

ADJUSTMENTS AND THIRD PARTY LIABILITY

2015 Fall Provider Training



DISCLAIMER

SoonerCare policy is subject to change

The information provided in this presentation is
current as of August 1, 2015



AGENDA

Adjustments

- Rules
- What is an adjustment?
- When and why
- How to request an adjustment
- Internal Control Number (ICN) logic
- Refunds
- Resources



AGENDA

Third Party Liability (TPL)

- What is TPL?
- HMOs and PPOs
- When to bill a member
- Can a TPL edit be bypassed?
- HMS and the recovery process
- Resources
- Questions



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ADJUSTMENTS



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RULES

OHCA 317:30-3-12

- “When an overpayment has occurred, the provider should immediately refund the Authority, by check, to the attention of the Finance Division.”
- Request for recoupment is accepted in place of a refund
- Wait until payment is received by OHCA



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RULES

42 CFR Part 433.312

- The state must refund the federal share of all overpaid claims to CMS within one (1) year of discovery of an overpayment
- "...whether or not the state has recovered the overpayment from the provider."



ADJUSTMENTS

What is an adjustment?

- Changes to a paid claim
- Overpayment
 - Negative adjustment — OHCA will recoup money paid in error
- Underpayment
 - Positive adjustment — OHCA will pay in addition to amount originally paid
- Correction of data not affecting payment



ADJUSTMENTS

Common adjustment reasons:

- Requested by provider
- Primary insurance coverage (TPL)
- Medicare primary
- Audits
 - State-contracted auditors are paid a flat rate, not a percentage of the recoupment
 - State-employed auditors are salaried only
- System issues



ADJUSTMENTS

There are two (2) types of adjustments:

- **Partial**
 - Claim shows to be in PAID status
 - OHCA recovers only part of the original payment or makes an additional payment
- **Full**
 - Claim shows to be in DENIED status
 - The full original payment is recouped
 - Claim can remain in PAID status if the recoupment is due to a TPL



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ADJUSTMENTS

How to request an adjustment:

- Telephone requests cannot be processed
- The proper form must be completed, and the appropriate paperwork must be attached
 - HCA-14
 - UB-04, Inpatient/Outpatient crossover claims
 - HCA-15
 - 1500, Dental and Part B crossover claims
 - Pharm-3
 - Pharmacy claims



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ADJUSTMENTS – REFUNDS

Reasons to refund OHCA:

- Billing error
- Medicare primary
- TPL – primary insurance carrier

Refunds vs. Recoupments:

- **Refunds** balance the account immediately
- **Recoupments** come out of future payments



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ADJUSTMENTS – REFUNDS

When sending a refund to OHCA, the following must be sent with the refund:

- Adjustment request form
 - HCA-14, HCA-15 or Pharm-3
- Remittance advice (RA)
 - Specific claim circled or highlighted in yellow
- Insurance EOB or Medicare EOB
- Payment
 - Ensure the accuracy of the amount being refunded



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ADJUSTMENTS – REFUNDS

SoonerCare is the payer of last resort:

- Amount to refund – TPL
 - If a TPL reimburses you *more* than the SoonerCare allowable, you are required to refund the full reimbursement to OHCA
 - When a TPL reimburses you *less* than the SoonerCare allowable, you should refund OHCA the amount paid to you by the TPL



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ADJUSTMENTS – REFUNDS

SoonerCare is the payer of last resort:

- Amount to refund – Medicare
 - When Medicare is the primary payer, the full OHCA reimbursement to you should be returned to OHCA
 - The claim should be resubmitted as a Medicare crossover claim to have it paid correctly



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COMPLETING THE HCA-14 FOR AN ADJUSTMENT/ REFUND

Mailing address:
 OHCA – Adjustments
 4345 N. Lincoln Blvd.
 Oklahoma City, OK
 73105

Oklahoma HealthCare Authority
LIBS3 AND INPATIENT/OUTPATIENT CROSSOVER ADJUSTMENT REQUEST
Mail completed requests to: OHCA - Adjustments, 4345 N. Lincoln, Oklahoma City, OK, 73105

(1) PROVIDER NUMBER: _____
 PROVIDER NAME/ADDRESS: _____
 PHONE NUMBER: _____
 CONTACT PERSON: _____

(2) REASON FOR ADJUSTMENT: (Check appropriate Box)
 Change TPL Amt. Change Patient LIABILITY (Attach all EOMB's that apply)
 Offset or Refund of entire claim amount (check block 18)
 Change information as indicated in blocks 13-16
 Medicare Adjustment (Attach all EOMB's that apply to this adjustment)

