ADVANCED CLAIM DENIALS

Pam Raisley, SoonerCare Education Specialist
July, 2020
DISCLAIMER

• SoonerCare policy is subject to change.
• The information included in this presentation is current as of July 2020.
PRESENTATION DESCRIPTION

• This presentation will take an in-depth look at claim denials for 1500, UB04 and dental claims on the provider portal as well as on a paper remittance advice.

• Providers will be shown how to read claim denials and the steps needed to correct those denials to achieve a successful resubmission of a denied claim.

• Recommended Audience
  • Billing staff for all provider types.
AGENDA

• Claim denials.
• Specialist requires referral.
• Name number mismatch.
• Ordering/referring required.
• Referring provider not contracted.
• Dates of service.
• Attachment required.
• Limit for service is exceeded.
AGENDA

• Third Party Liability (TPL).
• No prior authorization on database.
• Timely filing.
• Duplicate claim service.
• Recipient not eligible on dates of service.
• Missing Medicare data.
• Electronic Data Interchange (EDI).
• Resources.
CLAIM DENIALS
CLAIM DENIALS

• All claims, regardless of submission type, can be viewed on the provider portal. This includes: Electronic Data Interchange (EDI), provider portal or paper.

• There are 2 types of claim denials:
  • Claim (header).
    • Claim is denying before it gets to the line of service.
    • Fix the header denial before trying to correct line denials.
  • Detail (line item).
    • Claim line is denying.
    • Correct the line item(s).
SPECIALIST
REQUIRES
REFERRAL
SPECIALIST REQUIRES REFERRAL

I know the member is eligible, I checked it on the portal today.

Provider not eligible? I know we have a current contract.
### SPECIALIST REQUIRES REFERRAL - REMITTANCE ADVICE DENIAL

**Client Name:** SUZIE SOONERCARE  
**Client No.:** 000000123  
**2018001001123**  
**100118**  
**100118**  
**150.00**  
**0.00**  
**0.00**

<table>
<thead>
<tr>
<th>PL SERV</th>
<th>PROC CO</th>
<th>MODIFIERS</th>
<th>UNITS</th>
<th>FROM</th>
<th>THRU</th>
<th>PROVIDER</th>
<th>AMOUNT</th>
<th>DETAIL EOB</th>
<th>CODE</th>
</tr>
</thead>
<tbody>
<tr>
<td>22</td>
<td>99214</td>
<td></td>
<td>1.00</td>
<td>100118</td>
<td>100118</td>
<td>100000010</td>
<td>150.00</td>
<td>185 96 167 B7 165 A1</td>
<td></td>
</tr>
</tbody>
</table>

This is what the Detail EOBS look like. These codes are explained at the end of your remittance advice.

**HIPAA**  
**Reason Code/EOB Code**  
**185** THE RENDERING PROVIDER IS NOT ELIGIBLE TO PERFORM THE SERVICE BILLED.  
**96** NON-COVERED CHARGES ($)  
**167** THIS (THESE) DIAGNOSIS (ES) IS (ARE) NOT COVERED.  
**B7** THIS PROVIDER WAS NOT CERTIFIED/ELIGIBLE TO BE PAID FOR THIS PROCEDURE/SERVICE ON THIS DATE OF SERVICE.  
**185** PAYMENT DENIED/REDUCED FOR ABSENCE OF, OR EXCEEDED REFERRAL.  
**A1** CLAIM DENIED CHARGES.
SPECIALIST REQUIRES REFERRAL - SOLUTION

If a member has SoonerCare Choice, certain services require a referral for Providers to get paid for services rendered. And remember, if the PCP is a group, the referral needs to have the individual providers NPI/Legacy number on it.
SELF-REFERRED SERVICES (NOT ALL INCLUSIVE)

• Services provided outside the PCMH by primary care specialties
• Emergency room visits
• Inpatient hospital admissions (including professional services)
• Outpatient surgeries (facility only)
• Vision services for children
• Outpatient behavioral health services

