



THIRD PARTY LIABILITY LOGISTICS

August 2017 Webinar

DISCLAIMER

- SoonerCare policy is subject to change
- The information included in this presentation is current as of August 2017

AGENDA

- What is TPL?
- Claim Submission – EDI
- Claim Submission – Provider Portal
 - Commercial Insurance
 - HMO Copay
 - Medicare Dual Eligibility (Crossovers)
- Resources
- Questions



THIRD PARTY LIABILITY (TPL)

WHAT IS THIRD PARTY LIABILITY (TPL)?

- TPL means another party is responsible for paying health care costs before SoonerCare pays
- All other available third-party resources must meet their legal obligation to pay claims first; SoonerCare is the payer of last resort
- Exceptions to this policy include:
 - Indian Health Services
 - Crime Victims Compensation

EXAMPLES OF TPL

- Medicare
- Private health insurance
- Tricare
- Casualty/tort settlements
- Worker's compensation

TPL CARRIERS

To access a list of TPL carriers and a list of private pay HMO Medicare replacement policies, go to www.okhca.org/TPL.

- *Listings include carrier name, code, address, telephone and contact, if available*

Providers

- ◊ Types
- ◊ Claim Tools
- ◊ Forms
- ◊ Secure Sites
- ◊ Policies & Rules
- ◊ Training
- ◊ Updates
- ◊ Help

[Home](#) > [Providers](#) > [Claim Tools](#)

Third Party Liability

Medicaid is the payer of last resort in most circumstances. Medicaid pays for services only after a liable third party has met its legal obligation to pay. OHCA is responsible for pursuing third party payers for both fee-for-service and **SoonerCare** program areas.

Third Party Liability (TPL) Carriers

The TPL Carriers are the health insurance companies with which OHCA maintains a third party resource/billing relationship. Third parties include but are not limited to, private health insurance, casualty insurance, worker's compensation, estates, trusts, tort proceeds and Medicare.

The list below includes the OHCA carrier number and carrier billing address.

[TPL Carriers](#) 

[Private Pay HMOs Medicare Replacement Policies List](#)

[Adjustments and Third Party Liability PowerPoint - Provider Training](#)



CLAIM SUBMISSION – EDI

ELECTRONIC DATA INTERCHANGE (EDI)

If the primary payer paid:

- Under “Other Subscriber Information”, in loop 2320, send the SBR segment, CAS segment and AMT segment with the amount paid.
 - No attachment is required.

If the primary denied the claim or applied it to deductible:

- The same procedure is followed, with 0.00 entered in the SMT segment.
 - You will then add an attachment to the claim.

ELECTRONIC ATTACHMENTS (EDI)

- Provider indicates attachment required for claim and creates the attachment control number
- Clearinghouse creates a PWK segment, which includes the attachment control number created by the provider
- Once an electronic (EDI) claim is processed, provider will print and complete the HCA-13 (attachment cover sheet)
- Provider will fax/mail attachments

HCA-13 Attachment Cover Sheet



Oklahoma Health Care Authority Electronic Claim Paper Attachment Form Cover Sheet

The three fields below are required and must match claim.

1. **Provider Number**
2. **Client ID Number**
3. **Attachment Control Number**

Purpose:

This form is to be used when a claim requiring a paper attachment is being submitted electronically. Submission of this completed form along with the required attachment and electronically submitted claim will allow the appropriate review process to be conducted by the OHCA.

Instructions:

1. In box 1, fill in the pay to Provider Number used for filing the electronic claim.
2. In box 2, fill in the 9-digit client identification number submitted on the electronic claim.
3. In box 3, fill in the Attachment Control Number (ACN) used for filing the electronic claim. The ACN on this form must be the same number entered in the control number field of the direct data entry (DDE) screen (Medicaid on the Web) or the PWK segment of the 837 transaction. Make sure the ACN is clear and legible on the HCA-13. Illegible information could delay or stop the attachment process. Numbers are the only characters that should be used in the ACN section. Do not use dashes or spaces in the ACN section.
4. Place this completed form on top of the attachment(s) for each electronic claim. (DO NOT INCLUDE ADDITIONAL COVER SHEET)
5. Mail to: DXC Technology
P.O. Box 18500, OKC, OK 73154
Fax: 405-947-3394



NOTE: Do not place another fax cover sheet on top of this form.



***This form is for use with electronically filed claims requiring attachments.**

Sender's Name: Phone Number:

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CLAIM SUBMISSION – PROVIDER PORTAL

COMMERCIAL INSURANCE—PROFESSIONAL

Oklahoma HealthCare Authority

My Home Eligibility **Claims** Prior Authorizations Referrals Files Exchange Financial Letters Reports Resources

Search Claims | Submit Claim Dental | Submit Claim Inst | Submit Claim Prof | Submit Claim Pharm | Search Payment History

Contact Us | Logout
Friday 03/03/2017 08:04 AM CST

Claims

- ▶ [Search Claims](#)
- ▶ [Submit Claim Dental](#)
- ▶ [Submit Claim Inst](#)
- ▶ [Submit Claim Prof](#)
- ▶ [Submit Claim Pharm](#)
- ▶ [Search Payment History](#)

COMMERCIAL INSURANCE—PROFESSIONAL

Submit Professional Claim: Step 1 ?