(3) CLAIM NUMBER (ICN): _____ (4) CLIENT ID NO.: _____ (5) DATE OF SERVICE: From: _____ To: _____
 (6) CLIENT NAME: _____ (7) AMOUNT PAID: _____ (8) REPAYMENT ADVICE DATE: _____

(9) TYPE OF ADJUSTMENT (10) CLAIM TYPE (11) MEDICAID PROGRAM
 Underpayment Adjustment Inpatient Fee for Service
 Overpayment Adjustment (Deduct from future payments) Outpatient SoonerCare Choice
 Refund Adjustment (Check attached) Long Term Care SoonerCare Plus
 Check number: _____ Home Health Crossover

(12) GIVE COMPLETE EXPLANATION OF ADJUSTMENT OR REFUND REQUEST:

LIST THE INFORMATION TO BE CORRECTED IN THE BLOCKS BELOW. IF NO LINE NO. IS ASSOCIATED WITH THE CORRECTION, ENTER A ZERO (0) IN THE LINE NUMBER FIELD. (a.e. TPL APPLIED WOULD ALWAYS BE LINE # 0.)

(13) REVERSE CODE	(14) DESCRIPTION OF INFORMATION TO BE CORRECTED	(15) CURRENT INFORMATION	(16) CORRECTED INFORMATION

(17) SIGNATURE: _____ (18) DATE: _____
Mail Refunds to: OHCA - Finance, P.O. Box 18299, Oklahoma City, OK, 73154-0299
 OHCA Revised 03/14/2014 HCA-14 (p1)

COMPLETING THE HCA-15 FOR AN ADJUSTMENT/ REFUND

Mailing address:
 OHCA – Adjustments
 4345 N. Lincoln Blvd.
 Oklahoma City, OK
 73105

Oklahoma HealthCare Authority
CHS-1505, DENTAL, CROSSOVER PART B PAID CLAIM ADJUSTMENT REQUEST
Mail completed requests to: OHCA - Adjustments, 4345 N. Lincoln Blvd., Oklahoma City, OK, 73105
 Mail Refunds to: OHCA- Finance, P.O. Box 18299, Oklahoma City, OK, 73154-0299

(1) PROVIDER NUMBER: _____
 PROVIDER NAME/ADDRESS: _____
 PHONE NUMBER: _____
 CONTACT PERSON: _____

(2) REASON FOR ADJUSTMENT: (Check appropriate Box)
 Change TPL Amt. (Attach all EOMB's that apply)
 Offset or Refund of entire claim amount (check block 18)
 Change information as indicated in blocks 13-16
 Medicare Adjustment (Attach all EOMB's that apply to this adjustment)

(3) CLAIM NUMBER (ICN): _____ (4) CLIENT ID NO.: _____ (5) DATE OF SERVICE: From: _____ To: _____
 (6) CLIENT NAME: _____ (7) AMOUNT PAID: _____ (8) REPAYMENT ADVICE DATE: _____

(9) GIVE COMPLETE EXPLANATION OF ADJUSTMENT OR REFUND REQUEST:

(10) TYPE OF ADJUSTMENT (11) CLAIM TYPE (12) MEDICAID PROGRAM
 Underpayment Adjustment Dental Fee for Service
 Overpayment Adjustment (Deduct from future payments) Crossover SoonerCare
 Refund Adjustment (Check attached) CHS-1505

Check number: _____

LIST THE INFORMATION TO BE CORRECTED IN THE BLOCKS BELOW. IF NO LINE NO. IS ASSOCIATED WITH THE CORRECTION, ENTER A ZERO (0) IN THE LINE NUMBER FIELD. (a.e. TPL APPLIED WOULD ALWAYS BE LINE # 0.)

