MHS Coordination of Benefits (COB) 2020
Agenda

- Review Portal COB Submissions
- Where to Enter Primary Insurance Policy Info
- How to Enter Primary EOP/EOB Data:
  - Allowed amount
  - Payment amount
  - Applied to deductible
  - Applied to copayment
  - Applied to coinsurance
  - Disallowed amounts
- COB Through a Clearing House
- Reminders and Denial Codes
- Questions and Answers
- MHS Territory Maps
Provider Portal Login

Click on For Providers. Then click Login/Register for MHS Provider Portal on the Login Tab to view Vision/Dental Portal Login and Training Materials.
Secure Web Portal Login or Registration

Login/Register is the same for MHS, Ambetter from MHS, Allwell from MHS and Behavioral Health Providers
Training Documents Include:

- Account Manager Guide
- MHS Portal Brochure
- How To Guides:
  - Submit Claims
  - Correct Claims
  - View Payment History
  - Use Member Management Forms
Claims

Claims Features:
- Submit new claim.
- Review claims information on file for a patient.
- Correct claims.
- View payment history.

Submit a New Claim
- Click Create Claim and enter Member ID and Birthdate.
Claim Submission

Choose the Claim Type.

- Professional or Institutional claim submission.
Select the member for the claim you are submitting.

Enter the information necessary on general info screen such as Patient’s Account Number.

Enter the Diagnosis Codes.

On same page as Diagnosis Codes is a tab for Add Coordination of Benefits, once selected, under Primary Insurance.
COB on the Portal

Where to enter the primary carriers identifying information:

Select Carrier Type:
- Insurance Plan Name or Program Name

Policy Number:
- Enter the Primary Carriers Policy Number
COB on the Portal

- Continue entering your claim information.
- At Service Line Detail: At the bottom of the page you will need to complete the Primary Insurance Information from the EOP/EOB.
- The next three slides will be repeated for each service line that you enter.
COB on the Portal

- **Amount Allowed**: approved amount the primary carrier allowed of the billed service line.
- **Deductible**: the amount primary carrier applied to the member's deductible on this service line.
- **Copay**: flat dollar amount the member may owe for this service line.
- **Coinsurance**: the dollar amount the member may owe based on % owed on this service line.
- **Amount Paid**: this is the dollar amount the primary insurance carrier paid for this service line.
  - Dollar billed must match to the penny.
COB on the Portal

Service Line Denial Reasons:

Select the Denied Category: Be sure to select the best category for your situation from the drop down menu.

Example: Over allowable (the write off amount of the primary carrier).
Then enter the denied dollar amount for this category reason.

Then select the add denied reason.

- If this step is missed, the dollar amount will not match and the claim will deny.
COB on the Portal

Once each of the claim lines have been created and the Primary Insurance Information entered, on each claim line continue on by selecting next.

Enter Referring and Billing provider Information, select next.

If no attachments are being attached select next.

- With COB on portal you do not need to attach primary carriers EOP/EOB.

This should bring you to almost done screen, verify your information is complete and submit.
COB on the Portal

- The **Submitted** tab will show only claims created via the MHS portal.
  - **Paid** is a green thumbs up
  - **Denied** is an orange thumbs down
  - **Pending** is a clock

- **RTEP** claims also show if eligible. (i.e. line 2 was submitted. But was not eligible for RTEP.)
COB Electronic Submissions Through a Clearing House
COB Electronic Submission Through Clearing House

EDI COB Mapping Guide

This table will help your internal EDI staff and your EDI vendor understand what MHS / Centene requires to allow you to submit your secondary claims to MHS / Centene electronically. If the field segment and loop are not listed below, our system can accept the field, but the field is not required for processing of your secondary claims.

