COORDINATION OF BENEFITS

Before submitting a claim to Medicaid, a provider must submit and secure payment from all other liable parties such as Medicare Part A and B. (For more information refer to the Medicaid General Information Section, 11-4). Claims denied from Medicare as non-covered services should be submitted to Medicaid Fee for Service, not to Crossovers.

If the primary payer made line level payments on the claim, please report line level data, in addition to the claim level data, to Medicaid. Do not include co-payments received from the patient in the TPL reporting. Only send an explanation of benefits (EOB) when indicated by the table below for electronically billing secondary claims.

For Healthy U or Molina TPL claims, contact that health plan for specific billing instructions.

INSTRUCTIONS FOR ELECTRONIC CLAIMS

When submitting COB information in an electronic format, be sure to include payer payment amount, patient liability and reason codes with amounts for contractual write offs.
The Mail Boxes (Trading Partner Numbers) for claim submission are:

HT000004-001 Medicaid Fee for Service
HT000004-005 Utah Medicaid Crossovers (NOT when Medicare denies as non-covered)

To electronically bill secondary claims to Utah Medicaid * * * Do not fax paper claims * * *				
Enter third party payment and the patient responsibility and then transmit to the appropriate Medicaid Trading Partner Number (TPN)				
If primary payer	When primary payer is	Transmit electronic claim to	Will deny	Additional action to take
pays	Medicare	HT000004-005		none
	Commercial	HT000004-001		none
pays zero	Medicare	HT000004-005		none
	Commercial	HT000004-001	x	fax Medicaid Remittance w/ denial & EOBs to ORS (801) 536-8513
denies	Medicare	HT000004-001	x	fax Medicaid Remittance w/ denial & EOBs to Medicaid (801) 536-0481
	Commercial	HT000004-001	x	fax Medicaid Remittance w/ denial & EOBs to ORS (801) 536-8513

When sending a copy of the EOB via fax or mail also include the first name, last initial, and phone number of the individual requesting the adjustment along with the claim's identifiable information:

- Medicaid's remittance advice, or
- Medicaid TCN number, or
- Provider ID number, client's Medicaid ID number, and date of service.

If the identifiable information is not submitted, the request may not be fulfilled.

INSTRUCTIONS FOR PAPER CLAIMS

Third Party Liability (TPL) payments must be reported in the positions listed below. When reporting multiple payers on a CMS-1500 or dental claim, indicate the combined total payments and the final remaining patient responsibility. To identify a crossover claim check both the Medicare and Medicaid boxes in Box 1.

<table>
<tr><th colspan="2">CMS-1500 (8/05)</th></tr>
<tr><th>Box</th><th>Instructions</th></tr>
<tr><td>28</td><td>Total Claim Charge.</td></tr>
<tr><td>29</td><td>Amount Paid by other payer(s). Contractual adjustments should not be reported. The contractual amount will be calculated by Medicaid (Total claim charge - Amount Paid by other Payer - Patient Responsibility = Contractual Adjustment).</td></tr>
<tr><td>30</td><td>Balance Due.</td></tr>
<tr><td>19</td><td>If amount in Box 30 is different than the claim level patient responsibility as reported by the other payer(s), report patient responsibility in Box 19 by using PR01 and then the amount (example: PR01:13).</td></tr>
<tr><td>24
SHADED</td><td>Required for crossover when Medicare reports Patient Responsibility at the line level, optional for Fee for Service.

Each line of service must contain the following information:
(1) Indicator of “T” to identify a third party payment, and amount paid by other payer(s).
(2) Indicator of “PR” to identify patient responsibility, reason code reported by other payer(s) related to the PR, and patient responsibility amount. If no reason code is available from other payer(s) to identify the patient responsibility, use “01".
(3) All reason codes as reported by other payer(s) and amounts (contractual obligation or write-offs). Codes should contain a qualifier of either CO or CR and then a number. If no reason codes given by the payer, report all contractual obligations using “CO45". Report the amount of the contractual obligation. There may be multiple reason codes and amounts per line.

EXAMPLE:
<table>
<tr><th colspan="6">24 A. DATE(S) OF SERVICE
From To
MM DD YY MM DD YY</th><th>B.
PLACE OF SERVICE</th><th>C
EMG</th><th colspan="5">D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)
CPT/HCPCS MODIFIER</th><th>E.
DIAGNOSIS POINTER</th><th>F.
$CHARGES</th></tr>
<tr><td colspan="14">T:40.35 PR01:10 CO45:9.65</td></tr>
<tr><td>03</td><td>11</td><td>06</td><td>03</td><td>11</td><td>06</td><td>11</td><td></td><td>99213</td><td></td><td></td><td></td><td></td><td>1</td><td>60.00</td></tr>
</table>
</td></tr>
</table>

UB-04	
Form Locator	**Instructions**
54 A,B,C	Prior Payments made by other insurance carrier. Contractual adjustments should not be reported. The contractual amount will be calculated by Medicaid (Total charge - Prior Payments - Patient Estimated Amount Due = Contractual Adjustment).
55 A,B,C	Patient Estimated Amount Due or Patient Responsibility as listed by other insurance carrier. Amount should be on the same line as the payer reporting the patient estimated amount.

DENTAL	
Box	**Instructions**
35	The following information is needed to report third party payments: (1) Indicator of “T” to identify a third party payment, and amount paid by other payer(s). (2) Indicator of “PR01” to identify patient responsibility and amount reported by other payer(s). (3) Indicator of “C” to identify any contractual adjustment or write-off, and amount reported by other payer(s). Example: T:23.50 PR01: 6.50 C:10