(13) LINE NO.	(14) DESCRIPTION OF INFORMATION TO BE CORRECTED	(15) CURRENT INFORMATION	(16) CORRECTED INFORMATION

(17) SIGNATURE: _____ (18) DATE: _____
OHCA Revised 08/03/2014 HCA-15 (p1)

COMPLETING THE PHARM-3 FOR AN ADJUSTMENT/ REFUND FOR A PRESCRIPTION CLAIM

STATE OF OKLAHOMA
 OKLAHOMA HEALTH CARE AUTHORITY
PHARMACY PAID CLAIM ADJUSTMENT REQUEST

List no more than 10 claims per request

(1) PROVIDER NUMBER: _____
 PROVIDER NAME/ADDRESS: _____
 PHONE NUMBER: _____
 CONTACT PERSON: _____

Mail completed adjustment request forms to:
 OHCA - Adjustments
 4345 N. Lincoln Blvd.
 Oklahoma City, OK 73105
Mail Refunds to: OHCA - Finance, P.O. Box 18299, Oklahoma City, OK, 73154-0299

(2) MEDICAID PROGRAM (3) TYPE OF ADJUSTMENT
 Fee for Service Underpayment Adjustment
 SoonerCare Overpayment Adjustment (Deduct from future payments)
 Refund Adjustment (Check attached)
 Check number: _____

Complete blocks 4 - 10 for each Pharmacy claim to be adjusted. If all information is not complete, this request will be returned.

(4) CLAIM NUMBER (ICN)	(5) CLIENT ID NO.	(6) DATE DISPENSED	(7) AMOUNT PAID	(8) CURRENT INFORMATION	(9) CORRECTED INFORMATION	(10) EXPLANATION OF ADJUSTMENT

(11) SIGNATURE: _____ (12) DATE: _____
 OHCA Revised 04/23/2014 PHARM-3 (p1)

Mailing address: OHCA – Adjustments
 4345 N. Lincoln Blvd.
 Oklahoma City, OK 73105

PROVIDER PORTAL - VOIDING A CLAIM



View Professional Claim - ID: 100000103 Back to Search Results

Claim Type: Professional

Provider Information

Billing Provider ID	Contract Code	ID Type	NPI	Name
Zip Code		Telemetry	SC Provider Number	
Referring Provider ID		ID Type		Name
Service Facility Location ID		ID Type		Name
Ordering Provider ID		ID Type		Ordering Zip Code

Patient Information

Member ID 1	Member	Gender
	Birth Date	

Claim Information

Claim Status	Paid	Paid Date	03/27/2013
Date Type		Date of Current	
Accident Related		Admission Date	
Patient Account Number		Expected Delivery Date	03/21/2013
From Date	03/22/2013	To Date	03/22/2013
CLIA Number			
Adjusted Claim ICD			

Total Charged Amount: \$25.00

Diagnosis Codes Expand All | Collapse All

Seq #	From Date	To Date	Place of Service	EMG	Procedure Code	Mod	Diag Code Prio	Charge Amount	Units	EPSDT	Rendering Provider ID
1	03/22/2013	03/22/2013	11		99213		L	\$25.00	1.000 Unit		

Attachments

No Adjudication Errors exist for this claim.
No Other Insurance Details exist for this claim.



View Professional Claim - ID: 100000103 Back to Search Results

Claim Type: Professional

Provider Information

Billing Provider ID	Contract Code	ID Type	NPI	Name
Zip Code		Telemetry	SC Provider Number	
Referring Provider ID		ID Type		Name
Service Facility Location ID		ID Type		Name
Ordering Provider ID		ID Type		Ordering Zip Code

Patient Information

Member ID	Member	Gender
	Birth Date	

Claim Information

Claim Status	Paid	Paid Date	03/27/2013
Date Type		Date of Current	
Accident Related		Admission Date	
Patient Account Number		Expected Delivery Date	03/21/2013
From Date	03/22/2013	To Date	03/22/2013
CLIA Number			
Adjusted Claim ICD			

Total Charged Amount: \$25.00

Diagnosis Codes Expand All | Collapse All

Seq #	From Date	To Date	Place of Service	EMG	Procedure Code	Mod	Diag Code Prio	Charge Amount	Units	EPSDT	Rendering Provider ID
1	03/22/2013	03/22/2013	11		99213		L	\$25.00	1.000 Unit		

Attachments

No Adjudication Errors exist for this claim.
No Other Insurance Details exist for this claim.



Search Claims

Medical/Dental | Pharmacy

A minimum one field is required. Either Paid Date or Service From and To Date are required fields for the search when claim information is not entered.

Claim Information
 Claim ID _____ Patient Account Number _____

Member Information
 Member ID _____

Service Information
 Rendering Provider ID # _____ ID Type# _____ Claim Type _____
 Service From# 12/28/2012 To# 03/26/2013 Claim Status _____
 Paid Date# _____

Search [] Void []

Search Results

To see service line information, or to view a remittance advice or request an advice, click on the "+" next to the claims ID.

