The Life of a Claim

Nevada Medicaid Provider Training

2020

Objectives

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This course will cover:

- The Claim Cycle for Direct Data Entry and Electronic Data Interchange
- Paid Claims
- Denied Claims
- Suspended Claims

Acronyms

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CCE: Clinical Claim Editor

DDE: Direct Data Entry

EDI: Electronic Data Interchange

LOA: Letter of Agreement

MMIS: Medicaid Management Information System (interChange)

PA: Prior Authorization

PWP: Provider Web Portal

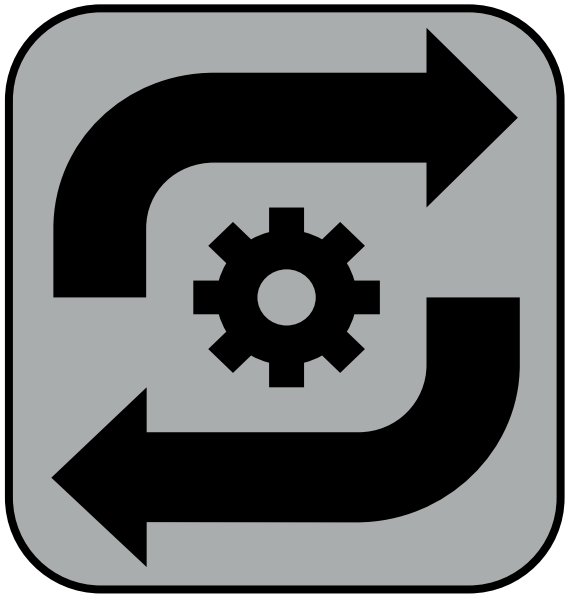
RA: Remittance Advice

SFTP: Secure File Transfer Protocol

TP: Trading Partner

The Claim Cycle

The Claim Cycle – Direct Data Entry



Provider submits claim electronically

Processed via MMIS rules (editing, auditing, PA verifications, pricing, eligibility, etc.)

Claim RECYCLED

Force Override

Claim SUSPENDED

Manual Review

In most cases, the claim processes via Clinical Claim Editor for higher level editing