<table>
<thead>
<tr>
<th>COB Field Name (From the primary payer’s Explanation of Payment)</th>
<th>837I - Institutional FDI Segment and Loop</th>
<th>837P - Professional FDI Segment and Loop</th>
</tr>
</thead>
<tbody>
<tr>
<td>COB Paid Amount</td>
<td>2400/SVD02</td>
<td>2400/SVD02</td>
</tr>
<tr>
<td>COB Allowed Amount</td>
<td>IF 2320/AMT01 = B6, map AMT02</td>
<td>IF 2320/AMT01 = B6, map AMT02</td>
</tr>
<tr>
<td>COB Patient Liability Amount</td>
<td>If 2300/CA501 = PR, map CAS02 (This segment can have 6 occurrences. Tibco will validate all occurrences.)</td>
<td>IF 2320/AMT01 = F2, map AMT02</td>
</tr>
<tr>
<td>COB Discount Amount</td>
<td>CAS02 = 44 (prompt pay discount)</td>
<td>IF 2320/AMT01 = D8, map AMT02</td>
</tr>
<tr>
<td>COB Patient Paid Amount</td>
<td>IF 2320/AMT01 = C4, map AMT02</td>
<td>IF 2320/AMT01 = F5, map AMT02</td>
</tr>
<tr>
<td>Total Claim Before Taxes Amount</td>
<td>IF 2320/AMT01 = T3, map AMT02</td>
<td>IF 2320/AMT01 = T2, map AMT02</td>
</tr>
<tr>
<td>COB Claim Adjudication Dato</td>
<td>IF 2330B/DTPO1 = 573, map DTPO3</td>
<td>IF 2320/AMT01 = D8, map AMT02</td>
</tr>
<tr>
<td>COB Claim Adjustment Indicator</td>
<td>IF 2330B/REF01 = T4, map REF02</td>
<td>IF 2320/AMT01 = D8, map AMT02</td>
</tr>
<tr>
<td>Patient’s Full Name</td>
<td>IF 2010BA/BLK02 = 18, map NM103, NM104 &amp; NM105 ELSE map 2010CA/NM103, NM104 &amp; NM105</td>
<td>IF 2010BA/BLK02 = 18, map NM103, NM104 &amp; NM105 ELSE map 2010CA/NM103, NM104 &amp; NM105</td>
</tr>
<tr>
<td>Patient’s Date of Service</td>
<td>IF 2300/DTPO1 = 434, map DTPO3</td>
<td>IF 2400/DTPO1 = 472, map DTPO3</td>
</tr>
</tbody>
</table>

If you have any questions, please contact our EDI Help Desk at EDIBA@centene.com or by calling 1-800-225-2573 extension 25525.
MHS payment along with the Primary Carriers payment on a COB claim (Coordination of Benefits) can not be more than the Medicaid allowed amount.

- If primary pays more than the Medicaid allowed, MHS will owe no additional payment. Will see EXMX process code.

COB claim submission is 365 days from the date of service.

- However, it is recommended to submit a claim at same time you submit to primary carrier to protect your filing timeline, in the case that primary is no longer in effect or is retro updated.
Common Denial Codes

EXL6: DENY: BILL PRIMARY INSURER 1ST RESUBMIT WITH EOB

EXLR: DENY: WHEN PRIME INS RECEIVES INFO - RESUBMIT TO SECONDARY INS

EXMX: PAY: MAXIMUM ALLOWABLE HAS BEEN PAID BY PRIME INS

EXI1: OTHER INSURANCE EOB SUBMITTED DOES NOT MATCH BILLED, PLEASE RESUBMIT
Questions

Why when I entered all the information in the portal did my claim deny for EXI1?

• Verify the dollars billed to primary carrier and the dollars billed to MHS match.
• Verify the payment and write off amounts equal to the penny what was entered. Normally the Write off amount was not added so dollars do not match.

The state file does not indicate this member has other insurance, so why does MHS?

• Each of the MCE’s are required to do their own COB verification of other insurance. We have listed other carrier information, on the portal under the patient’s information on the Coordination of Benefits tab.
• If you believe the other insurance information listed on the portal is incorrect, please send us a request to re-verify COB by using contact us on the portal, by calling the Provider Service line, or by sending an email to the correct regional mailbox and ask us to verify this information.
• Also notify us if the member has other insurance that may not yet be posted.
Available online: https://www.mhsindiana.com/content/dam/centene/mhsindiana/medicaid/pdfs/ProviderTerritory_map_2020.pdf
MHS Provider Network Territories

**Network Leadership**

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**Available online:**
Thank you for being our partner in care.