SUBMITTING CLAIMS VIA THE MITS WEB PORTAL WITH "OTHER PAYER" INFORMATION

Considering Medicaid is the "payer of last resort," providers must receive a payment or denial from other payers (i.e., payers other than Medicaid) 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 three 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 when a commercial payer (a payer other than Medicaid or Medicare) denied payment, and the detail regarding the commercial payer's denial is noted at the claim level.

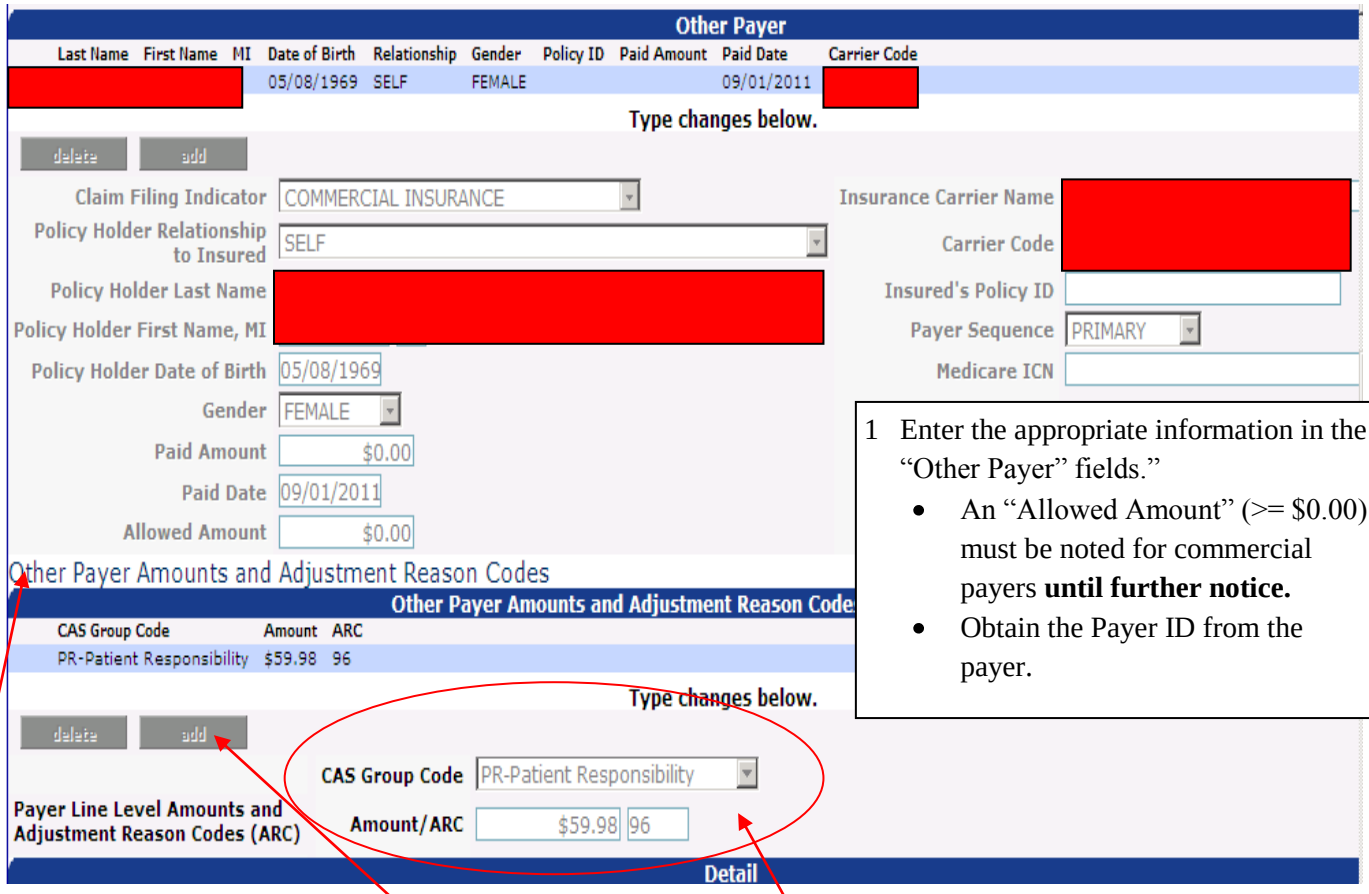
SECOND EXAMPLE: This example reflects other payer information when a commercial payer partially paid, and the detail regarding the commercial payer's payment and denial are noted at the claim level.

