

FOR CBHCS ONLY: Third-Party Liability Provider Information Grid by Fee-For-Service and Medicaid Managed Care Plan

	FFS	Buckeye	CareSource	Molina	Paramount	UHC
What resources are available to determine if an individual has a third-party insurer?	<ul style="list-style-type: none"> - The MITS Provider Portal (for an individual eligibility search). - The last page of a Remittance Advice (RA) lists all explanation of benefits (EOB) code descriptions, including TPL denial EOBs. 	<ul style="list-style-type: none"> - Buckeye Provider Portal (for individual member lookup) - Customer Service Call Center at 1-866-296-8731 - Explanation of Payment (EOP) will include a DENY code indicating another payer is primary. 	<ul style="list-style-type: none"> - CareSource Provider Portal - Caresource.com (for individual member lookup) - CareSource Provider Services Call Center at 1-800-488-0134. 	<ul style="list-style-type: none"> - Molina Web Portal (for individual member lookup.) - Molina Provider Call Center at 855-322-4079. - EOB as a result of a denied claim includes primary payment information. 	<ul style="list-style-type: none"> - Paramount Provider Portal (for individual member lookup) - Paramount Provider Services Call Center at 419-887-2564. - On the EOP as a result of a denied claim. 	<ul style="list-style-type: none"> - UHC Provider Portal (for individual member lookup) - UHC Provider Services Department at 800-600-9007. M-F 8 a.m. to 5 p.m. - Fax 877-877-7697 - EOB as a result of a denied claim.
What information is required when the TPP does not recognize the provider or there is no out-of-network benefit?	<ul style="list-style-type: none"> - If the services being billed are required to be billed to a primary insurance then yes, the information from the EOB is required to be on the claim. If the services being billed are on the Medicare and Third-Party Payer bypass list, then no. 	<ul style="list-style-type: none"> - When the CAS code from the EOB/EOP is included on the claim submission, along with all other COB loops and segments (e.g., allowed amount, paid amount, charged amount, deductible amount), the claim will process. However, managed care plans may request additional information such as the EOB/EOP to process the claim correctly when these details are not included in the claim submission. 				
Can a provider submit a list of all Medicaid recipients for whom they provide services?	<ul style="list-style-type: none"> - Contact Email: OhioMCD-EDI-Support@dxc.com - Phone: 844-324-7089 M-F 8 a.m. – 4:30 p.m. 	<ul style="list-style-type: none"> - Providers can request batch 270/271 through our clearinghouse (Change Healthcare), and at a transaction level through our call center or provider portal. Current infrastructure planning for 2020 does not include a direct option for 270/271 to Buckeye, although the eligibility information is available currently through our clearinghouse. 	<ul style="list-style-type: none"> - CareSource uses the 270/271 process including TPL information. 	<ul style="list-style-type: none"> - Molina Healthcare is capable of returning COB payer information via the 270/271 process if the provider has EDI connectivity with our vendor. 	<ul style="list-style-type: none"> - Paramount will accept small files (containing fewer than 25 inquiries) and look up member TPL information, then return to the provider. Large files cannot be processed in this manner. - Paramount is currently working to include TPL in the 270/271 process. The projected go live for the new system is June 2020. 	<ul style="list-style-type: none"> - The 270/271 process may be used for TPL information. - UHC will accept a list of members sent to the provider advocate and will provide TPL information on a small scale with a turnaround time of 7-10 days. (This is not intended for frequent use.) - Guidance can be found on the UHC Provider website: https://www.uhcprovi

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						der.com/en/resource-library/edi/edi-270-271.html .
How often is TPL term date information updated?	<ul style="list-style-type: none"> - TPL information can be updated at any time through Ohio Benefits or a CDJFS. - ODM may process the 6614 forms, from a provider reporting the change, making appropriate updates to MITS. 	<ul style="list-style-type: none"> - Daily 				
How long does it take to have third party insurer information verified?	<ul style="list-style-type: none"> - Usually 10 business days or less. 	<ul style="list-style-type: none"> - Usually verified and corrected within 10 business days or sooner. 				
How do I dispute when ODM or the MCP shows a third-party payer incorrectly?	<ul style="list-style-type: none"> - See the below process for how to update third party payer information quickly, using the 6614 form. 	<ul style="list-style-type: none"> - Contact Buckeye's Customer Service Call Center at 1-866-296-8731. 	<ul style="list-style-type: none"> - Contact the CareSource provider services team at: 1-800-488-0134. - Submit an inquiry to the caresource.com provider portal. - Supply proof of the TPL information with your dispute. 	<ul style="list-style-type: none"> - Send a secure email to MHOEnrollment@Molinahealthcare.com - Send a FAX to the attention of the Enrollment Department at (855) 714- 2414. 	<ul style="list-style-type: none"> - Claims can be submitted via the provider portal or mail when supporting documentation is required. - If not resolved, call provider services at 419-887-2564 to open an inquiry. 	<ul style="list-style-type: none"> - Submit a claim reconsideration via the portal - Contact the UHC Provider Services Center. - File an appeal.
What is the process for removing TPL?	<ul style="list-style-type: none"> - A Medicaid individual may report the change and provide the documentation to their CDJFS office. - A provider may follow the process outlined below regarding the 6614 form. 	<ul style="list-style-type: none"> - Buckeye updates TPL from several sources including MITS and an enhanced monthly HMS File. Buckeye also makes daily updates on an ad hoc basis. - Buckeye's HMS file includes data that has been validated based on a vendor contract 	<ul style="list-style-type: none"> - When we receive information that suggests information is inaccurate, CareSource verifies the request for removal and deletes TPL information or applies correct dates. - Once this occurs, claims are 	<ul style="list-style-type: none"> - If a member or provider contests the TPL that we have in our system, Molina enrollment staff calls the insurance carrier or looks up their website for a term date. If the term date is correct, it is updated into our system. 	<ul style="list-style-type: none"> - If a member challenges the TPL info, Paramount follows up with the TPP to validate coverage effective dates. - Providers may submit a print out from Availity, however, if that is not a resource, 	<ul style="list-style-type: none"> - TPL coverage is validated and if the other coverage is no longer active, we terminate the record in our system with the date supplied by the other carrier. - If the other coverage was loaded in error or validated the member