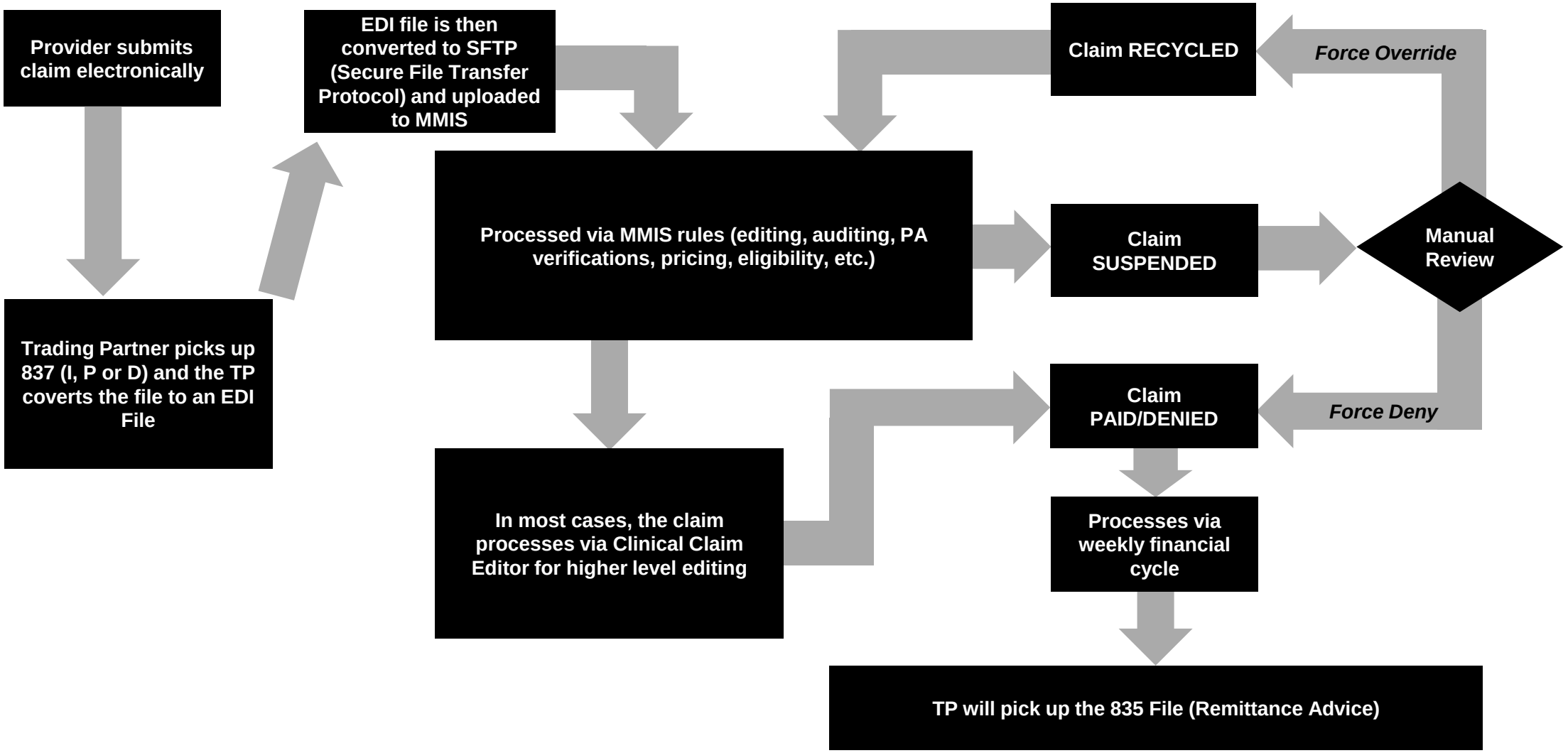
Claim PAID/DENIED

Force Deny

Processes via weekly financial cycle

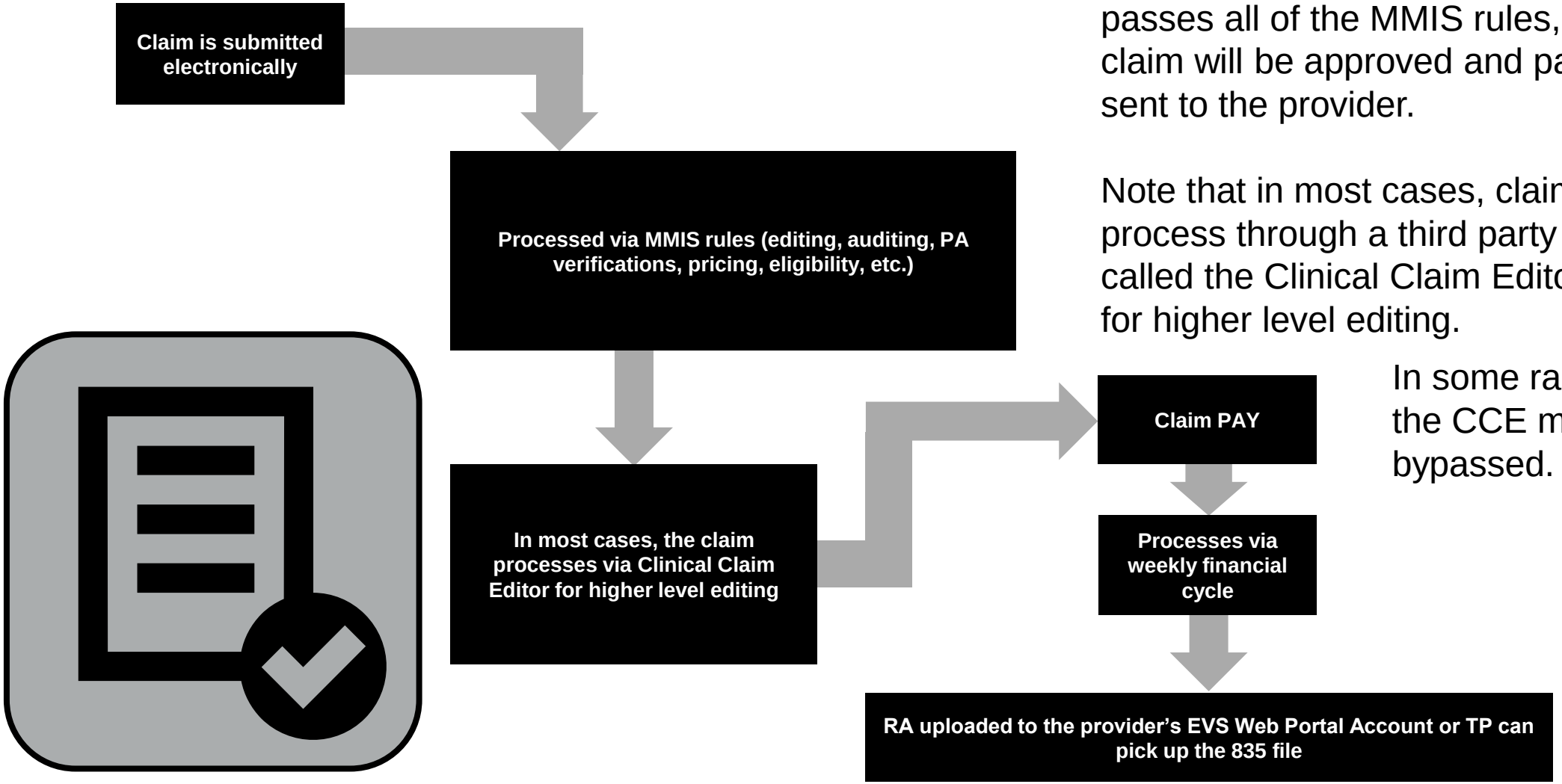
RA uploaded to the provider's EVS Web Portal Account

