

BILLING FOR TPL

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AGENDA

- What is Third Party Liability (TPL)?
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 - TPL
- Claim Submission
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 - Attachment Cover Sheet (HCA-13)
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- Resources
- Questions

DISCLAIMER

- SoonerCare policy is subject to change.
- The information included in this presentation is current as of April 2019.
- Current information can be found on the OHCA public website:
www.okhca.org.

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 (IHS).
 - Crime victims compensation.

ELIGIBILITY

NOTICE: Member's medical benefits will end soon. Please advise them to reapply.

Effective/End dates are shown only for the period of time requested.

Verification Number 1x23sas12: Status A

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



Coverage	Effective Date	End Date
SoonerCare Choice	03/06/2018	03/06/2018
Non Emergency Transportation	03/06/2018	03/06/2018
Mental Health and Substance Abuse	03/06/2018	03/06/2018
Title 19	03/06/2018	03/06/2018

Provider Name	Provider Phone	Health Plan Name	Health Plan Phone
PCMH CLINIC	1-405-555-2000		

- EPSDT 
 - TPL 
- 

TPL

TPL 							
Click '+' to add a row.							
Carrier Name (Carrier ID)	Policy Number	Group ID (Employer ID)	Policy Holder (Relationship)	Policy Type	Coverage Type	Effective	End
BLUE ADVANTAGE ADMINISTRATORS OF AR	YABADABA2	- (-)	Fee <u>Lingbetter</u>	-	MAJOR MEDICAL	11/25/2017	12/31/2018

CLAIM SUBMISSION

EDI

ELECTRONIC DATA INTERCHANGE (EDI) SUBMISSION

If the primary payer paid:

- Under Other Subscriber Information, in loop 2320, send the SBR segment, AMT segment and IO segment with the amount paid.
 - All CAS segments at the line level.
 - No attachment is required.

EDI SUBMISSION

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

- The same procedure is followed, with 0.00 entered in the AMT segment.
 - You will then add an attachment to the claim.
 - Add PWK segment with Attachment Control Number (ACN).

EDI SUBMISSION

- 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 submitted, provider prints and completes the HCA-13 (attachment cover sheet).
- Provider faxes or mails attachments.

Attachment Cover Sheet (HCA-13)

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:

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.

PORTAL SUBMISSION PROFESSIONAL

TPL ON THE PROVIDER PORTAL

- The Other Insurance box on step 1 must have either Include if you received a payment, or Denied if you did not receive a payment.
- Any amount received from the primary insurance will be added on the TPL amount area on step 2 of the portal claim.

PRIMARY PAID

Submit Professional Claim: Step 1 ?

* Indicates a required field.

Claim Type **Professional** ▼

Provider Information

This panel contains provider information.

Billing Provider ID	11221122334	ID Type	NPI	Name	FIXEM UP MEDICINE
Zip Code	74105	Contract Code	G	Taxonomy	11221122334
Referring Provider ID	<input type="text"/>	ID Type	<input type="text"/>	SC Provider Number	100123456A
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	<input type="text"/>
CLIA Number	<input type="text"/>	To Date	<input type="text"/>
*Other Insurance	Include ▼	HMO Copay	<input type="text"/>
		Total Charged Amount	\$0.00

Continue **Cancel**



TPL AMOUNT

Submit Professional Claim: Step 2 ?

* Indicates a required field.

Claim Type Professional

Provider Information

Billing Provider ID 144739 11221122334	ID Type NPI	Name THERAP	FIXEM UP MEDICINE
Zip Code 74105	Contract Code G	Taxonomy 261QP: 11221122334	IC Provider Number 100721: 100123456A

Patient and Claim Information

Member ID B11510 812345678	Gender Male
Member TOMMIL	Total Charged Amount \$0.00
Birth Date 07/11/2010	
CLIA Number _	

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

Diagnosis Codes -

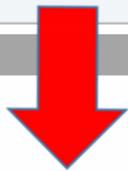
Select the row number to edit the row. Click the **Remove** link to remove the entire row.

#	ICD Version	Diagnosis Code	Action
1			

1 *ICD Version *Diagnosis Code

Other Insurance Details -

TPL Amount



TPL ON THE PORTAL

- If you were denied payment then the EOB from the primary must be submitted with your claim.

PRIMARY DENIED

Submit Professional Claim: Step 1 ?

* Indicates a required field.

Claim Type

Provider Information

This panel contains provider information.

Billing Provider I	11221122334	ID Type	NPI	Nam	FIXEM UP MEDICINE
Zip Code	74105	Contract Code	G	Taxonomy	11221122334
Referring Provider ID	<input type="text"/>	ID Type	<input type="text"/>	SC Provider Numbe	100123456A
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	812345678	First Nam	Fee	Middle	
Last Nam	Lingbetter				
Birth Date	07/11/2010				

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="Denied"/>	HMO Copay	<input type="text" value="No"/>
		Total Charged Amount	\$0.00

Continue **Cancel**



ADDING ATTACHMENTS

Submit Professional Claim: Step 3 ?

