Billing for Third Party Liability Webinar
April, 2019

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SoonerCare Education Specialist
Agenda

• What is Third Party Liability?
  • Eligibility.
  • TPL.
• Claim Submission.
  • Electronic date interchange.
  • Attachment cover sheet (HCA-13).
Agenda

• Portal Submission Professional.
  • Primary paid.
  • TPL amount.
  • Primary denied.
• Adding attachments.
• Insurance denied.
• Fax attachment.
  • Attachment cover sheet.
• HMO copay.
• Commercial insurance (institutional).
• Resources.
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 website: www.okhca.org.
What is Third Party Liability?

• Third Party Liability 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.
Eligibility

<table>
<thead>
<tr>
<th>Eligibility</th>
<th>Coverage</th>
<th>Effective Date</th>
<th>End Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>SoonerCare Choice</td>
<td></td>
<td>03/06/2018</td>
<td>03/06/2018</td>
</tr>
<tr>
<td>Non Emergency Transportation</td>
<td></td>
<td>03/06/2018</td>
<td>03/06/2018</td>
</tr>
<tr>
<td>Mental Health and Substance Abuse</td>
<td></td>
<td>03/06/2018</td>
<td>03/06/2018</td>
</tr>
<tr>
<td>Title 19</td>
<td></td>
<td>03/06/2018</td>
<td>03/06/2018</td>
</tr>
</tbody>
</table>

Managed Care Information

<table>
<thead>
<tr>
<th>Provider Name</th>
<th>Provider Phone</th>
<th>Health Plan Name</th>
<th>Health Plan Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCMH CLINIC</td>
<td>1-405-555-2000</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
# Third Party Liability

<table>
<thead>
<tr>
<th>Carrier Name (Carrier ID)</th>
<th>Policy Number</th>
<th>Group ID (Employer ID)</th>
<th>Policy Holder (Relationship)</th>
<th>Policy Type</th>
<th>Coverage Type</th>
<th>Effective</th>
<th>End</th>
</tr>
</thead>
<tbody>
<tr>
<td>BLUE ADVANTAGE ADMINISTRATORS OF AR</td>
<td>YABADABA2</td>
<td>(-)</td>
<td>Fee Lingbetter</td>
<td>MAJOR MEDICAL</td>
<td></td>
<td>11/25/2017</td>
<td>12/31/2018</td>
</tr>
</tbody>
</table>
Claim Submission
Electronic Data Interchange
Electronic Data Interchange 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.
Electronic Date Interchange 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.
Electronic Data Interchange 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 claim is submitted, provider prints and completes the HCA-13 (attachment cover sheet).

- Provider faxes or mails attachments.
Attachment
Cover Sheet
(HCA-13)
Portal Submission Professional
# Primary Paid

## Submit Professional Claim: Step 1

* Indicates a required field.

**Claim Type:** Professional

### Provider Information

<table>
<thead>
<tr>
<th>Field</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Billing Provider ID</td>
<td>11221122334</td>
</tr>
<tr>
<td>Zip Code</td>
<td>74105</td>
</tr>
<tr>
<td>Referring Provider ID</td>
<td></td>
</tr>
<tr>
<td>Ordering Provider ID</td>
<td></td>
</tr>
<tr>
<td>ID Type</td>
<td></td>
</tr>
<tr>
<td>Taxonomy</td>
<td>11221122334</td>
</tr>
<tr>
<td>SC Provider Number</td>
<td>FIXEM UP MEDICINE 100123456A</td>
</tr>
</tbody>
</table>

### Patient Information

- **Member ID**
- **Last Name**
- **First Name**
- **Middle**

### Claim Information

- **Date Type**
- **Accident Related**
- **Patient Account Number**
- **From Date**
- **CLIA Number**
- **Expected Delivery Date**
- **To Date**
- **HMO Copay**
- **Total Charged Amount** $0.00

**Other Insurance** Include

**Date of Current**

**Include**

**Continue** | **Cancel**
Third Party Liability Amount

Submit Professional Claim: Step 2

* Indicates a required field.

