Quick Reference Guide:

Submitting Claims for FQHC and RHC Wraparound Payments in the Provider Network Module (PNM)

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Step 1	*For full guidance on all the Professional Claim submission panels, please refer to the Professional Claims User Guide and the Professional Claims Billing Guide located under the 'Learning' tab.* *This Quick Reference Guide provides detail on the specific sections where the information related to claims submitted for wraparound payments need to be entered on the Claims Submission page in the PNM system.* A red asterisk (*) listed next to any field, indicates that field is required to be completed within that section of the Claims Submission page. On the Claims Submission page, select the 'Professional' Claim Type. Select the following information from the drop-down lists: • Destination Payer Name: Ohio Department of Medicaid • Destination Payer ID: MMISODJFS – Ohio Department of Medicaid • Destination Payer Responsibility Sequence: The role of ODM as payer of the claim.	

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		o Medicaid is the payer of last resort in most cases. If the individual has other coverage in addition to Medicaid, the other insurance coverages are always listed before Medicaid. o For example, when an FQHC submits a claim to ODM for a wraparound payment, the Managed Care Organization (MCO) is the Primary payer, and the Ohio Department of Medicaid (ODM) is the Secondary payer. When a member also has commercial insurance, the commercial carrier is the Primary payer, the MCO is Secondary, and ODM is Tertiary. When a member also has two other insurance carriers, the main carrier is the Primary payer, the next carrier is Secondary, the MCO is Tertiary, and ODM is 4th-level (Quaternary).	
Step 2	Scroll down and locate the Other Payer Information section. Click '+' to expand that section and enter information for the Medicaid Managed Care Organization (MCO).		
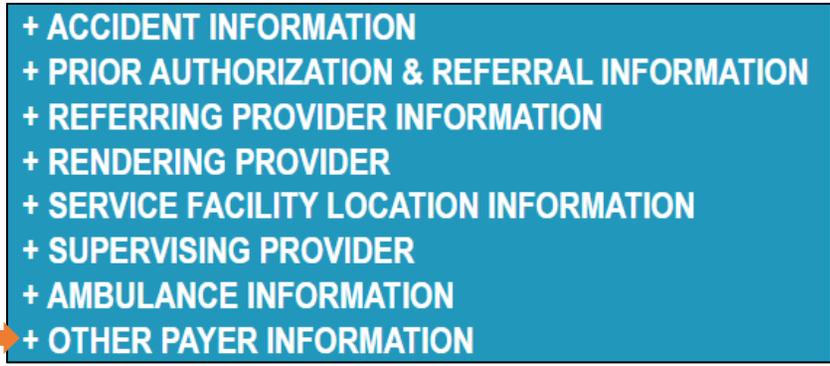
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Step 3	Enter the information for the other payer. In some fields, specific information is needed. Enter all other applicable coordination-of-benefits (COB) information. ('Subscriber' is the Medicaid Recipient.)
	
	Other Payer Name: The full name of the organization involved with the payment of the claim.
	
	Health Plan ID: The Medicaid Provider ID number for the payer.
	• Aetna Better Health of Ohio:
	   - MyCare – 0082400
	• Aetna Better Health OhioRISE:
	   - OhioRISE – 0445886
	• AmeriHealth Caritas:
	   - ABD – 0461036
	   - CFC – 0462293
	• Buckeye Community Health Plan:
	   - ABD – 0077145
	   - CFC – 0077148
	   - MyCare – 0082408
	• CareSource:
	   - ABD – 0077191
	   - CFC – 0077193
	   - MyCare – 0082409
	• Comm. Ins. Co. DBA Anthem BCBS:
	   - ABD – 0464227
	   - CFC – 0464229
	   - MyCare - 0115302
	• Humana Health Plan of Ohio, Inc.:
	   - ABD – 0461038
	   - CFC – 0462285
	• Molina HealthCare of Ohio Inc:
	   - ABD – 0077182
	   - CFC – 0077186
	   - MyCare – 0082414
	• Paramount Advantage:
	   - ABD – 0077188
	   - CFC – 0077190
	• United Healthcare Community Plan:
	   - ABD – 0077110
	   - CFC – 0077115
		- OTHER PAYER INFORMATION ⬅
		
		* Other Payer Name :
		* Health Plan ID :
		* Claim Filing Indicator :
		* Payer Responsibility Sequence :
		* Subscriber Number:
		Policy Number:
		Group Name:
		Insurance Type Code :
		
		* Patient Relationship To Subscriber :
		* Subscribers First Name :
		* Subscriber Last Name :
		Subscriber's Middle Name :
		Subcriber's Address Line 1:
		Subcriber's Address Line 2:
		Subcriber's City:
		Subcriber's State :
		Subcriber's Zip :
		
		Claim Adjudication Level :
		Claim Number :
		Paid Date :
		Paid Amount :
		Non Covered Amount:
		
		ADD

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- MyCare – 0082405

Claim Filing Indicator:
  Select "HM - Health Maintenance Organization (HMO)" for Medicaid wraparound payments.
  Select "MB – Medicare Part B" for Medicare wraparound payments from the Medicare Administrative Contractor (MAC).

Payer Responsibility Sequence: Select the MCO's (or other third-party insurance's) level of responsibility for the payment of the claim.

Subscriber Number: Enter the Medicaid Billing Number (the same Medicaid Billing Number entered under the Recipient Information section of the Claims Submission page).

Policy Number: Enter the same number listed under Subscriber Number (the Medicaid Billing Number).

Group Name: Leave this line item blank.

Insurance Type Code: Leave this line item blank.

