Frequently Asked Questions for Long Term Care (LTC) Cost Avoidance Claims Filing Through TMHP

Information posted March 6, 2013

Where should the Other Insurance (OI) information be reported on the claim?
The Other Insurance (OI) information for the individual (Medicaid Recipient) should be conveyed in the 2320 Loop.

Which Other Insurance policies should be reported on the claim?
Providers are only responsible for reporting LTC relevant OI policies that have effective and termination dates that span some part of the claim dates of service. The provider is responsible for telling TMHP about the disposition they receive from all LTC relevant OI policies, even if they do not receive a response or if the other insurer says they are not responsible for payment.

How should the termination dates of the Other Insurance policy be reported?
In **NM103 (2330B loop),** if the provider does not know the Termination Date of the Policy, they can enter any date as long as it follows the valid format of YYYYMMDD. If this policy is not on file at TMHP for the individual, it will be sent to our verification department to determine the correct date and will be updated in the Other Insurance Database

How should multiple OI information be reported on the claim?
If the individual has multiple other other insurance policies, multiple 2320 loops should be included. Each instance of the 2320 loop must have the following segments accompanying it: **NTE (Claim Note) (2300 loop), K3 (2300 loop), PWK (2300 loop).** The provider must also show the Other Insurance Paid Amount in **SV207 (2400 loop)**

What should be conveyed in the K3 segment?
K3 segment (2300 loop) should convey the Other Insurance Policy Subscriber DOB, NOT the Medicaid Subscriber DOB

How should the OI Paid Amount be reported at the detail level?
In **SV207 (2400 loop)**, populate the Total Other Insurance Paid Amount of all the policies submitted on the claim. If multiple detail lines exist, allocate the Total Other Insurance Paid amount(s) in **NTE02 (Claim Note)** across the details. The sum of all **SV207** (2400 loop) segments equals the sum of all **NTE02** (Claim Note) Positions 6-15 (2300 loop)

Do I need to account for the Other Insurance Paid Amount in the Claim Total Billed Amount?
No, do not account for any Other Insurance Paid Amounts in this segment. Continue to convey the Total Claim Billed amount in **CLM02 (2300 loop)**

Does the OI Attestation have to be included for every claim?
An OI Attestation Indicator of '**Y'** must be included on <u>every</u> claim billed for individuals in Service Groups (SG) 1 (Nursing Facility), 6 (Intermediate Care Facility), or 8 (Hospice). The indicator should be included in Position 1 of NTE02 (Billing Note) to indicate that the individual does not have OI *OR* that the OI information being reported is true and accurate.

The attestation flag must be 'Y' even if no OI information is provided to indicate that the submitter is attesting that no OI information is available.

What should be reported on the claim if the individual (Medicaid Recipient) is in SG 1, 6, or 8 and does not have OI?
In NTE (Billing Note) (2300 loop), if the individual DOES NOT have any other insurance on record (and does not have any new policies they would like to tell TMHP about), they need to submit 'Y' in Position 1 of NTE (Billing Note). Position 1 should always be 'Y' or the claim will be rejected. (See other applicable questions/answers regarding Medicare).

What positioning should be used in the NTE segments?
Fill space positions to the left of the information submitted in the **NTE** segments of the 2300 loop. Include the decimal before the 10th and 100th place for amounts. Providers can fill spaces for amounts with either zeros or spaces

Are providers now required to submit all claims to Medicare prior to Medicaid?

No, services not covered by Medicare are not required to be billed to Medicare. Medicare Attestation 'Y' is only applicable when billing skilled nursing facility Medicare coinsurance.

What should be entered in the Medicare Total Amount fields?
When billing the coinsurance or copay/deductible for a Medicare Skilled nursing facility stay, an amount must be provided for Part A OR Part C, not both. For individuals with traditional Medicare, enter the ***total coinsurance amount due*** per the Medicare Remittance Advice in the Medicare Part A Total Amount field. For individuals with non-traditional Medicare Part C, enter the ***total copay/deductible amount due*** per the Medicare Part C Explanation of Benefits (EOB) in the Medicare Part C Total Amount field. The amount entered must equal the sum of all Medicare Skilled stay detail lines on the claim,

The provider bills Medicaid only after receipt of the Medicare Remittance Advice (Part A) which authorizes the total coinsurance amount due or the Part C EOB which authorizes the total copay/deductible amount due.

EXAMPLE:
a. Traditional Medicare Part A approves 30 days in a Skilled Nursing facility stay.
b. The Medicare Part A daily coinsurance rate for 2013 is $148.00.
c. The provider bills Medicaid the coinsurance at 30 units * $148.00 for a total of $4,440.00. This is the total the user enters in the Medicare part A field.
d. The Medicare total does not change if the individual's OI paid for the coinsurance.

Is Medicare considered the same as Other Insurance?
No, Medicare and Other Insurance are considered separately. Medicare coinsurance or copay /deductible amounts should only be conveyed in the **NTE02 (Billing Note) (2300 loop)**. All Other OI information should be conveyed in the 2320 loop.

How should the Medicare Attestation flag be set?
Medicare Attestation should be conveyed in Position 2 of NTE02 (Billing Note) 2300 loop using the following guidelines:

- The Medicare Attestation must be 'Y' in Position 2 if Medicare has approved the coinsurance days for Service Group 1 Service Code 3.

- If Medicare has not approved the Skilled Nursing Facility stay, then submit an ‘N’ in Position 2 and 0.00 for the Medicare Part A and Part C amounts.

If the provider is not billing Medicare Skilled Nursing Facility Coinsurance, then submit an ‘N’ in Position 2 and 0.00 for the Medicare Part A and Part C amounts. .