• OB care
• Child abuse/sexual abuse exams
• Family planning services
• Dental services
• Diagnostic lab and X-ray services
• PT/OT/ST/Audiology services
• Services provided to a Native American at an IHS/ Tribal/Urban Indian Clinic
NAME NUMBER MISMATCH
Our system captures the first 2 letters of the last name and the first 3 letters of the first name.
### NAME NUMBER MISMATCH - REMITTANCE ADVICE DENIAL

<table>
<thead>
<tr>
<th>PL SERV</th>
<th>PROC CD</th>
<th>MODIFIERS</th>
<th>UNITS</th>
<th>SERVICE DATES</th>
<th>RENDERING PROVIDER</th>
<th>BILLED AMOUNT</th>
<th>DETAIL EOB</th>
<th>HIPAA REASON CODE/EOB CODE</th>
<th>HIPAA ADJ REASON/EOB CODE DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>22</td>
<td>99214</td>
<td></td>
<td>1.00</td>
<td>100118</td>
<td>100118</td>
<td>150.00</td>
<td>A1</td>
<td>A1</td>
<td>CLAIM DENIED CHARGES.</td>
</tr>
</tbody>
</table>

**CLIENT NAME:** SUZIE SOONERCARE  
**CLIENT NO.:** 000000123  
**2018001002222**  
**100118 100118 150.00 .00 0.00**  

**OKLAHOMA HEALTH CARE AUTHORITY**
NAME NUMBER MISMATCH - SOLUTION

Cut the member ID from the field, tab to get the error, then paste the number back in and tab. As you can see, the member name field is populated with the correct name. You can then go to step 3 and resubmit the claim.
ORDERING/REFERRING REQUIRED
Once again, the “real” denial makes both the provider and the member ineligible for the service rendered. Once the claim is corrected, this issue is resolved.
ORDERING/REFERRING REQUIRED - SOLUTION

Edit the claim, make the corrections on step 1, go to step 3 and resubmit the claim.
REFERRING PROVIDER NOT CONTRACTED
All referring providers must have a current SoonerCare contract.
Under the resources tab, click on “Search Provider”. You can search by NPI number, or provider type/specialty. The results are only current contracted SoonerCare providers.
REFERRING PROVIDER NOT CONTRACTED - SOLUTION

• Ordering/referring/rendering NPI must have a current SoonerCare contract.
• Ordering/referring/rendering NPI must be an individual’s number not a group number.
• If PCMH is a group, the referral should have the rendering provider NPI and name in the “Reason for Referral” section of the referral.
• Provider must be of a specialty type that is eligible to order, refer or attend.
DATES OF SERVICE
This claim isn’t really denying for dates in different months, but that is the denial that you see. If you look at the covered dates at the top of the page and then look at the dates of service on the line items, they don’t match.
### DATES OF SERVICE - SOLUTION

**Claim Information**

Enter information applicable to the claim. If Other Insurance information needs to be entered, then Include should be selected in the Other Insurance dropdown. The Other Insurance details can be entered on Submit Step 2.

<table>
<thead>
<tr>
<th>Claim Status</th>
<th>Denied</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Covered Dates</strong></td>
<td>11/23/2018 - 11/28/2018</td>
</tr>
<tr>
<td>Admission Date/Time</td>
<td></td>
</tr>
<tr>
<td>Admission Type</td>
<td></td>
</tr>
<tr>
<td>Admitting ICD Version</td>
<td>ICD-10-CM</td>
</tr>
<tr>
<td>Patient Status</td>
<td></td>
</tr>
<tr>
<td>Patient Account Number</td>
<td></td>
</tr>
</tbody>
</table>

**Total Charged Amount** $600.00

**Claim Information**

Enter information applicable to the claim. If Other Insurance information needs to be entered, then Include should be selected in the Other Insurance dropdown. The Other Insurance details can be entered on Submit Step 2.