Total Records: 15

Claim ID	Claim Type	Claim Status	Service Date #	Member ID	Patient Acct Number	Rendering Provider ID	Medicaid Paid Amount	Paid Date	Member Responsibility
1000000103	Dental	Suspended	03/26/2013	11			\$0.00	-	
1000000105	Dental	Paid	03/26/2013	1			\$0.00	-	
1000000103	Professional	Paid	03/22/2013	1			\$0.00	-	
1000000085	Home Health	Paid	01/28/2013	1			\$0.00	-	

Confirmation

Your Professional Claim ID 200000012 was successfully voided.

OK



Claim Type Professional

Provider Information

Billing Provider ID	ID Type	NP1	Name
Zip Code	Contract Code	Taxonomy	SC Provider Number
Referring Provider ID	ID Type	NP1	Name
Service Facility Location ID	ID Type		Name
Ordering Provider ID	ID Type		Ordering Zip Code

Patient Information

Member ID	Member	Gender
Birth Date		

Claim Information

Claim Status	Paid	Paid Date	02/14/2013
Voided By ID	johnm	Voided By Name	Clerk JOHN
Date Type	-	Date of Care	-
Accident Related	-	Admission Date	-
Patient Account Number	-	Expected Delivery Date	-
From Date	01/27/2013	To Date	01/27/2013
CLA Number	-		
Adjusted Claim ICN	-		

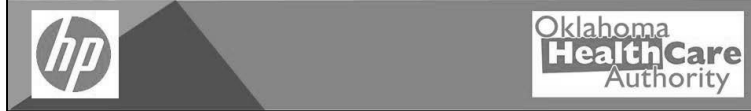
Does the provider have a signature on file? Yes

Does the provider accept assignment for claim processing? Yes

Are benefits assigned to the provider by the patient or their authorized representative? Yes

Does the provider have a signed statement from the patient releasing their medical information? Yes

Total Charged Amount \$234.00



INTERNAL CONTROL NUMBER (ICN) LOGIC

What is an ICN and what information does it provide?



ICN – INTERNAL CONTROL NUMBER

Logical format:

- Region code
- Year of submission
- Julian date
- Claims processing sequence

Example: 2214001123456

- 22 – Region code
- 14 – Year submitted
- 001 – Julian date
- 123456 – 6-digit claims processing sequence #



ICN LOGIC – REGION CODES

- 10 — Paper claim
- 11 — Paper claim with attachment
- 20 — Electronic claim (Electronic Data Interchange)
- 21 — Electronic claim with attachment
- 22 — Web submission (Direct Data Entry)
- 23 — Web submission with attachment
- 49 — Recipient linked adjustment
- **50s — Adjustments**
- **59 — Provider voided claim on the portal**
- **60s — HMO copay adjustments**
- 90s — Special processed claims
- 92 — HMO copay claims submitted on paper
- 94 — HMO copay claims submitted on the Provider Portal

ICN LOGIC – REGION CODES

Region codes 50-65 – Adjustments

- 50 — Partial adjustment – recoupment or pay out
- 51 — Partial adjustment – refund
- 52 — Mass adjustment
- 55 — Mass rate adjustment
- 56 — Full void – recoupment
- 57 — Full void – refund
- **59 — Provider voided claim**
- **64 — HMO copay adjustment with refund**
- **65 — HMO copay adjustment without refund**



RESOURCES – WHERE TO LOOK FOR HELP

OHCA Adjustment Unit

800-522-0114 or 405-522-6205

- Option 3, 1
- Adjustments – Amy Whiteley
- Refunds – Tonya Martin

OHCA Call Center

800-522-0114 (toll-free) or 405-522-6205

- Option 1



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THIRD PARTY LIABILITY (TPL)



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WHAT IS TPL?

TPL – Third Party Liability

- Another party is responsible for paying health care costs prior to (and sometimes after) SoonerCare
- SoonerCare is the payer of last resort, with exceptions
 - All other available third party resources must meet their legal obligation to pay claims before the Medicaid program pays for the care of an individual eligible for SoonerCare



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TPL – THIRD PARTY LIABILITY

How does OHCA determine a member's TPL?