Claim Type: Professional

Provider Information

Billing Provider ID: 11221122334
Contract Code: G
NPI: 11221122334
SC Provider Number: FIXM UP MEDICINE 1001234567A

Patient and Claim Information

Member ID: 812345678
Member Name: Fee Lingbetter
Birth Date: 07/11/2010
Gender: Male
Total Charged Amount: $0.00

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>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>ICD-10-CM</td>
<td></td>
</tr>
</tbody>
</table>

Other Insurance Details

TPL Amount

Back to Step 1   Continue   Cancel
Primary Denied

Submit Professional Claim: Step 1

Provider Information

- Billing Provider ID: 1122112233
- Zip Code: 74105
- Contract Code: G
- ID Type: NPI
- Taxonomy: 1122112233
- Name: FIXEM UP MEDICINE
- SC Provider Number: 100123456A

Patient Information

- Member ID: B12345678
- Last Name: Lingbetter
- First Name: Fee
- Middle Name: Middle
- Birth Date: 07/11/2010

Claim Information

- Other Insurance: Denied
- Total Charged Amount: $0.00
- HMO Copay: No

Continue  Cancel
Adding Attachments

NOTE: Attachments work the same for all claim types.
Insurance Denied
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 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:
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 destroy the fax you received. Fax transmission 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.

OKLA HCA  
Revised 06/24/09  

HCA-13
Health Maintenance Organization Copay

Submit Professional Claim: Step 1

Provider Information
This panel contains provider information.

Billing Provider ID 11221122334
Zip Code 74105
Contract Code G

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
Accident Related
Patient Account Number
From Date
CLIA Number
*Other Insurance None

HMO Copay Yes
Total Charged Amount $0.00

Continue Cancel
Portal Submission
Institutional
Commercial Insurance (Institutional)

Step 1—Primary Paid

Bob SoonerCare, MD
1000000000D
# 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.

- **ICD Version**: ICD-9-CM

- **Diagnosis Code**: 

### 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>

- **Payer Code**: 

- **Prior Amount**: 

- **Estimated Amount Due**: 

  - [ ]

  - [ ]

  - [ ]

  - [ ]
Commercial Insurance (Institutional)

Step 1—Primary 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
- Admission Date/Time
- Admission Type
- Admitting ICD Version
- Patient Status
- Patient Account Number
- HMO Copay

Covered Days
Discharge Hour
Admission Source
Admitting Diagnosis
Type of Bill
Other Insurance

Total Charged Amount $0.00

Continue Cancel
# Institutional Claim – HMO Copay

## Step 1—HMO Copay

### Submit Institutional Claim: Step 1

* Indicates a required field.

**Claim Type**

<table>
<thead>
<tr>
<th>Claim Type</th>
<th>Inpatient</th>
</tr>
</thead>
</table>

#### Provider Information

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

<table>
<thead>
<tr>
<th>Billing Provider ID</th>
<th>100000000D</th>
</tr>
</thead>
</table>

**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.

<table>
<thead>
<tr>
<th>Member ID</th>
<th>First Name</th>
<th>Middle</th>
<th>Last Name</th>
<th>Birth Date</th>
</tr>
</thead>
</table>

#### 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.

<table>
<thead>
<tr>
<th>Covered Dates</th>
<th>Admission Date/Hour</th>
<th>Admission Type</th>
<th>Admitting ICD Version</th>
<th>Patient Status</th>
<th>HMO Copay</th>
<th>Covered Days</th>
<th>Discharge Hour</th>
<th>Admission Source</th>
<th>Admitting Diagnosis</th>
<th>Type of Bill</th>
<th>Other Insurance</th>
</tr>
</thead>
</table>

| **Patient Account Number**: HMO Copay **Yes** |

**Total Charged Amount**: $0.00

[Continue, Cancel]
Resources

• OHCA website: www.okhca.org.
• OHCA provider forms: www.okhca.org/forms.
  • TPL-1 form.
• Billing manual (Chapter 14).
• OHCA provider helpline.
  • 800-522-0114 (toll free) or 405-522-6205 (OKC area).
  • Option 3,2 for Third Party Liability.
• Onsite visits: soonercareeducation@okhca.org.