<table>
<thead>
<tr>
<th>Claim Status</th>
<th>Denied</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Covered Dates</strong></td>
<td>11/23/2018 - 11/28/2018</td>
</tr>
<tr>
<td>Admission Date/Time</td>
<td></td>
</tr>
<tr>
<td>Admission Type</td>
<td></td>
</tr>
<tr>
<td>Admitting ICD Version</td>
<td>ICD-10-CM</td>
</tr>
<tr>
<td>Patient Status</td>
<td></td>
</tr>
<tr>
<td>Patient Account Number</td>
<td></td>
</tr>
</tbody>
</table>

**Total Charged Amount** $600.00

**Edit the claim, change the covered dates to match the actual dates on the lines of service.**
ATTACHMENT REQUIRED
## ATTACHMENT REQUIRED

First look at your claim ID number, if it starts with a 10, 20 or 22 it was NOT submitted with an attachment.

If it starts with an 11, 21 or 23 it was submitted with an attachment.

If your claim is still denying and you sent the attachment, the information we received is not what was needed to adjudicate the claim.

<table>
<thead>
<tr>
<th>Claim / Service #</th>
<th>HIPAA Adj</th>
<th>Description</th>
<th>HIPAA Adj Remark</th>
<th>Description</th>
<th>EOB</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claim</td>
<td>50</td>
<td>These are non-covered services because this is not deemed a 'medical necessity' by the payer.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Claim</td>
<td>A1</td>
<td>Claim denied charges.</td>
<td>N115</td>
<td>This decision was based on a Local Coverage Determination (LCD). An LCD provides a guide to assist in determining whether a particular item or service is covered. A copy of this policy is available at <a href="http://www.cms.gov/mcl">www.cms.gov/mcl</a>, or if you do not have web access, you may contact the contractor to request a copy</td>
<td></td>
<td>9998</td>
</tr>
<tr>
<td>Claim</td>
<td>16</td>
<td>Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate</td>
<td></td>
<td></td>
<td></td>
<td>NO ATTACHMENT HAS BEEN RECEIVED</td>
</tr>
<tr>
<td>Claim</td>
<td>45</td>
<td>Charge exceeds contracted/legislated fee arrangement. Note: This adjustment amount cannot equal the total service or claim charge amount; and must not duplicate provider adjustment amounts (payments and contractual reductions) that have resulted from prior payer(s) adjudication.</td>
<td></td>
<td></td>
<td></td>
<td>PRICING ADJUSTMENT - DRG PRICING APPLIED</td>
</tr>
</tbody>
</table>
### ATTACHMENT REQUIRED - SOLUTION

#### Attachments Form

<table>
<thead>
<tr>
<th>#</th>
<th>Transmission Method</th>
<th>File</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Click to collapse.</td>
<td></td>
</tr>
</tbody>
</table>

- **Transmission Method**: FT-File Transfer
- **Upload File**: Browse...
- **Attachment Type**: 77-Support Data for Verification
- **Description**: Primary Insur denial attached

**Actions**
- Add
- Cancel
- Submit
- Cancel

**Back to Step 1**
**Back to Step 2**
INTERNAL CONTROL NUMBER (ICN)

ICN Region Code examples:
• 10 – paper claim.
• 11 – paper claim with attachment.
• 20 – electronic claim (EDI).
• 21 – electronic claim with attachment.
• 22 – web claim submission (DDE).
• 23 – web claim submission (DDE) with attachment.
LIMIT FOR SERVICE IS EXCEEDED
LIMIT FOR SERVICE IS EXCEEDED

This is not a duplicate on the same date of service, but is a duplicate because the service has limitations.
LIMIT FOR SERVICE IS EXCEEDED - REMITTANCE ADVICE DENIAL