THIRD EXAMPLE: This example reflects a Medicare Crossover claim (traditional Medicare or a Medicare Managed Care plan), and the detail regarding Medicare's payment and denial are noted at the line level. These steps are also applicable if a commercial payer partially paid, and the detail regarding the commercial payer's payment and denial are noted at the line level.

COMMON MISTAKES:

- Providers must enter other payer information in the required fields, and they don't notice the links that allow them to access those fields. The instructions noted in this document will show providers where those links are located.
- Providers mistakenly click the add button and create 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 carrier code field. Providers can access the payer IDs from the other payers' electronic remittance advice notices or contact the other payers directly.
- For a single payer, providers mistakenly enter other payer information at the claim and line level. Providers should enter other payer information at the claim or line level (not both) for a single payer.
- Providers don't review their clients' eligibility (prior to submitting claims) to determine if their clients are receiving services via a Medicare Managed Care plan (aka, Medicare Advantage Plan), and they 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 on the claims.
- 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 notices and enter those ARC amounts in the appropriate fields.

SUBMITTING COMMERCIAL PAYER DENIAL INFORMATION AT THE CLAIM LEVEL



1 Enter the appropriate information in the "Other Payer" fields."

- An "Allowed Amount" (>= $0.00) must be noted for commercial payers **until further notice.**
- Obtain the Payer ID from the payer.

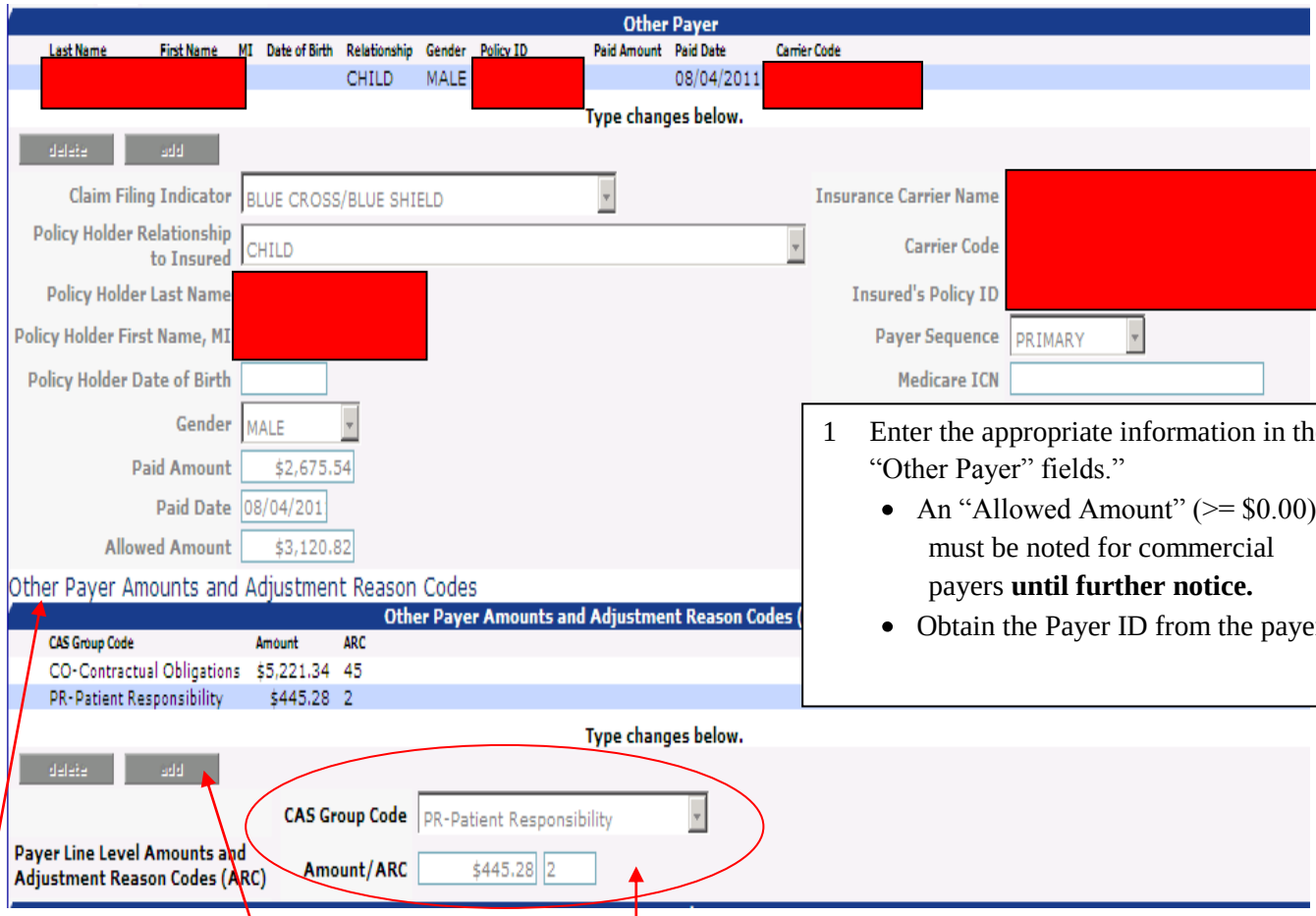
2. Click the "Other Payer Amounts and Adjustment Reason Codes" link.