The Claim Cycle – Electronic Data Interchange



Paid Claims

Paid Claims

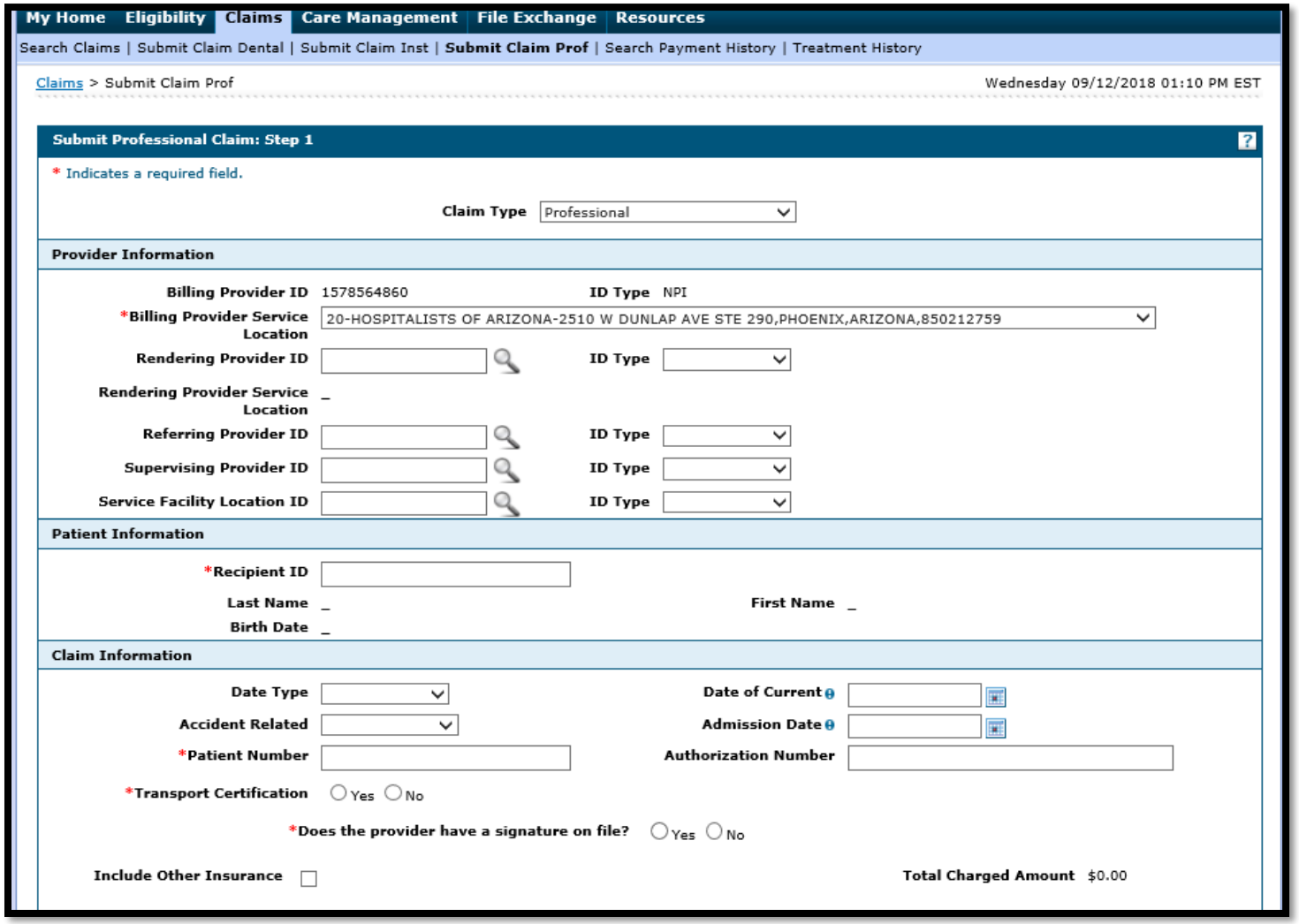


If a claim is submitted properly and passes all of the MMIS rules, then the claim will be approved and payment sent to the provider.

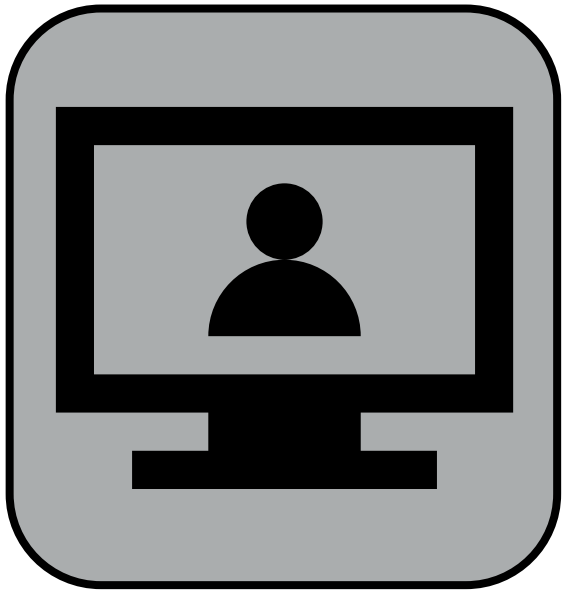
Note that in most cases, claims will process through a third party software called the Clinical Claim Editor (CCE) for higher level editing.