* Indicates a required field.

Claim Type

Provider Information

This panel contains provider information.

Billing Provider ID	0123456789	ID Type	NPI	Name	Bob SoonerCare, MD
Zip Code		Contract Code	-	Taxonomy	
Referring Provider ID	<input type="text"/>	ID Type	<input type="text"/>	SC Provider Number	100000000D
Ordering Provider ID	<input type="text"/>	ID Type	<input type="text"/>	Ordering Zip Code	<input type="text"/>

Patient Information

Enter the Member ID. If Member ID is valid, the rest of the member information will populate.

*Member ID	<input type="text"/>	First Name		Middle	
Last Name					
Birth Date					

Claim Information

Enter information applicable to the claim. If Other Insurance information needs to be entered, then Include should be selected in the Other Insurance dropdown. The Other Insurance details can be entered on Submit Step 2.

Date Type	<input type="text"/>	Date of Current	<input type="text"/>
Accident Related	<input type="text"/>	Expected Delivery Date	<input type="text"/>
Patient Account Number	<input type="text"/>	From Date	<input type="text"/>
CLIA Number	<input type="text"/>	To Date	<input type="text"/>
*Other Insurance	<input type="text" value="Include"/>	HMO Copay	<input type="text" value="No"/>

Total Charged Amount \$0.00

Step 1—Primary Paid



COMMERCIAL INSURANCE—PROFESSIONAL

Step 2—Primary Paid

[Expand All](#) | [Collapse All](#)

Diagnosis Codes

Select the row number to edit the row. Click the **Remove** link to remove the entire row.

#	ICD Version	Diagnosis Code	Action
<u>1</u>			

1 *ICD Version *Diagnosis Code

Other Insurance Details

TPL Amount

Key in the amount paid by the primary insurance

COMMERCIAL INSURANCE—PROFESSIONAL

Submit Professional Claim: Step 1 ?

* Indicates a required field.

Claim Type

Step 1—Primary Denied

Provider Information

This panel contains provider information.

Billing Provider ID	0123456789	ID Type	NPI	Name	Bob SoonerCare, MD
Zip Code		Contract Code	-	Taxonomy	
Referring Provider ID	<input type="text"/>	ID Type	<input type="text"/>	SC Provider Number	100000000D
Ordering Provider ID	<input type="text"/>	ID Type	<input type="text"/>	Ordering Zip Code	<input type="text"/>

Patient Information

Enter the Member ID. If Member ID is valid, the rest of the member information will populate.

*Member ID	<input type="text"/>	First Name		Middle	
Last Name		Birth Date			

Claim Information

Enter information applicable to the claim. If Other Insurance information needs to be entered, then Include should be selected in the Other Insurance dropdown. The Other Insurance details can be entered on Submit Step 2.

Date Type	<input type="text"/>	Date of Current	<input type="text"/>
Accident Related	<input type="text"/>	Expected Delivery Date	<input type="text"/>
Patient Account Number	<input type="text"/>	From Date	-
CLIA Number	<input type="text"/>	To Date	-
*Other Insurance	<input type="text" value="Denied"/>	HMO Copy	No
		Total Charged Amount	\$0.00