- Providers, members and HMS notify OHCA if a member has TPL or if the policy has terminated
- HMS does data matches with the insurance carriers to verify the coverage start and end dates



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TPL – THIRD PARTY LIABILITY

TPL and the Medical Home (SoonerCare Choice)

Effective 7/1/2014:

- Policy was amended to make individuals with other forms of creditable health insurance coverage ineligible for SoonerCare Choice
- Additionally, members currently enrolled in SoonerCare Choice who have or gain other forms of creditable insurance will be unenrolled from SoonerCare Choice



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TPL EXAMPLES

- Medicare
- Private health insurance
- TRICARE
- Casualty/Tort settlements
- Worker's compensation



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TPL EXAMPLES

- To access a list of TPL carriers (including carrier name, code, address, telephone and contact, if available) and a list of private pay HMO Medicare replacement policies, go to:
 - www.okhca.org
 - Providers>Claim Tools>Third Party Liability
 - www.okhca.org/TPL



TPL – 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



1500 CROSSOVER INFORMATION

Claim Type: Crossover Professional

Provider Information

General Provider Header Instructions

Billing Provider ID	Contract Code	ID Type	HPI	Name
Referring Provider ID		Taxonomy		SC Provider Number
Service Facility Location ID		ID Type		Name
Ordering Provider ID		ID Type		Name
		ID Type		Ordering Zip Code

Patient Information

General Patient Instructions

*Member ID

Last Name First Name Middle

Birth Date

Claim Information

Claim Header Instructions

Date Type

Accident Related

Patient Account Number

From Date

ELIA Number

*Other Insurance

Date of Current

Admission Date

Expected Delivery Date

To Date

*Does the provider have a signature on file? Yes No

*Does the provider accept assignment for claim processing? Yes No Clinical Lab Services Only

*Are benefits assigned to the provider by the patient or their authorized representative? Yes No N/A

*Does the provider have a signed statement from the patient indicating their medical information? Yes No

Total Charged Amount \$0.00

Medicare Crossover Details

Medicare Crossover Instructions

Allowed Medicare Amount

Deductible Amount

Medicare Payment Amount

Co-insurance Amount

Psychiatric Service Amount

*Medicare Payment Date

Continue Cancel

UB-04 CROSSOVER INFORMATION

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	Contract Code	ID Type	HPI	Name
Zip Code		Taxonomy		SC Provider Number
Institutional Provider ID		ID Type		
Attending Provider ID		ID Type		
Operating Provider ID		ID Type		
Referring Provider ID		ID Type		

Medicare Crossover Details

Institutional Medicare Crossover Instructions

Deductible Amount 75.00

Blood Deductible Amount

Co-insurance Amount 25.00

*Medicare Payment Date 01/21/2012

Continue Cancel

TPL - MEDICARE HMO



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
- In the following situations, Medicare HMOs revert back to traditional Medicare:
 - Durable Medical Equipment (DME)
 - Long-Term Care (LTC)
 - Hospice



MEDICARE HMO

- Blue Cross Medicare Advantage
- AARP Medicare Complete – Secure Horizons
- Generations Healthcare Classic
- Coventry Advantage
- Humana Gold Plus
- Aetna Medicare Value Plan
- Arcadian Health Plans
- Community Care Senior
- Select Care of Oklahoma/Tribute



MEDICARE HMO – MENTAL HEALTH PLANS

- APS
- EverCare
- United Behavioral Health



MEDICARE HMO

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



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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



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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	
Referring Provider ID		ID Type		SC Provider Number	1000000000
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		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		Date of Current	
Accident Related		Expected Delivery Date	
Patient Account Number		From Date	
CLIA Number		To Date	
*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:

Provider Information

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

Billing Provider ID: 1000000000 ID Type: NPI Name: Bob SoonerCare, MD
 Zip Code: Contract Code: Taxonomy: SC Provider Number: 1000000000
 Institutional Provider ID: 0123456789 ID Type: NPI
 Attending Provider ID: ID Type:
 Operating Provider ID: ID Type:
 Referring Provider ID: 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: Covered Days:
 *Admission Date/Hour: Discharge Hour:
 *Admission Type: *Admission Source:
 *Admitting ICD Version: *Admitting Diagnosis:
 *Patient Status: *Type of Bill:
 Patient Account Number: Other Insurance: None
 HMO Copay: Yes

Total Charged Amount: \$0.00

MEDICARE – HMO COPAY

Step 3: Attachment

- When billing for the copay, only submit one (1) line of service with the amount of the copay
- 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: <input type="button" value="Browse"/>				
	*Attachment Type: OZ-Support Data for Claim				
	Description: Insurance Denial attached				
	<input type="button" value="Add"/> <input type="button" value="Cancel"/>				
	<input type="button" value="Back to Step 1"/> <input type="button" value="Back to Step 2"/>			<input type="button" value="Submit"/> <input type="button" value="Cancel"/>	