In some rare cases, the CCE may be bypassed.

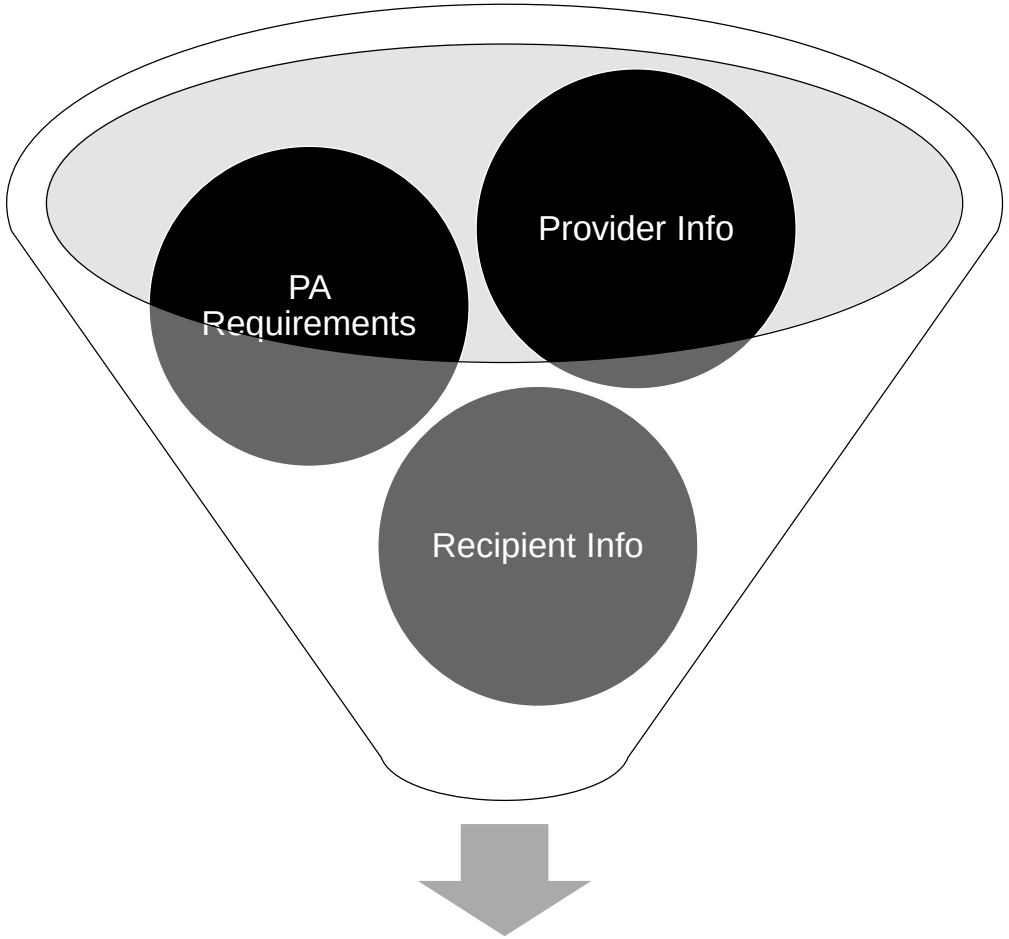
Paid Claims



To receive payment for services rendered to a Medicaid recipient, a provider must submit a claim electronically, either by direct data entry (DDE) via the Provider Web Portal (shown on the left) or by using a clearinghouse.