COMMERCIAL INSURANCE—PROFESSIONAL

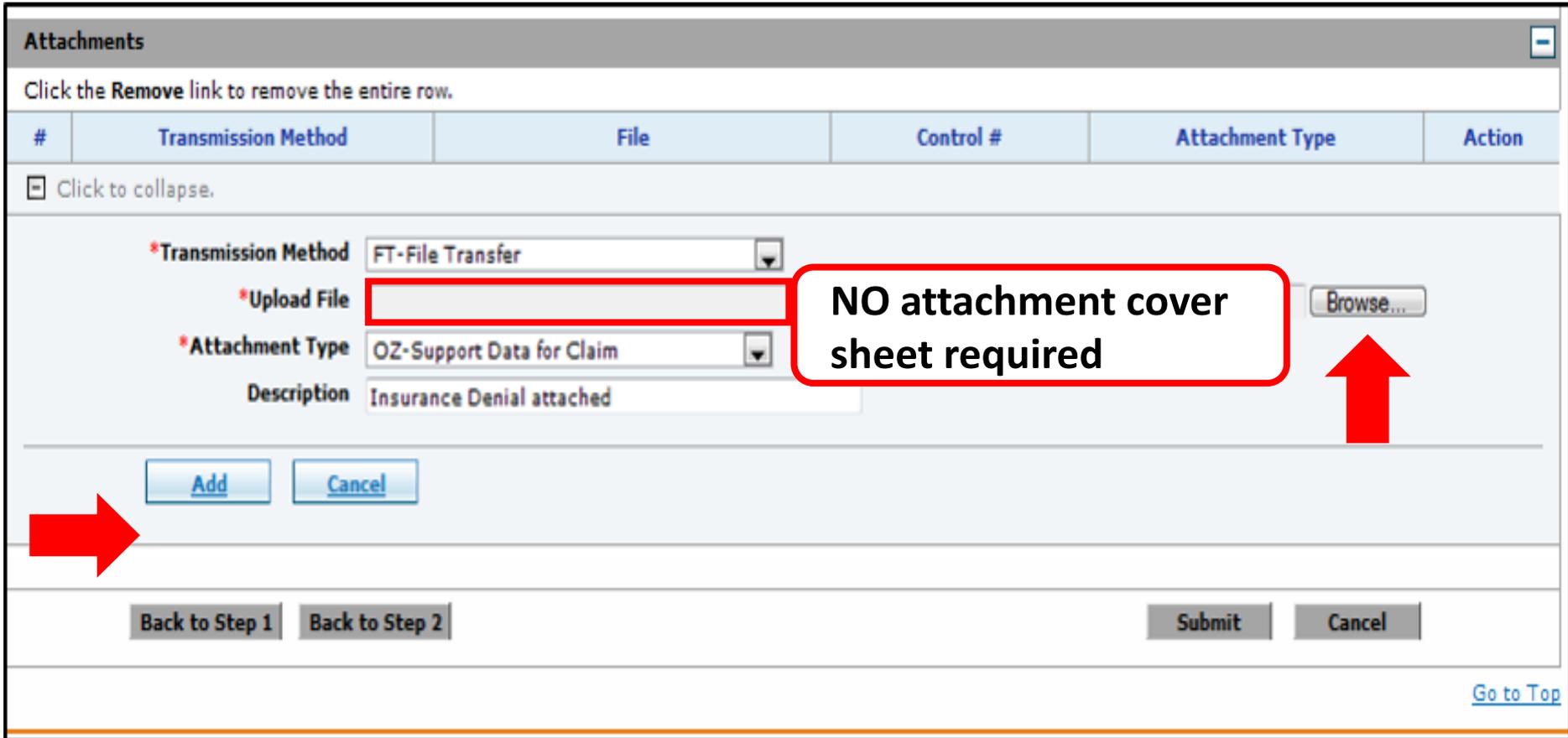
Step 3—Primary Denied

Attachments

Click the **Remove** link to remove the entire row.

#	Transmission Method	File	Control #	Attachment Type	Action
Click to collapse.					
	*Transmission Method	FT-File Transfer			
	*Upload File	<input type="text"/>			<input type="button" value="Browse..."/>
	*Attachment Type	OZ-Support Data for Claim			
	Description	Insurance Denial attached			

[Go to Top](#)



COMMERCIAL INSURANCE—PROFESSIONAL

Step 3—Primary Denied

Attachments

Click the **Remove** link to remove the entire row.

#	Transmission Method	File	Control #	Attachment Type	Action
Click to collapse.					
*Transmission Method	FX-By Fax				
*Attachment Type	OZ-Support Data for Claim				
Description	Insurance Denial attached				

[Add](#) [Cancel](#)

[Back to Step 1](#) [Back to Step 2](#)  [Submit](#) [Cancel](#)

HCA-13 attachment cover sheet required

PRINT ATTACHMENT COVER SHEET

[Contact Us](#) | [Logout](#)

[Claims](#) > Claim Receipt

Your Claim was successfully submitted. The claim status is Suspended.
The Claim ID is 2300123987456

Click **Attachment Coversheet(s)** to view the claim attachments coversheet(s).
Click **Print Preview** to view the claim details as they have been saved on the payer's system.
Click **Copy** to copy member or claim data.
Click **View** to view the details of the submitted claim.

Attachment Coversheet(s) Print Preview Copy New View

HCA-13 Attachment Cover Sheet



Oklahoma Health Care Authority Electronic Claim Paper Attachment Form Cover Sheet

The Four fields below are required and must match claim.

1. **1. Provider Number**
2. **2. Client ID Number**
3. **3. Attachment Control Number** 20170714366677
4. **4. Claim Number** 2317195600001
5. **5. Date/Time** 07/14/2017 11:06 AM

submitted electronically. Submission of this completed form along with the required attachment and electronically submitted claim will allow the appropriate review process to be conducted by the OHCA.

Instructions:

1. In box 1, fill in the pay to Provider Number used for filing the electronic claim.
2. In box 2, fill in the 9-digit client identification number submitted on the electronic claim.
3. In box 3, fill in the Attachment Control Number (ACN) used for filing the electronic claim. The ACN on this form must be the same number entered in the control number field of the direct data entry (DDE) screen (Medicaid on the Web) or the PWK segment of the 837 transaction. Make sure the ACN is clear and legible on the HCA-13. Illegible information could delay or stop the attachment process. Numbers are the only characters that should be used in the ACN section. Do not use dashes or spaces in the ACN section.
4. Place this completed form on top of the attachment(s) for each electronic claim. (DO NOT INCLUDE ADDITIONAL COVER SHEET)
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Fax: 405-947-3394



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COMMERCIAL INSURANCE—INSTITUTIONAL

Submit Institutional Claim: Step 1

* Indicates a required field.

Claim Type

Step 1—Primary Paid

Provider Information

If Surgical Procedure Code(s) are to be submitted with the claim, an Operating Provider ID is required.