Note: A callout box points to the Attachment Type field with the text: "No attachment cover sheet required"

[Go to Top](#)

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	FX-By Fax		*Attachment Type	
		OZ-Support Data for Claim			
	Description	Insurance Denial attached			
<div style="border: 1px solid black; padding: 2px; display: inline-block;">Attachment cover sheet required</div>					
<input type="button" value="Add"/> <input type="button" value="Cancel"/>					
<input type="button" value="Back to Step 1"/> <input type="button" value="Back to Step 2"/> <input type="button" value="Submit"/> <input type="button" value="Cancel"/>					

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** 100000000
2. **Client ID Number** 001122334
3. **Attachment Control Number** 2001070899555
2310001111111
4. **Claim Number** 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 OCHA.

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 PWC 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:** _____

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 fax by mistake and delete the fax you received. Fax transmissions cannot be guaranteed to be secure or error-free and information may be intercepted, modified, late, destroyed, arrive late or incomplete. The sender therefore does not accept liability for any errors or omissions in the contents of this message, which may be a result of fax transmission.

OKLA HCA Revised 06/24/09 HCA-13

MEDICARE – HMO COPAY

Paper Submission

- HMO claims can be sent to:
HP Administrative Services
P.O. Box 18500
Oklahoma City, OK 73154
- HMO claims submitted on paper that have been processed correctly have an ICN number that begins with **92**
- Do **NOT** bill for any charges other than the copay on the claim
- Do **NOT** enter payment in any TPL field
- HMOs are also available on the Provider Portal



TPL – MEDICARE PPO



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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



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MEDICARE PPO

- Blue Cross Medicare Advantage Choice
- Coventry Freedom
- Humana Choice
- Today's Options Premier
- Lovelace Medicare Plan of Oklahoma



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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



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MEDICARE PPO – CLAIM SUBMISSION

Paper claim submission

- Write “crossover claim” at the top of the claim
- Must include HCA-28 form
- Do NOT put the Medicare payment on the claim form
- EOB not required



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TPL – PRIVATE PAY HMO



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HealthCare
Authority

PRIVATE PAY HMO

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



PRIVATE PAY HMO

- Aetna U.S. Healthcare
- BlueLincs HMO
- Community Care HMO
- Global Health
- PacifiCare of Oklahoma



PRIVATE PAY – 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	
Referring Provider ID		ID Type		SC Provider Number	1000000000
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		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		Date of Current	
Accident Related		Expected Delivery Date	
Patient Account Number		From Date	
CLIA Number		To Date	
*Other Insurance	None	HMO Copay	Yes
		Total Charged Amount	\$0.00

Continue Cancel

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: 1000000000 ID Type: NPI Name: Bob SoonerCare, MD
 Zip Code: Contract Code: Taxonomy: SC Provider Number: 1000000000
 Institutional Provider ID: 0123456789 ID Type:
 Attending Provider ID: ID Type:
 Operating Provider ID: ID Type:
 Referring Provider ID: 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: - Covered Days:
 *Admission Date/Hour: (hh:mm) Discharge Hour: (hh:mm)
 *Admission Type: *Admission Source:
 *Admitting ICD Version: *Admitting Diagnosis:
 *Patient Status: *Type of Bill:
 Patient Account Number: Other Insurance:
 HMO Copay: Total Charged Amount: \$0.00

PRIVATE PAY – HMO COPAY

Step 3: Attachment

- When billing for the copay, only submit one (1) line of service with the amount of the copay
- The process for sending your attachment is the same as for the 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



PRIVATE PAY – 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			*Attachment Type: OZ-Support Data for Claim	<input type="button" value="Browse"/>
	*Upload File:	Description: Insurance Denial attached			
	<input type="button" value="Add"/> <input type="button" value="Cancel"/>				
<input type="button" value="Back to Step 1"/> <input type="button" value="Back to Step 2"/> <input type="button" value="Submit"/> <input type="button" value="Cancel"/>					

Note: A callout box points to the Attachment Type field with the text: "No attachment cover sheet required"

[Go to Top](#)

PRIVATE PAY – 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	FX-By Fax		*Attachment Type	
				OZ-Support Data for Claim	
	Description	Insurance Denial attached			
<div style="border: 1px solid black; padding: 2px; display: inline-block;">Attachment cover sheet required</div>					
<input type="button" value="Add"/> <input type="button" value="Cancel"/>					
<input type="button" value="Back to Step 1"/> <input type="button" value="Back to Step 2"/> <input type="button" value="Submit"/> <input type="button" value="Cancel"/>					

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** 2001070899655
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: _____

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 fax by mistake and delete the fax you received. Fax transmissions cannot be guaranteed to be secure or error-free as information may be intercepted, disclosed, 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 may be a result of fax transmission.