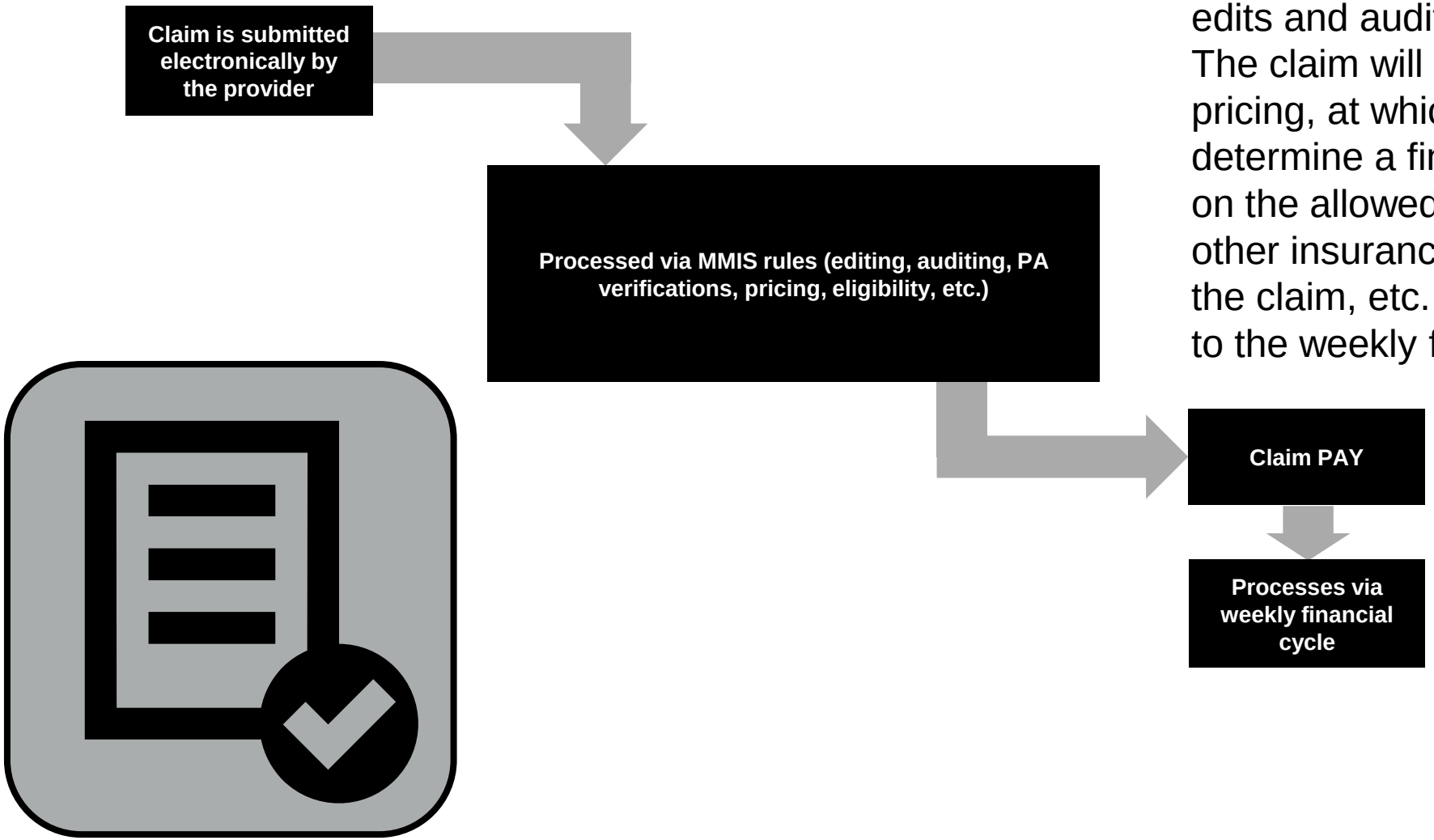
Paid Claims



Once the claim is submitted and received by the Medicaid Management Information System (MMIS), the claim will automatically undergo a series of evaluations called “edits and audits” to determine if the claim is to be approved for payment. The MMIS will check for a variety of details, including but not limited to:

- Whether the recipient has the appropriate eligibility to receive the services on the claim and meets the minimum criteria
- Whether the provider(s) (billing and/or rendering) involved in the claim have the appropriate licensure and up-to-date contracts
- Whether the procedure code is appropriate for the diagnosis
- Whether any PA requirements have been met

Paid Claims

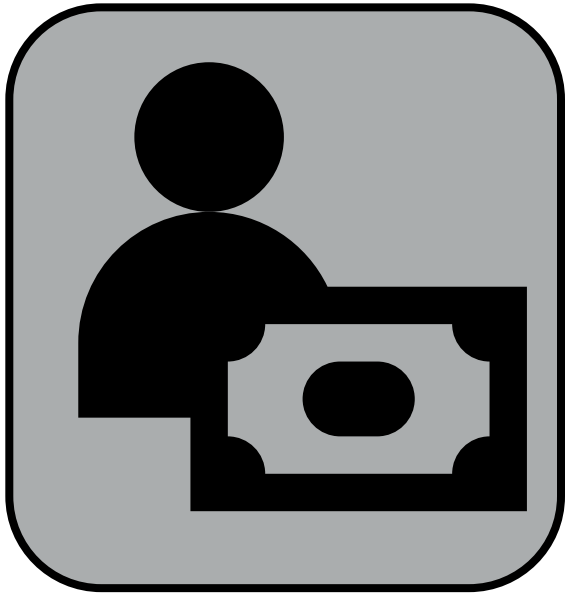


After processing through all appropriate edits and audits, the claim is set to pay. The claim will then go through final pricing, at which point the system will determine a final payment amount based on the allowed amount, patient liability, other insurance payment amount(s) on the claim, etc. The claim will then be sent to the weekly financial cycle.

Paid Claims

Claim is submitted electronically by the provider

Processed via MMIS rules (editing, auditing, PA verifications, pricing, eligibility, etc.)



In most cases, the claim processes via Clinical Claim Editor for higher level editing.

Claim PAY

Processes via weekly financial cycle

RA uploaded to the providers EVS Web Portal Account or TP can pick up the 835 file

The financial cycle will create an RA and 835 transaction file for providers and TPs who submit claims via EDI. The RA and 835 transactions show the payment to the providers. This financial cycle will process each Friday at 6 p.m. Pacific Time and providers and TPs will receive their RAs/835 transactions by the following Monday.