Billing Provider ID	100000000D	ID Type	NPI	Name	Bob SoonerCare, MD
Zip Code		Contract Code	-	SC Provider Number	100000000D
Institutional Provider ID	<input type="text" value="0123456789"/>	Taxonomy		ID Type	<input type="text" value="NPI"/>
Attending Provider ID	<input type="text"/>	ID Type	<input type="text"/>	ID Type	<input type="text"/>
Operating Provider ID	<input type="text"/>	ID Type	<input type="text"/>	ID Type	<input type="text"/>
Referring Provider ID	<input type="text"/>	ID Type	<input type="text"/>	ID Type	<input type="text"/>

Patient Information

Enter the Member ID. If Member ID is valid, the rest of the member information will populate.

*Member ID

Last Name	First Name	Middle
Birth Date		

Claim Information

Enter information applicable to the claim. If Other Insurance information needs to be entered, then Include should be selected in the Other Insurance dropdown. The Other Insurance details can be entered on Submit Step 2.

*Covered Dates	<input type="text"/> - <input type="text"/>	Covered Days	<input type="text"/>
*Admission Date/Hour	<input type="text"/> (hh:mm)	Discharge Hour	<input type="text"/> (hh:mm)
*Admission Type	<input type="text"/>	*Admission Source	<input type="text"/>
*Admitting ICD Version	<input type="text" value="ICD-9-CM"/>	*Admitting Diagnosis	<input type="text"/>
*Patient Status	<input type="text"/>	*Type of Bill	<input type="text"/>
Patient Account Number	<input type="text"/>	Other Insurance	<input type="text" value="Include"/>
HMO Copay	<input type="text" value="No"/>		

Total Charged Amount \$0.00

COMMERCIAL INSURANCE—INSTITUTIONAL

Step 2—Primary Paid

Diagnosis Codes

Select the row number to edit the row. Click the **Remove** link to remove the entire row.

#	ICD Version	Diagnosis Code	POA	Action
<u>1</u>				

1 *ICD Version *Diagnosis Code

Present on Admission

Emergency Diagnosis Code

Only one emergency diagnosis code is allowed per claim.

ICD Version Diagnosis Code

Other Insurance Details

Select the row number to edit the row. Click the **Remove** link to remove the entire row.

#	Payer Code	Prior Amount	Estimated Amount Due	Action
<u>1</u>				

1 *Payer Code *Prior Amount Estimated Amount Due



COMMERCIAL INSURANCE—INSTITUTIONAL

Submit Institutional Claim: Step 1 ?

* Indicates a required field.

Claim Type

Step 1—Primary Denied

Provider Information

If Surgical Procedure Code(s) are to be submitted with the claim, an Operating Provider ID is required.

Billing Provider ID 100000000D	ID Type NPI	Name Bob SoonerCare, MD
Zip Code	Taxonomy	SC Provider Number 100000000D
Contract Code -	ID Type <input type="text" value="NPI"/>	
Institutional Provider ID <input type="text" value="0123456789"/>	ID Type <input type="text"/>	
Attending Provider ID <input type="text"/>	ID Type <input type="text"/>	
Operating Provider ID <input type="text"/>	ID Type <input type="text"/>	
Referring Provider ID <input type="text"/>	ID Type <input type="text"/>	

Patient Information

Enter the Member ID. If Member ID is valid, the rest of the member information will populate.

*Member ID

Last Name **First Name** **Middle**

Birth Date

Claim Information

Enter information applicable to the claim. If Other Insurance information needs to be entered, then Include should be selected in the Other Insurance dropdown. The Other Insurance details can be entered on Submit Step 2.

*Covered Dates <input type="text"/> - <input type="text"/>	Covered Days <input type="text"/>
*Admission Date/Hour <input type="text"/> (hh:mm)	Discharge Hour <input type="text"/> (hh:mm)
*Admission Type <input type="text"/>	*Admission Source <input type="text"/>
*Admitting ICD Version <input type="text" value="ICD-9-CM"/>	*Admitting Diagnosis <input type="text"/>
*Patient Status <input type="text"/>	*Type of Bill <input type="text"/>
Patient Account Number <input type="text"/>	Other Insurance <input type="text" value="Denied"/>
HMO Copay <input type="text" value="No"/>	

Total Charged Amount \$0.00

←

ADDING ATTACHMENT – FILE TRANSFER

Attachments

Click the **Remove** link to remove the entire row.

#	Transmission Method	File	Control #	Attachment Type	Action
Click to collapse.					
	*Transmission Method	FT-File Transfer			
	*Upload File	<input type="text"/>			<input type="button" value="Browse..."/>
	*Attachment Type	OZ-Support Data for Claim			
	Description	Insurance Denial attached			

[Go to Top](#)

NO attachment cover sheet required

ADDING ATTACHMENT – FAX

Attachments

Click the **Remove** link to remove the entire row.

#	Transmission Method	File	Control #	Attachment Type	Action
Click to collapse.					
	*Transmission Method			*Attachment Type	
	FX-By Fax			OZ-Support Data for Claim	
	Description	Insurance Denial attached			

Add **Cancel**

Back to Step 1 **Back to Step 2** **Submit** **Cancel**

HCA-13 attachment cover sheet required

HCA-13 Attachment Cover Sheet



Oklahoma Health Care Authority Electronic Claim Paper Attachment Form Cover Sheet

The Four fields below are required and must match claim.