3 Click the "Add" button.

4 Submit the appropriate CAS Group Code, ARC Amount, and ARC.

NOTE: If the payer reports a payment at the detail level that is different than the billed charge, the COB information must be reported at the detail.

SUBMITTING COMMERCIAL PAYER PAYMENT INFORMATION AT THE CLAIM LEVEL



1 Enter the appropriate information in the "Other Payer" fields."

- An "Allowed Amount" (>= $0.00) must be noted for commercial payers **until further notice.**
- Obtain the Payer ID from the payer.

2 Click the "Other Payer Amounts and Adjustment Reason Codes" link.

3 Click the "Add" button.

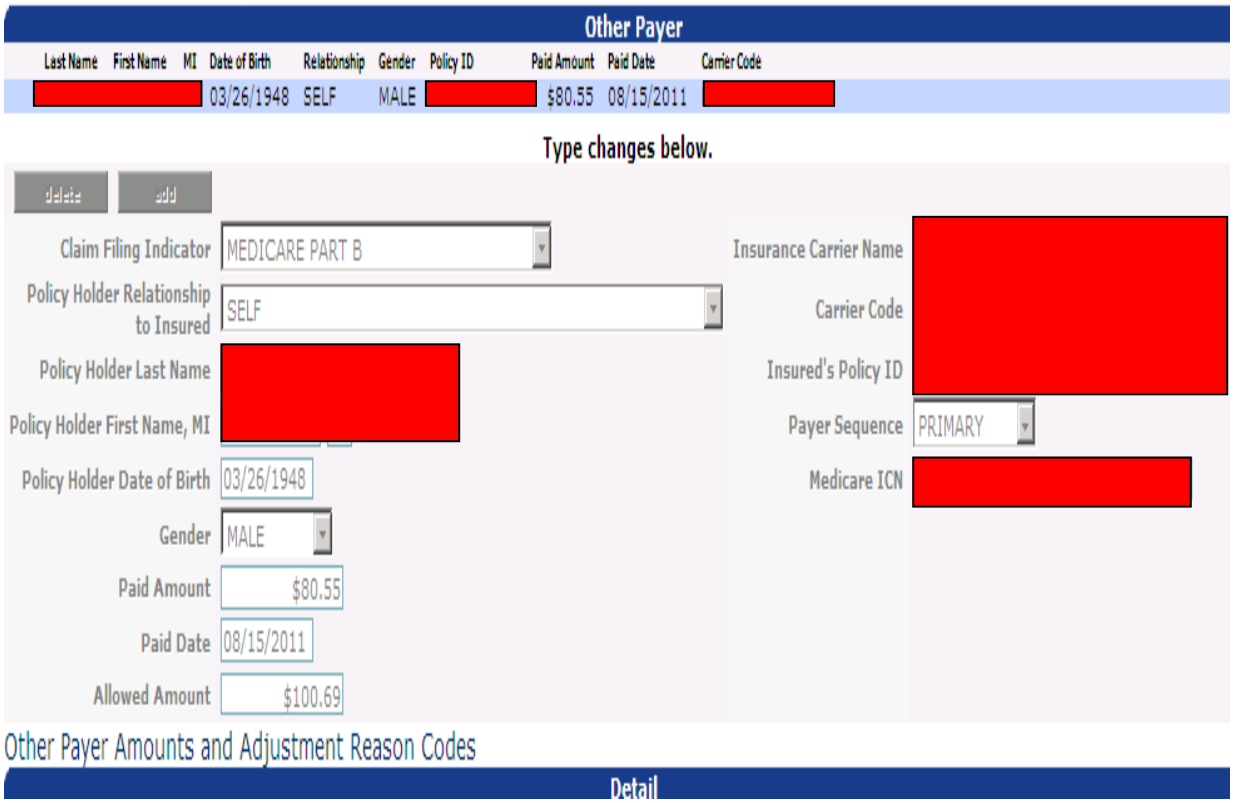
4 Submit the appropriate CAS Group Code, ARC Amount, and ARC.