Patient Relationship to Subscriber: Select "Self."

Subscriber First Name: Enter the first name of the subscriber to the coverage.

Subscriber Last Name: Enter the last name of the subscriber to the coverage.

Subscriber's Middle Name: Enter the middle name of the subscriber to the coverage.

Subscriber's Address Line 1: Leave this line item blank.

Subscriber's Address Line 2: Leave this line item blank.

Subscriber City: Leave this line item blank.

Subscriber State: Leave this line item blank.

Subscriber Zip: Leave this line item blank.

Claim Adjudication Level: Select "Header" or "Detail" depending on COB information (Header or Detail level).

Claim Number: Enter the ICN of the Managed Care Plan.

Paid Date: Enter the date that the Managed Care claim was paid.

Paid Amount: Enter the amount paid by the MCO.

Non Covered Amount: Leave this line item blank.

After all information has been entered, click **Add**.

- OTHER PAYER INFORMATION

* Other Payer Name :		* Patient Relationship To Subscriber :	[dropdown]	Claim Adjudication Level :	
* Health Plan ID :		* Subscribers First Name :		Claim Number :	
* Claim Filing Indicator :	[dropdown]	* Subscriber Last Name :		Paid Date :	
* Payer Responsibility Sequence :	[dropdown]	Subscriber's Middle Name :		Paid Amount :	
* Subscriber Number :		Subcriber's Address Line 1 :		Non Covered Amount :	
Policy Number :		Subscriber's Address Line 2 :			
Group Name :		Subcriber's City :		ADD	
Insurance Type Code :	[dropdown]	Subcriber's State : [dropdown]	Subcriber's Zip :		

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	Repeat the process if additional payers need to be entered.	
Step 4	*(If 'Header' was selected for the Claim Adjudication Level).* Click '+' to expand the Header Other Payer Adjustment Information section Health Plan ID: Select the appropriate Health Plan ID from the drop-down menu *(drop-down options will be based on Health Plans listed in the Other Payer Information section).* Adjustment Group: Select "CO." (Contractual Obligations) Reason Code: Enter code "45." (Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement). For example, if submitted charges are $100 and the MCO paid a total of $25, then the difference of $75 is reported with CO 45. Amount: Enter the difference between the PPS amount and the MCO (and, if applicable, another payer) amount. Quantity: Leave this line item blank. After all information has been entered, click **Add.** Repeat the process if additional payers need to be entered.	**+ OUTPATIENT ADJUDICATION INFORMATION** **+ HEADER OTHER PAYER ADJUSTMENT INFORMATION** **- HEADER OTHER PAYER ADJUSTMENT INFORMATION** * Health Plan ID * Adjustment Group * Reason Code Search * Amount Quantity Add

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Step 5	It is necessary to report COB payment information at the detail level only if the MCO is the secondary payer and another payer is primary. *(If 'Detail' was selected for the Claim Adjudication Level).* Click '+' to expand the Other Payer Paid Amount-Service Detail Screen and the Other Payer Adjustment Information–Service Detail sections. **Other Payer Paid Amount – Service Detail Screen** Service Line: Select the appropriate service line for service information entered in the Service Detail section as it relates to the other payer paid amount. Health Plan ID: Select the appropriate Health Plan ID from the drop-down menu *(drop-down options will be based on Health Plans listed under Other Payer Information section).* Amount Paid: Enter the amount paid by the other payer. Paid Service Unit Count: Enter the number of units paid by the other payer *(cannot be greater than billed unit).* After information has been entered, click **Add**. Repeat the process if additional payers need to be entered.	**- OTHER PAYER PAID AMOUNT-SERVICE DETAIL SCREEN** *Service Line Procedure Code *Health Plan ID *Amount Paid Paid Date *Paid Service Unit Count Add **- OTHER PAYER ADJUSTMENT INFORMATION-SERVICE DETAIL** *Service Line Procedure Code *Health Plan ID *Adjustment Group *Reason Code *Amount Quantity Add Search

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| | **Other Payer Adjustment Information – Service Detail**
 Service Line: Select the number of the service line in the Service Detail section for which other payer information is being entered.
 Health Plan ID: Select the appropriate Health Plan ID from the drop-down menu *(drop-down options will be based on Health Plans listed under Other Payer Information section)*.
 Adjustment Group: Select the option listed on the Explanation of Benefits (EOB) from the other payer.
     CO - Contractual Obligations
     CR - Correction and Reversals
     OA - Other adjustments
     PI - Payor Initiated Reductions
     PR - Patient Responsibility
 Reason Code: Enter the Reason Code listed on the Explanation of Benefits (EOB) from the other payer.
     If you do not know the Reason Code, click 'Search' to look up the appropriate code.

 Amount: Enter the amount paid by the other payer.
 Quantity: Enter the number of units of service.

 Information is reported about every payer and each payer is entered on a separate line.

 After information has been entered, click **Add**. Repeat the process if additional payers need to be entered. | **- OTHER PAYER PAID AMOUNT-SERVICE DETAIL SCREEN**

 *Service Line   Procedure Code   *Health Plan ID   *Amount Paid   Paid Date   *Paid Service Unit Count   **Add**

 - OTHER PAYER ADJUSTMENT INFORMATION-SERVICE DETAIL

 *Service Line   Procedure Code   *Health Plan ID   *Adjustment Group   *Reason Code   *Amount   Quantity   Search   **Add** |
| **Step 6** | Make sure that all necessary sections/panels are completed on the Claims Submission page.

 Click **Submit** to submit the claim for review. | Save   Submit   Cancel |

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