Paid Claims

PROGRAM: DIVISION OF HEALTH CARE FINANCING AND POLICY REPORT:
PAYEE ID: Enterprise Services, LLC. - Fiscal Agent REMIT DATE:
P.O.Box 30045 PAGE
Reno, Nevada 89520-3045 RA NUMBER:

PROFESSIONAL MEDICAL REMITTANCE ADVICE

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CLAIM TRANSACTION :

	CLAIM LINES	AMOUNT BILLED	AMOUNT PAID
ORIGINALS			
APPROVED	111	29,318.00	2,739.54
PENDED	6	3,811.00	0.00
DENIED	64	31,795.00	0.00
ADJUSTMENTS			
DEBITS	51	866.00	199.01
CREDITS	115	18,190.00-	1,055.78-
CAP. PYMTS	0	0.00	0.00
CASE MGMT.	0	0.00	0.00
NET CLAIMS TOTAL:	347	83,980.00	1,882.77

0
FINANCIAL TRANSACTION :

	PRIOR BALANCE	CYCLE INCREASE	CYCLE DECREASE	NET CYCLE	CURRENT BALANCE
NEG BALANCE	0.00	0.00	0.00	0.00	0.00
VOID CHECKS	0.00	0.00	0.00	0.00	0.00
ADD-PAYS	0.00	0.00	0.00	0.00	0.00
CUTBACKS	0.00	0.00	0.00	0.00	0.00

-

NET CLAIMS	(+)	1,882.77
ADD-PAYS	(+)	0.00
CUTBACKS	(+)	0.00
*NEGATIVE BALANCE	(-)	0.00
PROGRAM TOTAL:		1,882.77

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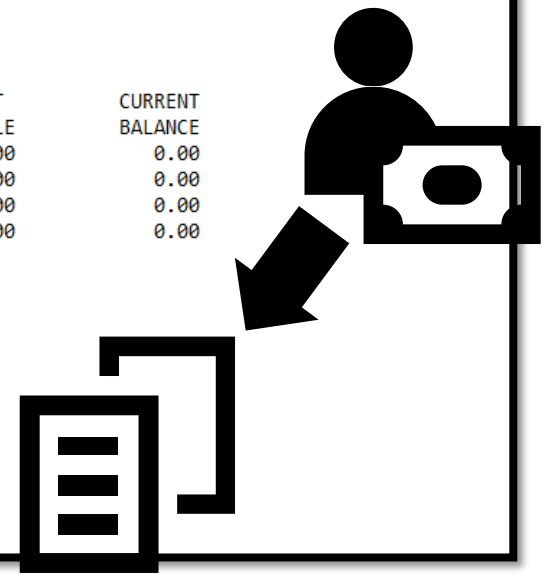
- *NEGATIVE BALANCE IS THE AMOUNT DECREASED DURING THE REMIT CYCLE