5 Repeat steps 3 and 4 until all of the CAS Group Code, ARC Amount, and ARC fields are completed.

In this example, two sets of CAS Group Codes, ARC Amounts, and ARCs are entered on the claim.

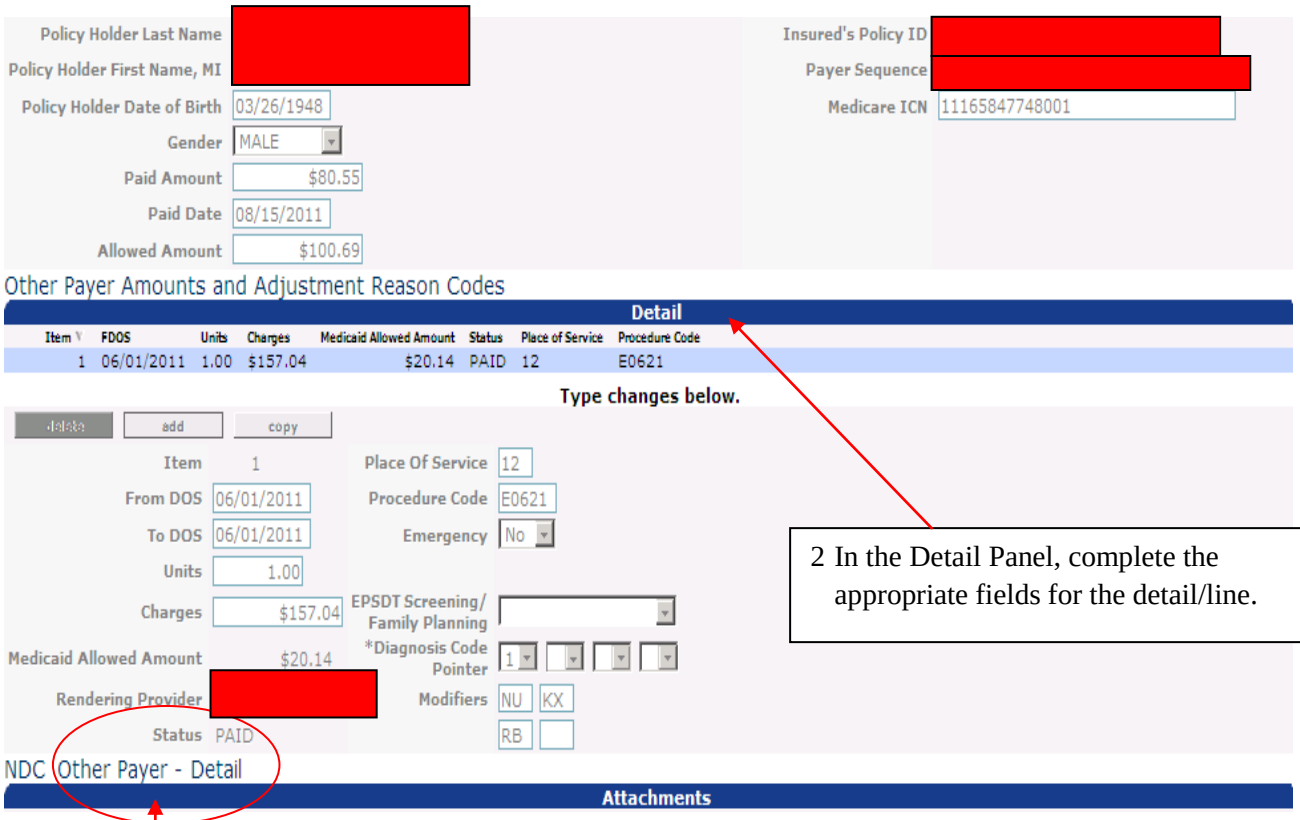
NOTE: If the payer reports a payment at the detail level that is different than the billed charge, the COB information must be reported at the detail.