<table>
<thead>
<tr>
<th>PL SERV</th>
<th>PROC CD</th>
<th>TOOTH</th>
<th>SURFACE</th>
<th>DATE SVC</th>
<th>BILLING AMOUNT</th>
<th>TPL AMOUNT</th>
<th>SPENDDOWN AMOUNT</th>
</tr>
</thead>
<tbody>
<tr>
<td>11</td>
<td>D0120</td>
<td></td>
<td></td>
<td>112918</td>
<td>75.00</td>
<td>119 185 96  B7 18  A1</td>
<td>0.00</td>
</tr>
<tr>
<td>11</td>
<td>D1120</td>
<td></td>
<td></td>
<td>112518</td>
<td>75.00</td>
<td>119 185 96  B7 18  A1</td>
<td>0.00</td>
</tr>
</tbody>
</table>

TOTAL DENTAL CLAIMS DENIED: 165.00 0.00 0.00

HIPAA REASON CODE/
EOB CODE: 119
119 BENEFIT MAXIMUM FOR THIS TIME PERIOD HAS BEEN REACHED.
185 THE RENDERING PROVIDER IS NOT ELIGIBLE TO PERFORM THIS SERVICE BILLED.
96 NON-COVERED CHARGE ($).
B7 THIS PROVIDER WAS NOT CERTIFIED/ELIGIBLE TO BE PAID FOR THE PROCEDURE/SERVICE ON THIS DATE OF SERVICE.
18 DUPLICATE CLAIM/SERVICE.
A1 CLAIM DENIED CHARGES.
LIMIT FOR SERVICE IS EXCEEDED - SOLUTION

You can search treatment history on the provider portal. In this case, choose dental. Type in the member ID, choose the code and date of service and search. The results show that this code was paid to a SoonerCare contracted provider on 11/29/2018.
LIMIT FOR SERVICE IS EXCEEDED -SOLUTION

• [www.okhca.org](http://www.okhca.org)
  • Provider > Claim Tools > Fee Schedule
    • Scroll down to the most recent fee schedule
    • Dental fee schedule 01/01/19

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Amount</th>
<th>Effective Date</th>
<th>Prior Authorize</th>
<th>Tooth # Required</th>
<th>Additional Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>D0470</td>
<td>36.30</td>
<td>1/1/2019</td>
<td>N</td>
<td></td>
<td>Once per 2 yrs</td>
</tr>
</tbody>
</table>

As you can see, the code we billed is only payable once per every 2 years.
THIRD PARTY LIABILITY (TPL)
Many members have insurance in addition to SoonerCare. They can have regular insurance policies, some have HMO’s, PPO’s, Medicare Replacements and Medicare Supplements.
# THIRD PARTY LIABILITY - SOLUTION

## Eligibility

<table>
<thead>
<tr>
<th>Coverage</th>
<th>Effective Date</th>
<th>End Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title 19</td>
<td>01/01/2019</td>
<td>01/31/2019</td>
</tr>
<tr>
<td>Waiver Advantage</td>
<td>01/01/2019</td>
<td>01/31/2019</td>
</tr>
<tr>
<td>Non Emergency Transportation</td>
<td>01/01/2019</td>
<td>01/31/2019</td>
</tr>
<tr>
<td>S.L.M.B.</td>
<td>01/01/2019</td>
<td>01/31/2019</td>
</tr>
<tr>
<td>Mental Health and Substance Abuse</td>
<td>01/01/2019</td>
<td>01/31/2019</td>
</tr>
</tbody>
</table>

## Medicare

<table>
<thead>
<tr>
<th>Coverage</th>
<th>Effective Date</th>
<th>End Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare A</td>
<td>01/01/2019</td>
<td>01/31/2019</td>
</tr>
<tr>
<td>Medicare B</td>
<td>01/01/2019</td>
<td>01/31/2019</td>
</tr>
</tbody>
</table>

