calculate the allowed amount.

### CLAIMS DENIED BY MEDICARE:

If a claim is denied by Medicare **for reasons other than lack of medical necessity**, the claim has to be submitted via the 6653 process through MITS. In this situation, providers **SHOULD NOT** denote any Medicare information at header or line level. Providers should also attach the following information to the claim and submit the claim via MITS:

- Attach a completed 6653 form;
- Attach the portion of the Medicare remittance advice notice that clearly indicates why Medicare didn't pay the claim; and
- Include any other attachments that support payment by Medicaid.



## RESOURCES FOR CLAIMS THAT INCLUDE OTHER PAYER INFORMATION

- Refer to the Claims Denied by Medicare document on this page.
  - <https://medicaid.ohio.gov/wps/portal/gov/medicaid/resources-for-providers/mits/mits-information-releases>
- Access the Health Insurance Fact Request form (ODM06614) via the Form Centralwebsite to correct “other payer” information for a Medicaid recipient.
  - <https://medicaid.ohio.gov/wps/portal/gov/medicaid/stakeholders-and-partners/legal-and-contracts/forms/forms>
- Access the Ohio Administrative Code (OAC) rules and policy updates.
  - <https://medicaid.ohio.gov/wps/portal/gov/medicaid/stakeholders-and-partners/legal-and-contracts/legal-and-contracts>
- For Adjustment Reasons Codes (ARCs), access the Washington PublishingCompany’s website.
  - <http://www.x12.org/codes/claim-adjustment-reason-codes/>
- Your trading partner/clearinghouse should contact the EDI Help Desk regarding problems related to EDI transactions.
  - <https://medicaid.ohio.gov/wps/portal/gov/medicaid/resources-for-providers/billing/trading-partners/trading-partners>
- For Payer IDs, refer to the payer’s electronic remittance advice or contact the payer directly.
- For Provider Assistance, call 1-800-686-1516.