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*
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
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

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.
CLAIM SUBMISSION – PROVIDER PORTAL
COMMERCIAL INSURANCE—PROFESSIONAL

Step 1—Primary Paid

Submit Professional Claim: Step 1

* Indicates a required field.

Claim Type: Professional

Provider Information

Billing Provider ID: 0123456789
ID Type: NPI
Name: Bob SoonerCare, MD
SC Provider Number: 100000000D

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

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
Accident Related
Patient Account Number
From Date
CLIA Number
Other Insurance: Include

Date of Current
Expected Delivery Date
Total Charged Amount: $0.00

Continue
Cancel

DXC.technology
### COMMERCIAL INSURANCE—PROFESSIONAL

**Step 2—Primary Paid**

#### Diagnosis Codes

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

<table>
<thead>
<tr>
<th>#</th>
<th>ICD Version</th>
<th>Diagnosis Code</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. **ICD Version**: [Input Field]
2. **Diagnosis Code**: [Input Field]

#### Other Insurance Details

Key in the amount paid by the primary insurance

<table>
<thead>
<tr>
<th>TPL Amount</th>
<th>[Input Field]</th>
</tr>
</thead>
</table>

- [Back to Step 1]
- [Continue]
- [Cancel]
### COMMERCIAL INSURANCE—PROFESSIONAL

**Step 1—Primary Denied**

#### Submit Professional Claim: Step 1

<table>
<thead>
<tr>
<th>Field</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claim Type</td>
<td>Professional</td>
</tr>
<tr>
<td>Billing Provider ID</td>
<td>0123456789</td>
</tr>
<tr>
<td>ID Type</td>
<td>NPI</td>
</tr>
<tr>
<td>Name</td>
<td>Bob SoonerCare, MD</td>
</tr>
<tr>
<td>SC Provider Number</td>
<td>1000000000D</td>
</tr>
<tr>
<td>Taxonomy</td>
<td></td>
</tr>
<tr>
<td>Contract Code</td>
<td>_</td>
</tr>
<tr>
<td>Referring Provider ID</td>
<td></td>
</tr>
<tr>
<td>Ordering Provider ID</td>
<td></td>
</tr>
<tr>
<td>Ordering Zip Code</td>
<td></td>
</tr>
<tr>
<td><strong>Member ID</strong></td>
<td></td>
</tr>
<tr>
<td><strong>First Name</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Middle</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Last Name</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Birth Date</strong></td>
<td></td>
</tr>
<tr>
<td>Date Type</td>
<td></td>
</tr>
<tr>
<td>Accident Related</td>
<td></td>
</tr>
<tr>
<td>Patient Account Number</td>
<td></td>
</tr>
<tr>
<td>From Date</td>
<td></td>
</tr>
<tr>
<td>CLIA Number</td>
<td></td>
</tr>
<tr>
<td>*Other Insurance</td>
<td>Denied</td>
</tr>
<tr>
<td>Total Charged Amount</td>
<td>$0.00</td>
</tr>
</tbody>
</table>
## COMMERCIAL INSURANCE—PROFESSIONAL

### Step 3—Primary Denied

#### NO attachment cover sheet required

<table>
<thead>
<tr>
<th>#</th>
<th>Transmission Method</th>
<th>File</th>
<th>Control #</th>
<th>Attachment Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>FT - File Transfer</td>
<td></td>
<td></td>
<td>OZ - Support Data for Claim</td>
<td>Insurance Denial attached</td>
</tr>
</tbody>
</table>

[Image of an insurance claim form with options for transmission method, file, control number, attachment type, and description.]

[Arrows indicating the step to select FT - File Transfer and browse for the attachment cover sheet.]
COMMERCIAL INSURANCE—PROFESSIONAL

Step 3—Primary Denied

HCA-13 attachment cover sheet required
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.
HCA-13
Attachment
Cover Sheet

The Four fields below are required and must match claim.

1. 1. Provider Number
   2. Client ID Number
2. c
   3. Attachment Control Number 20170714366677
3. i
   4. Claim Number 2317195600001
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)
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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OKLA HCA REVISED 4/2017
Step 1—Primary Paid
## 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.

<table>
<thead>
<tr>
<th>#</th>
<th>ICD Version</th>
<th>Diagnosis Code</th>
<th>POA</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>ICD-9-CM</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Present on Admission**

**Emergency Diagnosis Code**

Only one emergency diagnosis code is allowed per claim.