- 1. **1. Provider Number**
- 2. **2. Client ID Number**
- 3. **3. Attachment Control Number** 20170714366677
- 4. **4. Claim Number** 2317195600001
- 5. **5. Date/Time** 07/14/2017 11:06 AM

submitted electronically. Submission of this completed form along with the required attachment and electronically submitted claim will allow the appropriate review process to be conducted by the OHCA.

Instructions:

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MEDICARE DUAL ELIGIBILITY

MEDICARE DUAL ELIGIBILITY

- Medicare is primary; SoonerCare is secondary
 - Also known as crossover claims
- OHCA pays a percentage of the coinsurance and deductible
- Claims should cross over automatically from Medicare
 - If the claims don't cross over, they can be submitted on the Provider Portal
- Do **NOT** put the Medicare payment information in the TPL field of the claim

CROSSOVER PROFESSIONAL - HEADER (DOS PRIOR TO 06/01/2016)

Submit Professional Claim: Step 1

* Indicates a required field.

Claim Type

Provider Information

This panel contains provider information.

Billing Provider ID	ID Type	Name
Zip Code	Taxonomy	SC Provider Number
Contract Code	ID Type	
Referring Provider ID	ID Type	
Ordering Provider ID	ID Type	Ordering Zip Code

Patient Information

Enter the Member ID. If Member ID is valid, the rest of the member information will populate.

*Member ID

Last Name	First Name	Middle
Birth Date		

Claim Information

Enter information applicable to the claim. If Other Insurance information needs to be entered, then Include should be selected in the Other Insurance dropdown. The Other Insurance details can be entered on Submit Step 2.

Date Type	Date of Current	
Accident Related	Expected Delivery Date	
Patient Account Number	*From Date	*To Date
CLIA Number		
*Other Insurance		

Total Charged Amount \$0.00

Medicare Crossover Details

Medicare Crossover Instructions

Allowed Medicare Amount	\$0.00	Co-insurance Amount	\$0.00
Deductible Amount	\$0.00	Psychiatric Services Amount	\$0.00
Medicare Payment Amount	\$0.00	*Medicare Payment Date	

Continue Cancel

CROSSOVER PROFESSIONAL - DETAIL (DOS 06/01/2016 AND AFTER)

Service Details

Select the row number to edit the row. Click the **Remove** link to remove the entire row.

Svc #	From Date	To Date	Place of Service	Procedure Code	Charge Amount	Units	Action
1			01-Pharmacy	0001M-INFECTIOUS DIS HCV 6 ASSAYS	\$11.00	1.00 Unit	Remove
2							

2 *From Date To Date *Place of Service EMG

*Procedure Code Modifiers *Diagnosis Pointers

Charge Amount *Units Unit Type Unit EPSDT

CLIA Number

Rendering Provider ID ID Type Zip Code Contract Code

Taxonomy

Ordering Provider ID ID Type Zip Code

NDC for Item 2

Medicare Crossover Details for Item 2

Medicare Crossover Details must be entered in this step for each Service Detail item if the From Date is on or after [Configurable Claim Parm Date]

Allowed Medicare Amount	<input type="text" value="\$0.00"/>	Co-insurance Amount	<input type="text" value="\$0.00"/>
Deductible Amount	<input type="text" value="\$0.00"/>	Psychiatric Services Amount	<input type="text" value="\$0.00"/>
Medicare Payment Amount	<input type="text" value="\$0.00"/> x	*Medicare Payment Date	<input type="text"/>

Attachments

[Back to Step 1](#) [Back to Step 2](#) [Submit](#) [Cancel](#)

Key the crossover information for this line of service only

CROSSOVER INSTITUTIONAL – PART A

Medicare Part A claims will continue to process at the header level.

Submit Institutional Claim: Step 1 ?

* Indicates a required field.

Claim Type Crossover Inpatient ▼

Provider Information

If Surgical Procedure Code(s) are to be submitted with the claim, an Operating Provider ID is required.

Billing Provider ID	0123456789	ID Type	NPI	Name	Bob SoonerCare, MD
Zip Code	Contract Code	Taxonomy	SC Provider Number	100000000D	
Institutional Provider ID	0123456789	ID Type	NPI		
Attending Provider ID	<input type="text"/>	ID Type	<input type="text" value="▼"/>		
Operating Provider ID	<input type="text"/>	ID Type	<input type="text" value="▼"/>		
Referring Provider ID	<input type="text"/>	ID Type	<input type="text" value="▼"/>		

Patient Information

Enter the Member ID. If Member ID is valid, the rest of the member information will populate.

*Member ID

Last Name	First Name	Middle
Birth Date		

Claim Information

Enter information applicable to the claim. If Other Insurance information needs to be entered, then Include should be selected in the Other Insurance dropdown. The Other Insurance details can be entered on Submit Step 2.