## TPL

<table>
<thead>
<tr>
<th>Carrier Name (Carrier ID)</th>
<th>Policy Number</th>
<th>Group ID (Employer ID)</th>
<th>Policy Holder (Relationship)</th>
<th>Policy Type</th>
<th>Coverage Type</th>
<th>Rx-BIN</th>
<th>Rx-PCN</th>
<th>Effective</th>
<th>End</th>
</tr>
</thead>
<tbody>
<tr>
<td>SECOl HORIZONS MEDICARE (0008679)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>MAJOR MEDICAL</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>01/01/2019</td>
<td>01/31/2019</td>
</tr>
</tbody>
</table>
THIRD PARTY LIABILITY – SOLUTION PRIMARY PAID
THIRD PARTY LIABILITY – SOLUTION PRIMARY DENIED
THIRD PARTY LIABILITY - SOLUTION PRIMARY DENIED
When submitting an HMO copay claim, bill only one line of service for the amount of the copay. A copy of your EOB is required.
NO PRIOR AUTHORIZATION ON DATABASE
Prior Authorizations are required for specific services, equipment, procedures or drugs that require medical review prior to payment. Prior authorizations come from the OHCA or an OHCA agent.
NO PRIOR AUTHORIZATION ON DATABASE - SOLUTION

Fill out all fields with an asterisk and search. The benefit package defaults to Title 19.
TIMELY FILING
## TIMELY FILING

### Adjudication Errors

<table>
<thead>
<tr>
<th>Claim / Service #</th>
<th>HIPAA Adj</th>
<th>Description</th>
<th>HIPAA Adj Remark</th>
<th>Description</th>
<th>EOB</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service # 1</td>
<td>29</td>
<td>The time limit for filing has expired.</td>
<td>M139</td>
<td>Denied services exceed the coverage limit for the demonstration.</td>
<td>0125</td>
<td>TIMELY FILING</td>
</tr>
<tr>
<td>Service # 1</td>
<td>A1</td>
<td>Claim denied chargos.</td>
<td>N115</td>
<td>This decision was based on a Local Coverage Determination (LCD). An LCD provides a guide to assist in determining whether a particular item or service is covered. A copy of this policy is available at <a href="http://www.cms.gov/mcd">www.cms.gov/mcd</a>, or if you do not have web access, you may contact the contractor to request a copy</td>
<td>9998</td>
<td>CLAIM WAS PRICED IN ACCORDANCE WITH CURRENT OKLAHOMA HEALTH COVERAGE PROGRAM PO</td>
</tr>
</tbody>
</table>

### Diagnosis Codes

### Other Insurance Details

### Service Details

<table>
<thead>
<tr>
<th>Svc #</th>
<th>From Date</th>
<th>To Date</th>
<th>Place of Service</th>
<th>EMG</th>
<th>Procedure Code</th>
<th>Mod</th>
<th>Diag Code Pts</th>
<th>Units</th>
<th>EPSDT</th>
<th>Charge Amount</th>
<th>Allowed Amount</th>
<th>Co-pay Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>06/27/2018</td>
<td>06/27/2018</td>
<td>11</td>
<td>N</td>
<td>99213</td>
<td>1,2</td>
<td>1.00 Unit</td>
<td>$120.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

No Attachments exist for this claim
TIMELY FILING – SOLUTION

Proof of Timely
You can send a screenshot of your claim from the provider P portal for proof of timely. Open the claim, choose print and then save the screen as PDF, JPG or TIF. We must have steps 1 and 3, not just the claim number (ICN).
TIMELY FILING – SOLUTION

• You have 183 days from the date of service to get your claims timely filed.
  • If timely filed, you have up to one year to get the claim paid with proof of timely.
    • Example: date of service is June 1, 2020, you have until November 30, 2020 to get the claim timely filed, and then with proof of timely, you have until May 31, 2020 to get the claim adjudicated.

• Crossover claims have 183 days from the date of service or 90 days from Medicare payment (no paper crossovers accepted).
TIMELY FILING - SOLUTION

• All claims more than 183 days old require proof of timely filing as an attachment.

• Proof of timely filing:
  • The full page from your remittance advice that has the ICN and all lines of service related to the claim.
  • A copy of the portal screen that includes the ICN and line item details.
  • Date stamp on a paper claim returned by OHCA or DXC.
TIMELY FILING - SOLUTION

• All claims over 12 months old must meet at least one of four exceptions (provider letter 2001-33):
  • Administrative agency corrective action or action taken to resolve a dispute.
  • Reversal of the eligibility determination.
  • Investigation for fraud or abuse of the provider.
  • Court order or hearing decision.
TIMELY FILING - SOLUTION

Medicare to SoonerCare:

• Claims for coinsurance and/or deductible must meet the Medicare timely filing requirements.