SUBMITTING PAYMENT AND/OR DENIAL INFORMATION AT THE LINE LEVEL



1. Enter the appropriate information in the “Other Payer” fields and submit the CAS Group Code, ARC Amounts, and ARCs for each detail/line in the “Detail” panel.
   - Obtain the Payer ID from the payer.
   - For commercial payers, providers must submit the allowed amount in the "ALLOWED AMOUNT" field **until further notice.**
   - For Medicare payers, MITS will automatically calculate the allowed amount in the "ALLOWED AMOUNT" field **until further notice.**

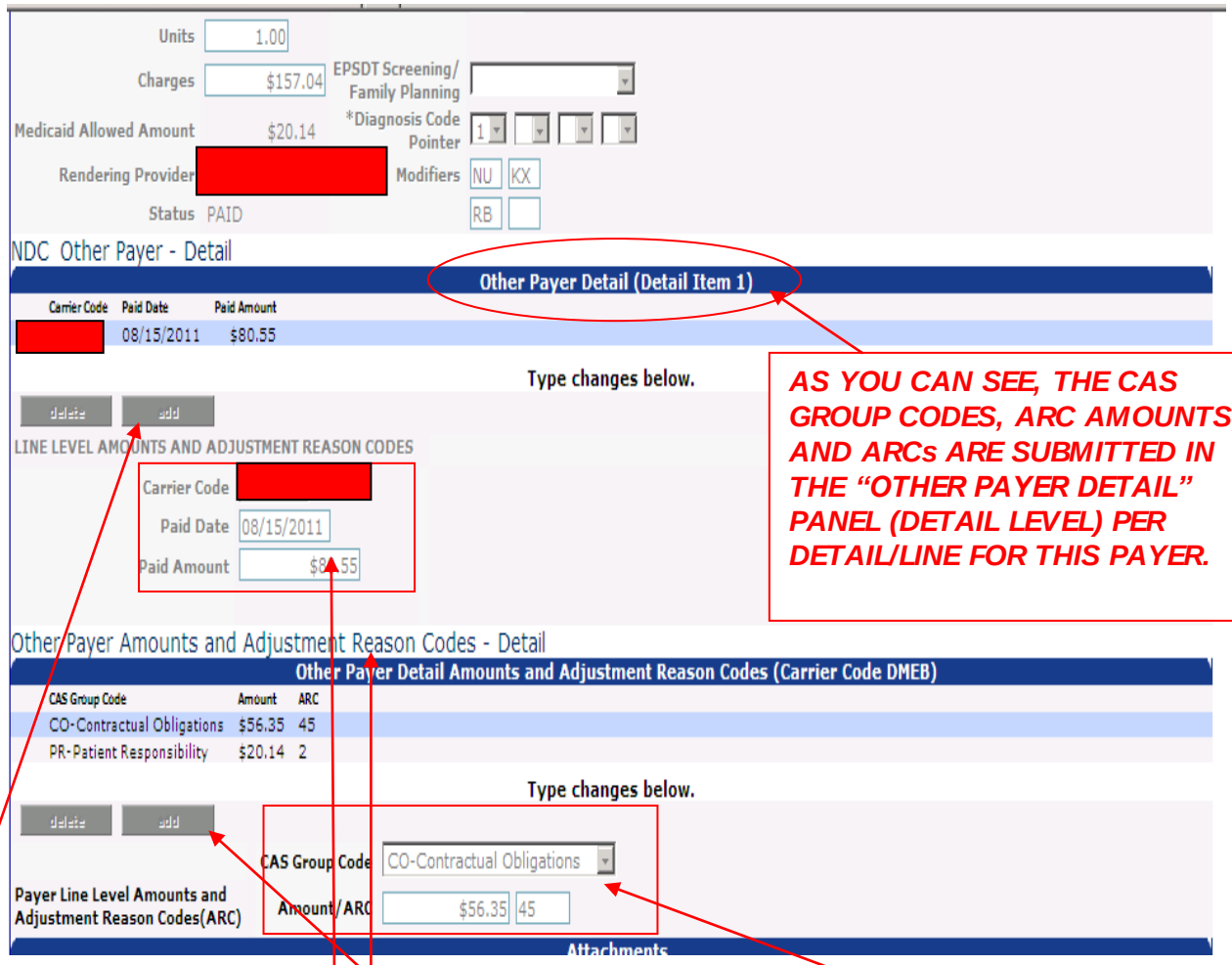
LINE LEVEL – CONTINUED:



2 In the Detail Panel, complete the appropriate fields for the detail/line.

3 Click the "Other Payer - Detail" link in the Detail Panel.

LINE LEVEL – CONTINUED:



AS YOU CAN SEE, THE CAS GROUP CODES, ARC AMOUNTS, AND ARCs ARE SUBMITTED IN THE "OTHER PAYER DETAIL" PANEL (DETAIL LEVEL) PER DETAIL/LINE FOR THIS PAYER.

4 Click the "Add" Button.

5 Complete the Carrier Code, Paid Date, and Paid Amount fields.

6 Click the "Other Payer Amounts and Adjustment Reason Codes – Detail" link.

7 Click the "Add" button.

8 Enter the appropriate CAS Group Code, ARC Amount, and ARC as noted on the payer's remittance advice notice.

9 Repeat steps 7 and 8 until all of the CAS Group Codes, ARC Amounts, and ARCs are completed for this detail/line.

For this line, two sets of CAS Group Codes, ARC Amounts and ARCs are noted.

10 If another payer paid or denied services at the detail/line level, repeat steps 4 to 9 until all of the CAS Group Code, ARC Amount, and ARC fields are completed for the **detail/line**.

11 When the first line is completed, click the add button to add another line (if necessary), and repeat steps 2 to 10 until all the lines/items are completed along with the other payer's payment/denial information.

RESOURCES FOR CLAIMS PAID OR DENIED BY PAYERS OTHER THAN MEDICAID

- Access Coordination of Benefit (COB) handouts and training material via the MITS website.
  - http://jfs.ohio.gov/mits/MITS%20Provider%20Training.stm

- Refer to the Information Release dated October 25, 2011 for more information regarding claims denied by Medicare.
  - http://jfs.ohio.gov/mits/information_releases.stm

- Access the Health Insurance Fact Request form (JFS 06614) via the Form Central website to correct "other payer" information for a Medicaid recipient.
  - http://www.odjfs.state.oh.us/forms/inter.asp

- Access the eManuals website for Ohio Administrative Code (OAC) rules, policy updates, and billing instructions.
  - http://emanuals.odjfs.state.oh.us/emanuals/

- For Adjustment Reasons Codes (ARCs), access the Washington Publishing Company's website.
  - http://www.wpc-edi.com/reference/

- Your trading partner/clearinghouse should contact the EDI Help Desk regarding problems related to EDI transactions.
  - http://jfs.ohio.gov/OHP/tradingpartners/info.stm

- For Payer IDs (Carrier Codes), refer to the payer's electronic remittance advice notice or contact the payer directly.

- For Provider Assistance call 1-800-686-1516.