*Covered Dates <input type="text"/> - <input type="text"/>	Covered Days <input type="text"/>
*Admission Date/Hour <input type="text"/> (hh:mm)	Discharge Hour <input type="text"/> (hh:mm)
*Admission Type <input type="text"/>	*Admission Source <input type="text"/>
*Admitting ICD Version ICD-9-CM ▼	*Admitting Diagnosis <input type="text"/>
Patient Status <input type="text"/>	*Type of Bill <input type="text"/>
Patient Account Number <input type="text"/>	Other Insurance None ▼
Total Charged Amount \$0.00	

Medicare Crossover Details

Institutional Medicare Crossover Instructions

Deductible Amount <input type="text" value="\$0.00"/>	Co-insurance Amount <input type="text" value="\$0.00"/>
Blood Deductible Amount <input type="text" value="\$0.00"/>	*Medicare Payment Date <input type="text"/>

Continue Cancel

CROSSOVER INSTITUTIONAL – PART B

DOS prior to 06/01/2016 will process at the header level.

Submit Institutional Claim: Step 1 ?

* Indicates a required field.

Claim Type Crossover Outpatient v

Provider Information

If Surgical Procedure Code(s) are to be submitted with the claim, an Operating Provider ID is required.

Billing Provider ID 0123456789	ID Type NPI	Name Bob SoonerCare, MD	
Zip Code	Contract Code -	Taxonomy	SC Provider Number 100000000D
Institutional Provider ID 0123456789	ID Type NPI		
Attending Provider ID <input type="text"/>	ID Type <input type="text"/>		
Operating Provider ID <input type="text"/>	ID Type <input type="text"/>		
Referring Provider ID <input type="text"/>	ID Type <input type="text"/>		

Patient Information

Enter the Member ID. If Member ID is valid, the rest of the member information will populate.

*Member ID

Last Name	First Name	Middle
Birth Date		

Claim Information

Enter information applicable to the claim. If Other Insurance information needs to be entered, then Include should be selected in the Other Insurance dropdown. The Other Insurance details can be entered on Submit Step 2.

*Covered Dates <input type="text"/> - <input type="text"/>	Covered Days <input type="text"/>
*Admission Date/Hour <input type="text"/> (hh:mm)	Discharge Hour <input type="text"/> (hh:mm)
*Admission Type <input type="text"/>	*Admission Source <input type="text"/>
*Admitting ICD Version <input type="text"/>	*Admitting Diagnosis <input type="text"/>
Patient Status <input type="text"/>	*Type of Bill <input type="text"/>
Patient Account Number <input type="text"/>	Other Insurance <input type="text"/>
Total Charged Amount \$0.00	

Medicare Crossover Details

Institutional Medicare Crossover Instructions

Deductible Amount <input type="text"/>	Co-insurance Amount <input type="text"/>
Blood Deductible Amount <input type="text"/>	*Medicare Payment Date <input type="text"/>

CROSSOVER INSTITUTIONAL – PART B

Effective 06/01/2016 Part B claims will process at the detail level.

Service Details

Select the row number to edit the row. Click the **Remove** link to remove the entire row.

Svc #	Revenue Code	HCPCS/Proc Code	From Date	To Date	Units	Charge Amount	Action
<u>1</u>	0-TESTING	0001F-HEART FAILURE ASSESSED			1.00 Unit	\$11.00	Remove
2							

2 *Revenue Code HCPCS/Proc Code

Modifiers

*From Date *To Date *Units *Unit Type

Charge Amount

NDC for Item 2

Medicare Crossover Details for Item 2

Medicare Crossover Details must be entered in this step for each Service Detail item if the Covered From Date is on or after [Configurable Claim Parm Date]

Deductible Amount Co-insurance Amount

Blood Deductible Amount *Medicare Payment Date

Medicare Payment Amount

[Add](#)

Attachments

[Back to Step 1](#) [Back to Step 2](#) [Submit](#) [Cancel](#)

Key the crossover information for this line of service only



HMO CLAIM SUBMISSION

HMO CLAIM SUBMISSION

- When billing the copay, submit all lines of service and the billed amount for line one is the copay; all other lines bill zero
- Must be a payable Medicaid procedure
- The process for sending your attachment is the same as for commercial insurance; you can fax or upload your documentation
 - Make sure to use the fax cover sheet generated by the Provider Portal, if you choose Fax

MEDICARE HMO

- HMO replaces Medicare as primary; SoonerCare is secondary
- OHCA pays ONLY the copay
 - Copay limit:
 - \$200 per 1500 claim
 - \$1,000 per UB-04 claim

MEDICARE HMO, *CONT.*

- In the following situations, Medicare HMOs revert back to traditional Medicare:
 - Durable medical equipment (DME)
 - Long-term care (LTC)
 - Hospice

MEDICARE HMO, *CONT.*

- DME, LTC and Hospice claims are processed as traditional crossover claims
- To do this, you must submit a letter explaining the “non-HMO” status of payments to:

OHCA Provider Services
P.O. Box 18506
Oklahoma City, OK 73154

MEDICARE – HMO COPAY

- HMOs can be submitted on the Provider Portal
- Do NOT bill for any charges other than the copay on the claim
- Do NOT enter payment in any TPL field
- A copy of the EOB is required

MEDICARE – HMO COPAY

Step 1

Submit Professional Claim: Step 1 ?

* Indicates a required field.

Claim Type **Professional**

Provider Information

This panel contains provider information.