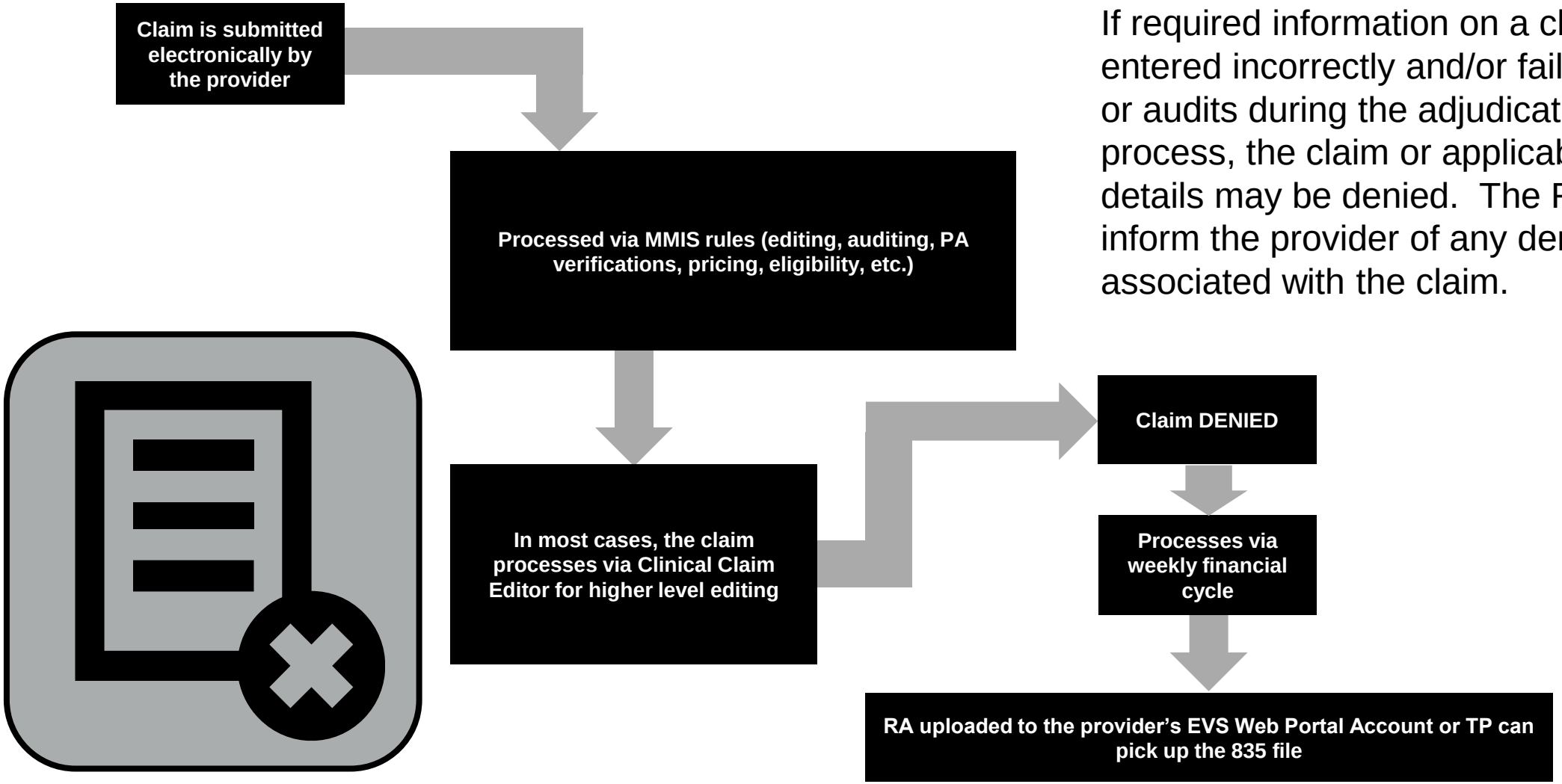


The RA that will be sent to the provider includes a description of the claim and denial information. The RA will include these details for all claims submitted in that pay period, both paid and denied claims.

The provider may review RAs in the PWP for up to six months.

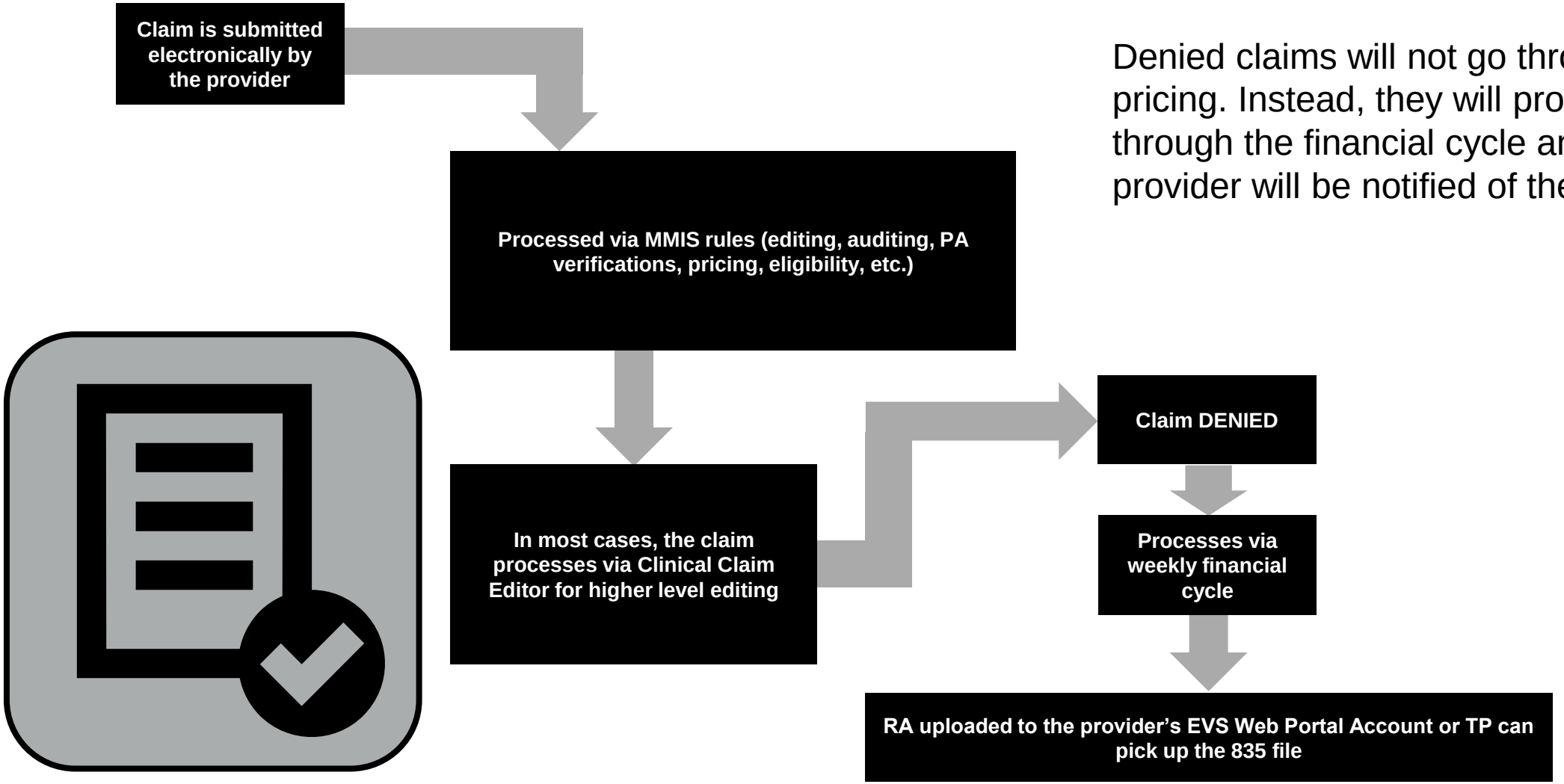
Denied Claims

Denied Claims



If required information on a claim is entered incorrectly and/or fails any edits or audits during the adjudication process, the claim or applicable service details may be denied. The RA will inform the provider of any denials associated with the claim.