<table>
<thead>
<tr>
<th>ICD Version</th>
<th>Diagnosis Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>ICD-9-CM</td>
<td></td>
</tr>
</tbody>
</table>

**Other Insurance Details**

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

<table>
<thead>
<tr>
<th>#</th>
<th>Payer Code</th>
<th>Prior Amount</th>
<th>Estimated Amount Due</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
COMMERCIAL INSURANCE—INSTITUTIONAL

Step 1—Primary Denied
**ADDING ATTACHMENT – FILE TRANSFER**

![Screen capture of attachment file transfer interface]

- **Transmission Method**: FT-File Transfer
- **Upload File**: OZ-Support Data for Claim
- **Attachment Type**: Insured Denial attached

**Instructions:**
- No attachment cover sheet required.
- Click the 'Add' button to proceed.
- Click 'Submit' to finalize the attachment.

**Options:**
- Back to Step 1
- Back to Step 2
- Cancel
**ADDING ATTACHMENT – FAX**

- **HCA-13 attachment cover sheet required**

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### Attachments

<table>
<thead>
<tr>
<th>#</th>
<th>Transmission Method</th>
<th>File</th>
<th>Control #</th>
<th>Attachment Type</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>FX - By Fax</strong></td>
<td></td>
<td></td>
<td><strong>OZ-Support Data for Claim</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>Insurance Denial attached</strong></td>
<td></td>
</tr>
</tbody>
</table>

- **Add**
- **Cancel**

- **Back to Step 1**
- **Back to Step 2**

- **Submit**
- **Cancel**
HCA-13
Attachment Cover Sheet

The four fields below are required and must match claim.

1. Provider Number
2. Client ID Number
3. Attachment Control Number
4. Claim Number
5. Date/Time

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.

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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)

### Claim Information
- **Claim Type**: Crossover Professional
- **Date Type**: 
- **Accident Related**: 
- **Patient Account Number**: 
- **From Date**: 
- **To Date**: 
- **CLIA Number**: 

### Patient Information
- **Member ID**: 
- **Last Name**: First Name Middle
- **Birth Date**: 

### Provider Information
- **Billing Provider ID**: 
- **Referring Provider ID**: 
- **Ordering Provider ID**: 
- **Contract Code**: 
- **Taxonomy**: 

### Medicare Crossover Details
- **Allowed Medicare Amount**: $0.00
- **Deductible Amount**: $0.00
- **Medicare Payment Amount**: $0.00
- **Co-insurance Amount**: $0.00
- **Psychiatric Services Amount**: $0.00
- **Medicare Payment Date**: 

### Claim Information
- **Date of Current**: 
- **Expected Delivery Date**: 

### Total Charged Amount
- **Total Charged Amount**: $0.00
CROSSOVER PROFESSIONAL – DETAIL
(DOS 06/01/2016 AND AFTER)

Key the crossover information for this line of service only
Medicare Part A claims will continue to process at the header level.
CROSSOVER INSTITUTIONAL – PART B

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

Claim Type: Crossover Outpatient

Bob SoonerCare, MD
100000000D

0123456789
0123456789

Total Charged Amount: $0.00

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

Key the crossover information for this line of service only
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
• 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

Claim Type: Professional

Provider Information

Billing Provider ID: 0123456789
ID Type: NPI
Name: Bob SoonerCare, MD
SC Provider Number: 100000000D

Patient Information

Member ID
Last Name
Birth Date
First Name
Middle

Claim Information

Date Type
Accident Related
Patient Account Number
From Date
CLIA Number
*Other Insurance
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: 1000000000
Zip Code:
Contract Code:
Institutional Provider ID: 0123456789
Attending Provider ID:
Operating Provider ID:
Referring Provider ID:

Patient Information

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

*Member ID
Last Name
Birth Date

First Name
Middle

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
*Admission Date/Time
*Admission Type
*Admitting ICD Version
*Patient Status
Patient Account Number
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

No attachment cover sheet required
MEDICARE – HMO COPAY WITH ATTACHMENT

Fax

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

Content:
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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: ___________________________
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)
PRIVATE PAY – 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
Zip Code: 
Contract Code: 
Institutional Provider ID: 0123456789
Attending Provider ID: 
Operating Provider ID: 
Referring Provider ID: 

Provider Name: Bob SoonerCare, MD
SC Provider Number: 100000000D

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: mm/dd/yyyy - mm/dd/yyyy
- Admission Date/Time: mm/dd/yyyy, hh:mm
- Admission Type: 
- Admitting ICD Version: ICD-9-CM
- Patient Status: 
- Patient Account Number: 
- HMO Copay: Yes

Covered Days: 
Discharge Hour: hh:mm

Admission Source: 
Admitting Diagnosis: 
Type of Bill: 
Other Insurance: None

Total Charged Amount: $0.00

Continue | Cancel
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](http://www.okhca.org)
• Provider Forms: [www.okhca.org/forms](http://www.okhca.org/forms)
  – TPL-1 form
• Provider Billing Manual (chapter 14)
• 800-522-0114 (toll-free) or 405-522-6205
  • Option 3,2 for Third Party Liability
Questions?