Billing Provider ID	0123456789	ID Type	NPI	Name	Bob SoonerCare, MD
Zip Code	Contract Code	Taxonomy	SC Provider Number	100000000D	
Referring Provider ID	<input type="text"/>	ID Type	<input type="text"/>		
Ordering Provider ID	<input type="text"/>	ID Type	<input type="text"/>	Ordering Zip Code	<input type="text"/>

Patient Information

Enter the Member ID. If Member ID is valid, the rest of the member information will populate.

*Member ID

Last Name	First Name	Middle
Birth Date		

Claim Information

Enter information applicable to the claim. If Other Insurance information needs to be entered, then Include should be selected in the Other Insurance dropdown. The Other Insurance details can be entered on Submit Step 2.

Date Type	<input type="text"/>	Date of Current	<input type="text"/>
Accident Related	<input type="text"/>	Expected Delivery Date	<input type="text"/>
Patient Account Number	<input type="text"/>	To Date	<input type="text"/>
From Date	<input type="text"/>		
CLIA Number	<input type="text"/>		
*Other Insurance	None	HMO Copay	Yes
		Total Charged Amount	\$0.00

Continue **Cancel**

MEDICARE – HMO COPAY

Step 1

Submit Institutional Claim: Step 1 ?

* Indicates a required field.

Claim Type Inpatient

Provider Information

If Surgical Procedure Code(s) are to be submitted with the claim, an Operating Provider ID is required.

Billing Provider ID 100000000D	ID Type NPI	Name Bob SoonerCare, MD	
Zip Code	Contract Code -	Taxonomy	SC Provider Number 100000000D
Institutional Provider ID <input type="text" value="0123456789"/>	ID Type NPI	ID Type ▼	
Attending Provider ID <input type="text"/>	ID Type ▼		
Operating Provider ID <input type="text"/>	ID Type ▼		
Referring Provider ID <input type="text"/>	ID Type ▼		

Patient Information

Enter the Member ID. If Member ID is valid, the rest of the member information will populate.

*Member ID

Last Name	First Name	Middle
Birth Date		

Claim Information

Enter information applicable to the claim. If Other Insurance information needs to be entered, then Include should be selected in the Other Insurance dropdown. The Other Insurance details can be entered on Submit Step 2.

* Covered Dates <input type="text"/> - <input type="text"/>	Covered Days <input type="text"/>
* Admission Date/Hour <input type="text"/> (hh:mm)	Discharge Hour <input type="text"/> (hh:mm)
* Admission Type <input type="text"/>	* Admission Source <input type="text"/>
* Admitting ICD Version ICD-9-CM	* Admitting Diagnosis <input type="text"/>
* Patient Status <input type="text"/>	* Type of Bill <input type="text"/>
Patient Account Number <input type="text"/>	Other Insurance None
HMO Copay Yes	Total Charged Amount \$0.00

Continue Cancel

MEDICARE – HMO COPAY

- Step 3: Attachment
- The process for sending your attachment is the same as for commercial insurance; you can fax or upload your documentation
 - Make sure to use the fax cover sheet generated by the Provider Portal, if you choose Fax

MEDICARE – HMO COPAY WITH ATTACHMENT

File Transfer

Attachments

Click the **Remove** link to remove the entire row.

#	Transmission Method	File	Control #	Attachment Type	Action
Click to collapse.					
	*Transmission Method	FT-File Transfer			
	*Upload File				Browse...
	*Attachment Type	OZ-Support Data for Claim			
	Description	Insurance Denial attached			





[Go to Top](#)

No attachment cover sheet required

MEDICARE – HMO COPAY WITH ATTACHMENT

Fax

Attachments

Click the **Remove** link to remove the entire row.

#	Transmission Method	File	Control #	Attachment Type	Action
Click to collapse.					
	*Transmission Method			*Attachment Type	
	FX-By Fax			OZ-Support Data for Claim	
	Description Insurance Denial attached				

Add **Cancel**

Back to Step 1 **Back to Step 2** **Submit** **Cancel**

HCA-13 attachment cover sheet required

HCA-13 Attachment Cover Sheet



Oklahoma Health Care Authority Electronic Claim Paper Attachment Form Cover Sheet

Four fields below are required and must match claim.

1. **Provider Number**
2. **Client ID Number**
3. **Attachment Control Number** 20170714366677
4. **Claim Number** 2317195600001
5. **Date/Time** 07/14/2017 11:06 AM

This form is to be used when a claim requiring a paper attachment is being submitted electronically. Submission of this completed form along with the required attachment and electronically submitted claim will allow the appropriate review process to be conducted by the OHCA.

Instructions:

1. In box 1, fill in the pay to Provider Number used for filing the electronic claim.
2. In box 2, fill in the 9-digit client identification number submitted on the electronic claim.
3. In box 3, fill in the Attachment Control Number (ACN) used for filing the electronic claim. The ACN on this form must be the same number entered in the control number field of the direct data entry (DDE) screen (Medicaid on the Web) or the PWK segment of the 837 transaction. Make sure the ACN is clear and legible on the HCA-13. Illegible information could delay or stop the attachment process. Numbers are the only characters that should be used in the ACN section. Do not use dashes or spaces in the ACN section.
4. Place this completed form on top of the attachment(s) for each electronic claim. (DO NOT INCLUDE ADDITIONAL COVER SHEET)
5. Mail to: DXC Technology
P.O. Box 18500, OKC, OK 73154
Fax: 405-947-3394

 **NOTE: Do not place another fax cover sheet on top of this form.**

 ***This form is for use with electronically filed claims requiring attachments.**

Sender's Name:

Phone Number:

This fax contains confidential information and is intended only for the individual named. If you are not the named addressee you should not disseminate, distribute or copy this fax. Please notify the sender immediately by phone if you have received this e-fax by mistake and destroy the fax you received. Fax transmissions cannot be guaranteed to be secure or error-free as information could be intercepted, corrupted, lost, destroyed, arrive late or incomplete. The sender therefore does not accept liability for any errors or omissions in the contents of this message, which arise as a result of fax transmission.



