Other Insurance Reporting Requirements

Claim Adjustment Reason Code: 22- this care may be covered by another payer per coordination of benefits

Policy: Medicaid Provider Manual (MPM) Chapter "Coordination of Benefits"

Federal regulations require that all identifiable financial resources be utilized prior to expenditure of Medicaid funds for most health care services provided to Medicaid beneficiaries. Medicaid is considered the payer of last resort. Billing Medicaid prior to exhausting other insurance resources may be considered fraud under the Medicaid False Claim Act if the provider is aware that the beneficiary had other insurance coverage for the services rendered Providers must secure other insurance adjudication response(s) which must include Claim Adjustment Reason Codes (CARCs) prior to billing Medicaid. Denials do not need to be obtained in cases where the parameters of the carrier would never cover a specific service (e.g., a dental carrier would never cover a vision service, etc.). In cases where the provider renders a service and the carrier indicates it does not cover that specific service, the provider needs only to bill the carrier once for the service and keep a copy of the denial in the beneficiary's file. When billing electronically, no attachment is necessary, as all required data must be included in the electronic submission.

When billing a secondary or tertiary claim to Medicaid it is important to report the correct claim filing indicator for the payer on the claim. Reporting an incorrect claim filing indicator can result in claims being unnecessarily suspended, denied, voided, or paid incorrectly.

The major categories of other insurance are:

- Commercial health insurance carriers (i.e., managed care carriers [MCC], preferred provider organizations [PPO], point of service organizations [POS], health maintenance organizations [HMO], long-term care [LTC] insurance policies), traditional indemnity policies, and military/veteran insurance (i.e., TRICARE and the Civilian Health and Medical Program of the Department of Veterans Affairs [CHAMPVA]).Auto Insurance (accident, no-fault)
- Workers' Disability Compensation
- Court-Ordered Medical Support
- General Liability Insurance
- Medicare

Notes:

- When using Direct Data Entry to enter a new claim or adjustment the Payer ID, Group Number, Policy Number, and Claim Filing Indicator information must match what is shown in the TPL files within CHAMPS eligibility subsystem.
- If submitting a claim electronically the claim filing indicator must match what is shown in the TPL files within CHAMPS eligibility subsystem. It is not currently required for the Payer ID, Group and Policy Number to match the beneficiary TPL files when submitting electronically.
- If the TPL files are incorrect then the online DCH 0078 Request to add/change/update other insurance needs to be completed.
    - **Exceptions**: To update TPL files for BCN, BCBSM, McLaren, Priority Health, Administration Systems Research (ASR), Physician's Health Plan (PHP), Medimpact, Express Scripts, OptumRX, and Delta Dental, please contact the health plans directly.

- **May 7, 2019: Health Savings Accounts**
  Attention ALL Providers: Health Savings Accounts (HSAs) are not considered to be commercial health insurance policies. Therefore, this type of asset does not need to be reported to Third Party Liability (TPL) or listed on a Medicaid claim as other insurance. Since these are counted as "assets," the beneficiary should report this to their case worker.

- MDHHS encourages providers to send claims electronically rather than sending paper claims. The scanner tends to not pick up pertinent information to process the claims correctly. Claims should be submitted by file transfer or through the Data Exchange Gateway (DEG) or via Direct Data Entry (DDE) through the Community Health Automated Medicaid Processing System (CHAMPS) free of charge versus submitting a paper claim. If you do not have access to CHAMPS, you may go to CHAMPS Quick Links to become a registered user with CHAMPS or by calling 1-800-292-2550 for assistance.

- J**une 13, 2017: Attention Outpatient Hospital Providers**: Providers may have noticed an increase in claims denied with Claim Adjustment Reason Code 23 "The impact of prior payers adjudication including payments/and or adjustments". If the other insurance information is reported at the header of the claim and there is a CARC reported from the other payer that is considered a denial (example: CARC 50) or would cause the claim to suspend (example: CARC 16) the claim is denied by CHAMPS. Claims will need to be rebilled with the other insurance information reported at each service line level for correct processing or providers will need to contact the primary payer to further resolve the primary payers' actions.

- **Examples**:

Payer	CHAMPS Claim Filing Indicator
BC BS Federal Employee Program	BL- BC/BS
Traditional Medicare	Medicare A or Medicare B
Medicare Advantage Plans	Commercial, HMO or Medicare B (Preferred)
Priority Health Plan	Commercial

MDHHS assigns coverage type codes which indicate the type of coverage a policy entails.

- **Examples**:

Coverage Type Code	Description
RX	Only Pharmacy
MD	Medical Dental- Medical and Dental Coverage Only
DO	Only Dental

**Please see below for instructions on how to report the Primary insurance information at the line level.

How to Submit Other Insurance at the Service Line Level

1. For each service line item, click on the Insurance Info hyperlink to report the insurance at the line level.

Add Service Line Item | Update Service Line Item

Previously Entered Line Item Information

Click a Line No. below to view/update that Line Item Information.

Total Submitted Charges: $60.00

Click on Insurance Info to enter each Line's Insurance Information.

Line No	Revenue Code	HCPCS Code	Modifiers 1	2	3	4	Dates Service Date	Last DOS	Units	Charges	Non covered Charges	
1	0255								2	2.00		Insurance Info / Copy / Delete
2	0301								4	58.00		Insurance Info / Copy / Delete

2. When reporting the other insurance information, make sure to complete the highlighted fields below. This the portion of the claim where you report the payment and reason code as reflected on the primary EOB. *The Adjustment quantity field is not required.

Close | Basic Claim Form | Reset

Note: asterisks (*) denote required fields.

INSURANCE INFORMATION

To save the information, Click 'Basic Claim Form' button.

Does the Beneficiary have insurance other than Medicaid? Yes No

OTHER INSURANCE INFORMATION

1. Service Line Other Payer Information

Primary Payer Responsibility: 1#P#25236523#MB-Medicare Part * | Amount Paid: $2.00 * | Remittance Date: mm dd yyyy

1.Reason Code: 45 | Amount: $18.00 | Adjustment Quantity: | Add Another Reason Code

2.Reason Code: 1 | Amount: $65.00 | Adjustment Quantity:

Add Another Payer

3. Once the insurance information has been reported, click on the Basic Claim Form button. This will take you back to your service line item. *Do not click close, this will erase all the information entered.

Close | Basic Claim Form | Reset

Close | Basic Claim Form | Reset

Note: asterisks (*) denote required fields.

INSURANCE INFORMATION

To save the information, Click 'Basic Claim Form' button.

Does the Beneficiary have insurance other than Medicaid? (•) Yes ( ) No

OTHER INSURANCE INFORMATION

1. Service Line Other Payer Information

Primary Payer Responsibility: 1#P#25236523#MB-Medicare Part I * Amount Paid: $2.00 * Remittance Date: mm dd yyyy

1.Reason Code: 45 Amount: $18.00 Adjustment Quantity: Add Another Reason Code

2.Reason Code: 1 Amount: $65.00 Adjustment Quantity:

Add Another Payer

4. Repeat the steps above to enter the insurance at the line level for each service item.

For additional assistance completing the other insurance information in CHAMPS, please contact Provider Support.