• The fiscal agent (DXC) must receive the electronic SoonerCare claim related to the Medicare service within 183 days of the date of service or within 90 days of the Medicare disposition (if more than 12 months).
DUPLICATE CLAIM SERVICE
DUPLICATE CLAIM SERVICE

Duplicate claim means there is another claim with the same dates of service.
Void the original paid claim.
DUPLICATE CLAIM SERVICE - SOLUTION

Then copy the original claim, add the additional line(s), and resubmit.
RECIPIENT NOT ELIGIBLE ON DATES OF SERVICE
RECIPIENT NOT ELIGIBLE ON DATES OF SERVICE

Member must be eligible for all dates of service on the claim. Also, you must know which program your claims pay from. It is so important to check eligibility on each date of service and to know what programs are payable for your provider type.
RECIPIENT NOT ELIGIBLE ON DATES OF SERVICE - SOLUTION

Should be checked on each visit.

Members eligibility can change on any given day.

Always click on expand all to see if the member has a primary insurance or for Behavioral Health providers, you can see if the member is enrolled in a Health Home.
These examples of eligibility show that not all members have the full scope of benefits, or in some cases, no coverage at all. Just because they have a card/number, does NOT mean they have eligibility. Remember, programs can differ from member to member.
MISSING MEDICARE DATA
MISSING MEDICARE DATA

This claim did not come across with any of the Medicare crossover information. The coinsurance and deductible should be found on each line of service on Part B claims. Part A claims still process on the header level.
Go to step 3, click on the line of service and key in the Medicare Crossover Details, click add and then resubmit the claim.
ELECTRONIC DATA INTERCHANGE (EDI)
ELECTRONIC DATA INTERCHANGE

• Submission
  • Provider, Clearing House or Billing Agency will upload the batch in the provider portal.
  • Processing time, once uploaded, is approximately three to four hours; longer on high volume days such as Tuesday and Wednesday.
  • Each batch is assigned a “Transaction ID Number” which populates back to the entity that uploaded the file in the portal.
  • 999 Report should be viewed.
ELECTRONIC DATA INTERCHANGE

• Adjudication
  • Once the batch passes compliance the claims will start to adjudicate in our system.
  • If after five to six hours you are unable to locate your claims in the portal, you should reach out to the EDI Helpdesk for troubleshooting.

• Cross Walk Failure
  • OHCA or DXC can locate the claims in the system, but the provider is unable to see them because they failed to cross over to the billing group. This happens when something either was missing or not sent correctly in loop 2010AA, N4 or NM1*85 segment (billing provider section of your claim).
ELECTRONIC DATA INTERCHANGE

• EDI will map your claims to the billing group, using the following four pieces of information:
  • NPI.
  • Zip plus 4.
  • Contract C
  • code; example “G”, it’s put on by enrollment and not every provider has one.
  • Taxonomy: You do not have to send it in your file, but if you do, it must match exactly with what we have on file for that biller.

• If any of the and components above are incorrect or missing in your batch, your claim will cross walk fail.

• Contact the EDI Helpdesk with a claims example, you will need to provide the member ID, date of service and amount billed.

• EDI will locate the failed claim and provide you with the corrections needed to fix the cross walk.
RESOURCES
RESOURCES

• **OHCA Provider Helpline:** 800-522-0114 or 405-522-6205.
  • Option 1 – OHCA Call Center.
  • Option 2,1 – Internet Help Desk.
  • Option 2,2 – EDI Helpdesk.

• **Onsite training:** [SoonerCareEducation@okhca.org](mailto:SoonerCareEducation@okhca.org).
• OKMMIS Provider Billing & Procedures Manual.
• SoonerCare Provider Portal - Medicaid on the Web Guide.