



08/15/2011

THE ANSWER KEY

A COMPENDIUM OF SOLUTIONS TO PROBLEMS ENCOUNTERED BY PROVIDERS IN SUBMITTING MEDICAID CLAIMS

Note: All information was current at the time of publication but is subject to change.

Claims for Supplemental Payment ("Wraparound Claims") for Services Provided by Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)

Ohio's New Medicaid Information Technology System (MITS) is editing claims for proper coding in accordance with HIPAA standards. To submit a wraparound claim successfully, providers and trading partners must include the following information on the claim:

1. The Medicaid provider ID number for the Medicaid Managed Care Plan (MCP; referred to in MITS as an "HMO") must be reported as the payer/carrier ID number.
2. The approved/allowed amount specified by the MCP must be reported at the claim (header) level, and this approved/allowed amount must equal the amount paid by the MCP. MCPs pay the same amounts to FQHCs and RHCs as they pay to similar providers for the same services.
3. If the provider's total billed charge is greater than the payment made by the MCP, then an amount equal to the difference must be reported, along with Adjustment Reason Code (ARC) 45 and the Code Group indicator CO (contractual obligation). For example, if billed charges are \$100, and the MCP paid \$25, then the difference of \$75 must be reported with CO 45.
4. All other required coordination-of-benefits (COB) information (such as the subscriber and the payer) must also be reported.
5. It is not necessary to report COB payment information at the detail level, unless another party is the primary payer and the MCP is secondary. Information about each payer must be reported on a separate detail line.

For more information, see the MITS Information Supplemental Release on Coordination of Benefits:

http://www.jfs.ohio.gov/mits/Supplemental_Policy_Release-Coordination_of_Benefits.pdf