* Indicates a required field. 11221122334 **Claim Type** Professional 11221122334 **FIXEM UP MEDICINE**
100123456A

Provider Information

Billing Provider I	B12345678	ID Type	NPI	Name	THERAPYSOURCE FOR KIDS INC		
Zip Code	74105	Contract Code	G	Taxonomy	261QP2000X	SC Provider Number	100721380 A

Patient and Claim Information

Member ID	B11510297	Gender	Male
Member	TOMMIE AUTEN	Total Charged Amount	_
Birth Date	07/11/2010		
CLIA Number	_		

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

Diagnosis Codes +

Service Details +

Attachments -

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

#	Transmission Method	File	Control #	Attachment Type	Action
+ Click to add attachment.					

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

NOTE: Attachments work the same for all claim types.

ADDING ATTACHMENTS

- File Transfer is the default setting and is the preferred method by OHCA.
- You can change the type to Fax or Mail and then the system will generate a cover sheet specific for that claim.

INSURANCE DENIED

Attachments

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

#	Transmission Method	File	Control #
<input type="checkbox"/> Click to collapse.			
	*Transmission Method	FT-File Transfer	
	*Upload File	<input type="text" value="Browse..."/>	
	*Attachment Type	77-Support Data for Verification	
	Description	Primary Insur denial attached	

Choose File to Upload

Libraries

Documents Library

Music Library

Pictures Library

Videos

File name: All Files (*.*)

FAX ATTACHMENT

[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**

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** 100000000D
2. **Client ID Number** 001122334
3. **Attachment Control Number** 2001070899555
4. **Claim Number** 2310001111111
5. **Date/Time** 7/15/2015 9:41 AM

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 that will be used for filing the electronic claim.
2. In box 2, fill in the nine-digit client identification number that was submitted on the electronic claim.
3. In box 3, fill in the fill in the Attachment Control Number (ACN) that was used for filing the electronic claim. The ACN on this form must be the same number as the assigned control number field of the SoonerCare Portal 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. Alphabetic and numeric are the only characters that should be used in the ACN selection. Do not use dashes and spaces in the ACNs.
4. In box 4, fill in the identification number that was assigned to the electronically submitted claim.
5. Place the completed form on top of the attachment(s) for each electronic claim.
6. Mail to EDS, P.O. Box 18500 OKC, OK 73154, fax 405-947-3394

Note: Do not place another Fax Cover Sheet on top.
***This form is for use with electronically filed claims requiring attachments.**

Sender's Name: _____ **Phone Number:** _____

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OKLA HCA
Revised 06/24/09

HCA-13

Print

Close

HOM COPAY

- On step 1 click the HMO Copay button and choose Yes.

HMO COPAY

Submit Professional Claim: Step 1 ?

* Indicates a required field.

Claim Type

Provider Information

This panel contains provider information.

Billing Provider ID	11221122334	ID Type	11221122334	Name	FIXEM UP MEDICINE
Zip Code	74105	Contract Code	G	Taxonomy	261QP2000X
Referring Provider ID	<input type="text"/>	ID Type	<input type="text"/>	SC Provider Number	100123456A
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	<input type="text"/>	First Name	<input type="text"/>	Middle	<input type="text"/>
Birth Date	<input type="text"/>				

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"/>
From Date	<input type="text"/>	To Date	<input type="text"/>
CLIA Number	<input type="text"/>		
*Other Insurance	<input type="text" value="None"/>	HMO Copay	<input type="text" value="Yes"/>

Total Charged Amount \$0.00



PORTAL SUBMISSION INSTITUTIONAL

COMMERCIAL INSURANCE (INSTITUTIONAL)

Submit Institutional Claim: Step 1 ?

* Indicates a required field.

Step 1—Primary Paid

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		Name	Bob SoonerCare, MD
Zip Code		Contract Code	_	Taxonomy	207V00000X
Institutional Provider ID	<input type="text" value="0123456789"/>	ID Type	<input type="text" value="NPI"/>	SC Provider Number	100000000D
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	<input type="text"/>	First Name	<input type="text"/>	Middle	<input type="text"/>
Birth Date	<input type="text"/>				

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

Continue **Cancel**

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.

Step 1—Primary Denied

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		Taxonomy		SC Provider Number	100000000D
Institutional Provider ID	<input type="text"/>	ID Type	<input type="text" value="NPI"/>		
Attending Provider ID	<input type="text" value="0123456789"/>	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

INSTITUTIONAL CLAIM – HMO COPAY

Submit Institutional Claim: Step 1 ?

* Indicates a required field.

Claim Type

Step 1—HMO Copay

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 Cod		Contract Code	_	SC Provider Number	100000000D
Institutional Provider ID	0123456789	Taxonomy			
Attending Provider ID	<input type="text"/>	ID Type	<input type="text" value="NPI"/>		
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="None"/>
HMO Copay <input type="text" value="Yes"/>	Total Charged Amount \$0.00

Continue **Cancel**

RESOURCES

RESOURCES

- OHCA Public Site: www.okhca.org
- OHCA Provider Forms: www.okhca.org/forms
 - TPL-1 form
- Billing Manual (Chapter 14)
 - www.okhca.org/provider/billings/manual/manual.pdf
- OHCA Provider Helpline
 - 800-522-0114 (toll free) or 405-522-6205 (OKC area)
 - Option 3,2 for Third Party Liability

RESOURCES

- Onsite visits: soonercareeducation@okhca.org