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	with HMS. Buckeye also has a claims operation team that validates and updates TPL information in the system as needed.	retroactively adjusted on a regular basis.	- The vendor updates records weekly with TPL effective and term dates and claims will be processed accordingly.	we re-investigate the validity based on any verbal or written info. - Weekly we receive, void, retroactive and term info from an outside vendor updating any TPP information.	never had active coverage, we add a termination date to the record in our system equal to the effective date of the record in order to be used as a reference.	
What documentation will be accepted regarding TPL?	<ul style="list-style-type: none"> - A copy of the insurance card showing dates of coverage - Screen print from primary insurance carrier showing coverage dates <p>Any of the following:</p> <ul style="list-style-type: none"> - A copy of insurance card showing dates of coverage. - Screen print from primary insurance carrier showing coverage dates. - EOB showing denial. - Communication on letterhead from TPP or email from the TPP. - Screen prints of eligibility systems. 					
What can I do to ensure third party insurer information is updated as quickly as possible?	<ul style="list-style-type: none"> - Fax 6614 Form to ODM (# located at bottom of form), making sure to complete the mandatory fields and include the documentation for terminations as outlined in the directions. If the 6614 information is not reflected after the above time period, call 614-752-5768. 	<ul style="list-style-type: none"> - Provide the necessary documentation to support the request, including the source of the information (OI denial EOP) or substantiating information that is acceptable for us to update the system(s). 	<ul style="list-style-type: none"> - Provide all relevant information related to the coordination of benefits information available to you. This would include the member information, COB payer information, and any other relevant claim/member information. 	<ul style="list-style-type: none"> - Include the Molina Healthcare ID number, a front and back copy of the other insurance ID card and verification of eligibility, including the member ID number and the coverage dates from the other TPP. - Molina also uses the ODM Health Insurance Fact Request ODM 6614. 	<ul style="list-style-type: none"> - Provided that the plan has received all the necessary information and documentation for the change, if the update is not completed within 5 business days, call provider inquiry at 419-887-2564. If the plan does not receive all the required information, additional time may be needed for the provider inquiry rep to contact the provider to obtain additional information, or for the Paramount team to outreach to the member. Any verification/EOB 	<ul style="list-style-type: none"> - Please call the Provider call center at 866-362-3368 to validate in real time as long there is proper documentation.

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<p>What steps can be taken by the provider when the third-party insurer is non-responsive?</p>	<ul style="list-style-type: none"> - Follow 5160-27-03, paragraph K regulations: http://codes.ohio.gov/oac/5160-27-03. - Is the code on the TPL bypass list? (found within the Final Services Billable to Medicare and Commercial Insurance document at https://bh.medicaid.ohio.gov/manuals) - If not, submit ODM 6653 form (available at https://medicaid.ohio.gov/RESOURCES/Publications/Medicaid-Forms) and upload the attestation. 	<ul style="list-style-type: none"> - Follow 5160-27-03, paragraph K regulations. - The provider has the option to submit an attachment through our secure web portal, electronic submission (clearinghouse), or paper claim showing billing outreach attempts or documentation showing non-responsiveness from the member’s primary insurance. - In addition, for claims which have already been submitted, the provider has the option to submit a provider adjustment request or corrected claim with any listed documentation required. 	<ul style="list-style-type: none"> - Follow 5160-27-03, paragraph K regulations. - CareSource will accept any document attached to the claim (both electronic or paper) submission and will then pay as the primary. When a third-party insurer is non-responsive, CareSource will look for the provider’s Certification Statement advising that they have not received a response/payment from the TPL. - A portal option is being implemented which will allow the provider to submit documentation online. Once the enhancement has been implemented, a notice will be sent to providers advising them of the option. 	<ul style="list-style-type: none"> - Follow 5160-27-03, paragraph K regulations. - Molina requires an attached letter from the provider attesting to the provider waiting 30 days from the time the payer is billed, having an access to care concern for the recipient, and the payer was not responsive in that 30 day timeframe from the bill date for services. - Providers can submit this letter with the associated claim either via Molina WebPortal or paper claim. - Upon receipt, Molina will review this information to ensure it meets the requirements and if met, will process the claim as primary. 	<p>makes the process faster.</p> <ul style="list-style-type: none"> - Follow 5160-27-03, paragraph K regulations. - Submit the required documentation on paper with a paper claim, or with a Claim Adjustment/Coding Review Request form for claim adjustments. <ul style="list-style-type: none"> - Follow 5160-27-03, paragraph K regulations. - Attachment to claim submissions can be done: <ul style="list-style-type: none"> • As an attachment to a paper claim submission • Through the LINK portal (Claims Portal), provider can attach documents through “Document Vault” and submit as an attachment https://www.uhcuprovider.com/en/resource-library/link-provider-self-service/document-vault.html
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The provider should refer to the bypass list on the BH Redesign website, “[Final Services Billable to Medicare and Commercial Insurance](https://bh.medicaid.ohio.gov/manuals)” under the Billing and IT Resources part of the webpage, found at <https://bh.medicaid.ohio.gov/manuals>. If the service being billed are on this list, there is no need to bill the primary insurance and Medicaid would then be billed as primary.