PRIVATE PAY – HMO

PRIVATE PAY – HMO COPAY

- HMO is primary; SoonerCare is secondary
- OHCA pays copay amount only
- EOB is required
- Copay limits:
 - \$200 per 1500 claim
 - \$1,000 per UB-04 claim

PRIVATE PAY – HMO COPAY (PROFESSIONAL)

Submit Professional Claim: Step 1

* Indicates a required field.

Claim Type **Professional**

Provider Information

This panel contains provider information.

Billing Provider ID	0123456789	ID Type	NPI	Name	Bob SoonerCare, MD
Zip Code		Contract Code	-	Taxonomy	
Referring Provider ID	<input type="text"/>	ID Type	<input type="text"/>	SC Provider Number	100000000D
Ordering Provider ID	<input type="text"/>	ID Type	<input type="text"/>	Ordering Zip Code	<input type="text"/>

Patient Information

Enter the Member ID. If Member ID is valid, the rest of the member information will populate.

*Member ID

Last Name	First Name	Middle
Birth Date		

Claim Information

Enter information applicable to the claim. If Other Insurance information needs to be entered, then Include should be selected in the Other Insurance dropdown. The Other Insurance details can be entered on Submit Step 2.

Date Type	<input type="text"/>	Date of Current	<input type="text"/>
Accident Related	<input type="text"/>	Expected Delivery Date	<input type="text"/>
Patient Account Number	<input type="text"/>	From Date	To Date
CLIA Number	<input type="text"/>	<input type="text"/>	<input type="text"/>
*Other Insurance	None	HMO Copay	Yes
		Total Charged Amount	\$0.00

PRIVATE PAY – HMO COPAY

Step 1

Submit Institutional Claim: Step 1 ?

* Indicates a required field.

Claim **Type**

Provider Information

If Surgical Procedure Code(s) are to be submitted with the claim, an Operating Provider ID is required.

Billing Provider ID	100000000D	ID Type	NPI	Name	Bob SoonerCare, MD
Zip Code		Contract Code	-	SC Provider Number	100000000D
Institutional Provider ID	<input type="text" value="0123456789"/>	Taxonomy		ID Type	<input type="text" value="NPI"/>
Attending Provider ID	<input type="text"/>	ID Type	<input type="text"/>	ID Type	<input type="text"/>
Operating Provider ID	<input type="text"/>	ID Type	<input type="text"/>	ID Type	<input type="text"/>
Referring Provider ID	<input type="text"/>	ID Type	<input type="text"/>	ID Type	<input type="text"/>

Patient Information

Enter the Member ID. If Member ID is valid, the rest of the member information will populate.

* Member ID

Last Name	First Name	Middle
Birth Date		

Claim Information

Enter information applicable to the claim. If Other Insurance information needs to be entered, then Include should be selected in the Other Insurance dropdown. The Other Insurance details can be entered on Submit Step 2.

* Covered Dates	<input type="text"/> - <input type="text"/>	Covered Days	<input type="text"/>
* Admission Date/Hour	<input type="text"/> (hh:mm)	Discharge Hour	<input type="text"/> (hh:mm)
* Admission Type	<input type="text"/>	* Admission Source	<input type="text"/>
* Admitting ICD Version	<input type="text" value="ICD-9-CM"/>	* Admitting Diagnosis	<input type="text"/>
* Patient Status	<input type="text"/>	* Type of Bill	<input type="text"/>
Patient Account Number	<input type="text"/>	Other Insurance	<input type="text" value="None"/>
HMO Copay	<input type="text" value="Yes"/>	Total Charged Amount	\$0.00



MEDICARE PPO

MEDICARE PPO

- PPO replaces Medicare as primary; SoonerCare is secondary
- These are processed exactly like Medicare dual eligible claims (also known as crossover claims)
- OHCA pays a percentage of the coinsurance and deductible
- If the member has a PPO and there is a copay due, the provider cannot bill the member for the copay

MEDICARE PPO – CLAIM SUBMISSION

- Provider Portal:
 - Do NOT put the Medicare payment information in any of the TPL fields
 - Put the copay amount in the deductible or coinsurance field



TPL RESOURCES

TPL RESOURCES

- www.okhca.org
- Provider Forms: www.okhca.org/forms
 - TPL-1 form
- Provider Billing Manual (chapter 14)
 - www.okhca.org/provider/billing/manual/manual.pdf
- 800-522-0114 (toll-free) or 405-522-6205
 - Option 3,2 for Third Party Liability

Questions?