OKLA HCA
Revised 06/24/09 HCA-13

PRINT EMAIL

PRIVATE PAY – HMO COPAY

Paper Submission

- HMO claims can be sent to:
HP Administrative Services
P.O. Box 18500
Oklahoma City, OK 73154
- HMO claims submitted on paper that have been processed correctly will have an ICN number that begins with **92**
- Do **NOT** bill for any charges other than the copay on the claim
- Do **NOT** enter payment in any TPL field
- HMOs are also available on the Provider Portal



TPL – PRIVATE PAY PPO



PRIVATE PAY PPO – 1500

Claims can be submitted on the Provider Portal

- If the primary pays, choose **Include** from Other Insurance drop-down menu

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 ⁰	<input type="text"/>
Accident Related	<input type="text"/>		
Patient Account Number	<input type="text"/>	Expected Delivery Date ⁰	<input type="text"/>
From Date	<input type="text"/>	To Date	<input type="text"/>
CLIA Number	<input type="text"/>		
*Other Insurance	<input type="text" value="Include"/>		
Total Charged Amount \$0.00			

PRIVATE PAY PPO – UB-04

Claims can be submitted on the Provider Portal

- If the primary pays, choose **Include** from Other Insurance drop-down menu

Claim Information

Claim Header Instructions

*Covered Dates ⁰	<input type="text" value="01/05/2013"/> - <input type="text" value="01/10/2013"/>	Covered Days	<input type="text" value="5"/>
*Admission Date/Hour ⁰	<input type="text" value="01/05/2013"/> - <input type="text" value="07:30"/> (hh:mm)	Discharge Hour ⁰	<input type="text" value="05:00"/> (hh:mm)
*Admission Type ⁰	<input type="text" value="1-Emergency"/>	*Admission Source ⁰	<input type="text" value="1-Physician Referral"/>
*Admitting ICD Version	<input type="text" value="ICD-9-CM"/>	*Admitting Diagnosis ⁰	<input type="text" value="4251-HYPERTROPHIC OBSTRUCTIVE CARDIOPATHY"/>
*Patient Status ⁰	<input type="text" value="01-Patient Discharged"/>	*Type of Bill	<input type="text" value="111"/>
Patient Account Number	<input type="text"/>	Other Insurance	<input type="text" value="Include"/>
*Does the provider accept assignment for claim processing?		<input checked="" type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Clinical Lab Service	
*Are benefits assigned to the provider by the patient or their authorized representative?		<input checked="" type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A	

PRIVATE PAY – PPO

If the primary insurance denies or applies the claim to deductible, choose **Denied** from Other Insurance drop-down menu

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

Patient Account Number Expected Delivery Date

From Date To Date

CLIA Number

*Other Insurance **Denied** Denied ←

Total Charged Amount \$0.00

UB-04 Carrier Denied

1500 Carrier Denied

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 - Covered Days

Admission Date/Hour (hh:mm) Discharge Hour (hh:mm)

*Admission Type *Admission Source

Admitting ICD Version *Admitting Diagnosis

*Patient Status *Type of Bill

Patient Account Number Other Insurance **Denied** Denied ←

Total Charged Amount \$0.00

PRIVATE PAY – PPO 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 <input type="text" value="FT-File Transfer"/>					
*Upload File <input type="button" value="Browse"/>					
*Attachment Type <input type="text" value="OZ-Support Data for Claim"/>					
Description Insurance Denial attached					
<input type="button" value="Add"/> <input type="button" value="Cancel"/>					
<input type="button" value="Back to Step 1"/> <input type="button" value="Back to Step 2"/> <input type="button" value="Submit"/> <input type="button" value="Cancel"/>					

[Go to Top](#)

No attachment cover sheet required

PRIVATE PAY – PPO COPAY WITH ATTACHMENT

Fax

Attachments

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#	Transmission Method	File	Control #	Attachment Type	Action
Click to collapse.					
*Transmission Method <input type="text" value="FX-By Fax"/>					
*Attachment Type <input type="text" value="OZ-Support Data for Claim"/>					
Description Insurance Denial attached					
<input type="button" value="Add"/> <input type="button" value="Cancel"/>					
<input type="button" value="Back to Step 1"/> <input type="button" value="Back to Step 2"/> <input type="button" value="Submit"/> <input type="button" value="Cancel"/>					

