



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 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 electronic payer ID 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 header and line level. Providers should enter other payer information at the header or line level (not both) for a single payer.
 - Providers should refer to the other payer’s remittance advice notice to determine if other payer information should be entered at the header or line 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 (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 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 “OTHER PAYER” INFORMATION AT THE HEADER LEVEL

*** No rows found ***

Header - Other Payer

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 “add an item” to complete the 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
				FATHER	MALE		\$0.00	07/01/2011	

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

delete add an item

Claim Filing Indicator: COMMERCIAL INSURANCE

Insurance Carrier Name: [REDACTED]

Policy Holder Relationship to Insured: FATHER

Electronic Payer ID: [REDACTED]

Policy Holder Last Name: [REDACTED]

Insured's Policy ID: [REDACTED]

Policy Holder First Name, MI: [REDACTED]

Payer Sequence: PRIMARY

Policy Holder Date of Birth: [REDACTED]

Gender: MALE

Medicare ICN: [REDACTED]

Paid Amount: \$0.00

Paid Date: 07/01/2011

Allowed Amount: \$0.00

Header - Other Payer Amounts and Adjustment Reason Codes

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

3. Click the line at the top of the Other Payer Panel so the
information populates the line.

Header - Other Payer

Last Name	First Name	MI	Date of Birth	Relationship	Gender	Policy ID	Paid Amount	Paid Date	Electronic Payer ID
				FATHER	MALE		\$0.00	07/01/2011	

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

delete add an item

Claim Filing Indicator: COMMERCIAL INSURANCE

Insurance Carrier Name: [REDACTED]

Policy Holder Relationship to Insured: FATHER

Electronic Payer ID: [REDACTED]

Policy Holder Last Name: [REDACTED]

Insured's Policy ID: [REDACTED]

Policy Holder First Name, MI: [REDACTED]

Payer Sequence: PRIMARY

Policy Holder Date of Birth: [REDACTED]

Gender: MALE

Medicare ICN: [REDACTED]

Paid Amount: \$0.00

Paid Date: 07/01/2011

Allowed Amount: \$0.00

Header - Other Payer Amounts and Adjustment Reason Codes

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

HEADER LEVEL – CONTINUED

Electronic Payer ID	CAS Group Code	ARC	Amount
	PR-Patient Responsibility	1	\$117.83
	CO-Contractual Obligations	45	\$232.17

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

delete **add an item**

Payer Header Level Adjustment Reason Codes (ARC) and Amounts

*Electronic Payer ID [dropdown]
CAS Group Code [PR-Patient Responsibility dropdown]
ARC [1 text box]
Amount [\$117.83 text box]

5. Click the “add an item” button.

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

7. Click the line at the top of the panel so the line populates with the appropriate information.

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 “add an item” to complete the 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
				SELF	MALE		\$27.50	08/07/2012	

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

Delete add an item

Claim Filing Indicator: HMO, MEDICARE RISK

Insurance Carrier Name: HUMANA MEDICARE

Policy Holder Relationship to Insured: SELF

Electronic Payer ID: [Redacted]

Policy Holder Last Name: [Redacted]

Insured's Policy ID: [Redacted]

Policy Holder First Name, MI: [Redacted]

Payer Sequence: PRIMARY

Policy Holder Date of Birth: [Redacted]

Gender: MALE

Medicare ICN: [Redacted]

Paid Amount: \$27.50

Paid Date: 08/07/2012

Allowed Amount: \$0.00

Header - Other Payer Amounts and Adjustment Reason Codes

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

3. Click the line at the top of the Other Payer panel so the information populates 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
1	07/17/2012	1.00	\$72.00	\$1.15	PAID	21	93970	26			

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

Item: 1
 From DOS: 07/17/2012
 To DOS: 07/17/2012
 Units: 1.00
 Charges: \$72.00
 Medicaid Allowed Amount: \$1.15
 Rendering Provider:
 Status: PAID

Place Of Service: 21
 Procedure Code: 93970
 Emergency:
 EPSDT Screening/ Family Planning:
 *Diagnosis Code Pointer: 01
 Modifiers: 26

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

6. Click the appropriate line at the top of the Detail panel so the information populates the line.

7. If you need to add additional lines, click the “add an item” button, and complete the appropriate fields for the detail/line. After the information is entered for each line, click the line at the top of the Details panel so the information populates the line.

Item	FDOS	Units	Charges	Medicaid Allowed Amount	Status	Place of Service	Procedure Code	Modifier 1	Modifier 2	Modifier 3	Modifier 4
1	07/17/2012	1.00	\$72.00	\$1.15	PAID	21	93970	26			

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

Item: 1
 From DOS: 07/17/2012
 To DOS: 07/17/2012
 Units: 1.00
 Charges: \$72.00
 Medicaid Allowed Amount: \$1.15
 Rendering Provider:
 Status: PAID

Place Of Service: 21
 Procedure Code: 93970
 Emergency:
 EPSDT Screening/ Family Planning:
 *Diagnosis Code Pointer: 01
 Modifiers: 26

8. Click the “Detail-Other Payer” button.

LINE LEVEL – CONTINUED

The screenshot shows a table with the following data:

Detail Item #	Electronic Payer ID	Paid Date	Paid Amount
1		08/07/2012	\$27.50

Below the table, there are two buttons: "delete" and "add an item". The "add an item" button is circled in red. Below the buttons is a section titled "LINE LEVEL ADJUSTMENT REASON CODES AND AMOUNTS" with the following fields:

- Detail Item: 1
- Electronic Payer ID: [dropdown]
- Paid Date: 08/07/2012
- Paid Amount: \$27.50
- Allowed Amount: \$28.65

At the bottom of the section is a button labeled "Detail - Other Payer Amounts and Adjustment Reason Codes".

9. Click the “add an item” button.

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

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

This screenshot is identical to the one above, but the button at the bottom, "Detail - Other Payer Amounts and Adjustment Reason Codes", is circled in red.

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

LINE LEVEL – CONTINUED

Detail Item / Electronic Payer ID	CAS Group Code	ARC	Amount
	PR-Patient Responsibility	2	\$1.15
	PI-Payer Initiated Reductions	45	\$43.35

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

delete **add an item**

*Detail Item/Electronic Payer ID

CAS Group Code

ARC

Amount

14. Click the “add an item” button.

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

Detail Item / Electronic Payer ID	CAS Group Code	ARC	Amount
	PR-Patient Responsibility	2	\$1.15
	PI-Payer Initiated Reductions	45	\$43.35

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

delete add an item

*Detail Item/Electronic Payer ID

CAS Group Code

ARC

Amount

16. Click the 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.wpc-edi.com/reference/>).

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

- Access questions and answers regarding Coordination of Benefits (COB) 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, refer to the payer’s electronic remittance advice notice or contact the payer directly.
- For Provider Assistance, call 1-800-686-1516.