Attachment cover sheet required

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Cover Sheet

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3. Attachment Control Number 2001070899555
4. Claim Number 2310001111111
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OKLA HCA
Revised 05/24/09

HCA-13

Print Close

CHANGES TO 1500 CLAIM FORM

14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (M/P) MM DD YY				15. OTHER DATE QUAL: MM DD YY				16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY			
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE QUAL: 17a. NPI				17b. NPI				18. HOSPITAL/CLINIC DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY			
19. CONDITIONAL CLAIM INFORMATION (designated by NUCC)											
20. ICD-9-CM OR NATURE OF ILLNESS OR INJURY - Select An. to service the code (ZMS) ICD 9-CM: A. L. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.											
21. PRIOR AUTHORIZATION NUMBER											
22. A. DATES OF SERVICE FROM MM DD YY TO MM DD YY				22. B. PROCEDURE, SERVICE, OR SUPPLY CPT/HCPCS				22. C. CHARGES MONETARY \$ CHARGES			
23. A. RESUBMISSION CODE				23. B. ORIGINAL REF. NO.				23. C. PRIOR AUTHORIZATION NUMBER			
24. A. FEDERAL TAX ID NUMBER				24. B. PATIENT'S ACCOUNT NO.				24. C. ACCEPT ASSESSMENT?			
25. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS (Identify that the statements on the reverse apply to this bill and are made in part thereof)				26. SERVER FACILITY LOCATION INFORMATION				27. BILLING PROVIDER INFO & PH #			

PHYSICIAN OR SUPPLIER INFORMATION

1
2
3
4
5
6

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

CHANGES TO 1500 CLAIM FORM (cont.)

#	Field	Change
1	17	Field will now require the following qualifiers: <ul style="list-style-type: none"> • "DN" for Referring Provider • "DK" for Ordering Provider • If you have an electronic referral, the referring NPI number is not required on the claim
2	19	Field will now be used to report "Carrier Denied" on a claim
3	21	Field has expanded to allow a maximum of 12 diagnosis codes with 7 characters per code
4	29	Field will now be used to report TPL payments

Note: fields 10d and 30 will no longer be used; leave these fields blank



CHANGES TO 1500 CLAIM FORM *(cont.)*

Additional information can be accessed on the public website:

▶ www.okhca.org/provider/billing/manual/manual.pdf

▶ New 1500/Professional Claim Form Instructions



Oklahoma
HealthCare
Authority

CASUALTY CASES

Billed to SoonerCare

- You can bill SoonerCare for casualty cases and OHCA will pay the SoonerCare allowable
- When third parties are identified, OHCA presents all claims associated with the accident to the responsible third party for reimbursement



Oklahoma
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CASUALTY CASES

Billed to insurance

- If payments are received from a casualty insurance, OHCA can still be billed and will pay up to the allowable minus what the casualty insurance paid



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HealthCare
Authority

BILLING THE MEMBER

Providers **CAN** bill the member for the following:

- SoonerCare copay
- Service rendered is a non-covered service
- Member went to a non-participating provider with either their private insurance or SoonerCare
- Member does not adhere to all rules of the primary and SoonerCare
 - Example: prior authorization (PA) requirements or network requirements



BILLING THE MEMBER

Providers **CANNOT** bill the member for the following:

- If the patient has a potential casualty case
 - Example: auto accidents or worker's compensation cases
- Covered services
 - Member is not responsible for the primary insurance copay, only the SoonerCare copay



HMS: RECOVER AND RECOUPMENT PROCESS

- If you receive a letter from HMS about a recoupment, contact the number on the letter; failure to do so will result in recoupment
- Do NOT self-void your claim or go through the Adjustments Unit; this only makes the process more difficult in the long run



HMS: RECOVER AND RECOUPMENT PROCESS

If it is discovered that a member has another insurance after OHCA has paid the provider:

- Do NOT void or adjust your claim until you receive payment from the other insurance company
- The insurance company may have already paid OHCA for this claim
- If insurance shows up on the member's eligibility after the provider has been paid by OHCA, there is a good chance OHCA has already filed a claim and/or been paid by the insurance company



Oklahoma
HealthCare
Authority

TPL RESOURCES

www.okhca.org

- Provider Forms: www.okhca.org/forms
 - TPL-1 Form
 - HCA-28 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



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QUESTIONS



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