Denied Claims



Denied claims will not go through final pricing. Instead, they will process through the financial cycle and the provider will be notified of the decision.

Denied Claims

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NET CLAIMS	(+)	1,882.77
ADD-PAYS	(+)	0.00
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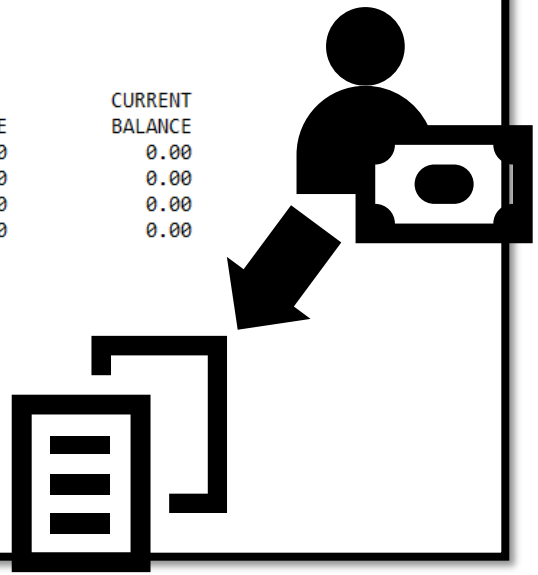
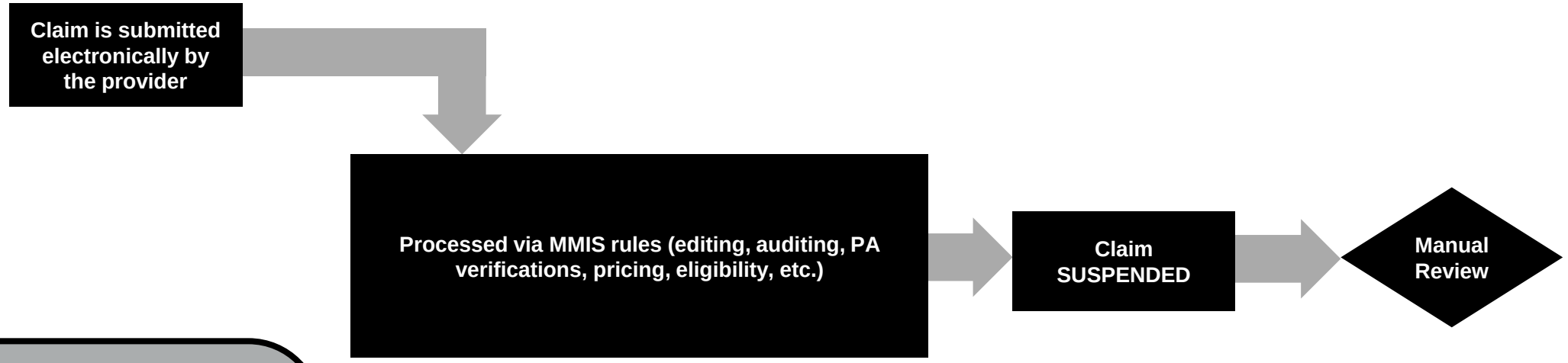


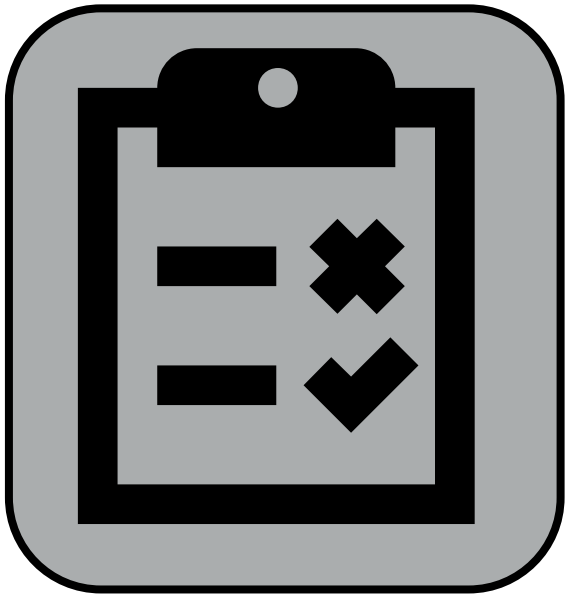
Once the claim has finished processing and run through the financial cycle, the RA that will be sent to the provider will include a description of the claim and denial information. The RA will include these details for all submitted claims in that pay period.

The provider may review RAs in the PWP for up to six months.

Suspended Claim

Suspended Claims

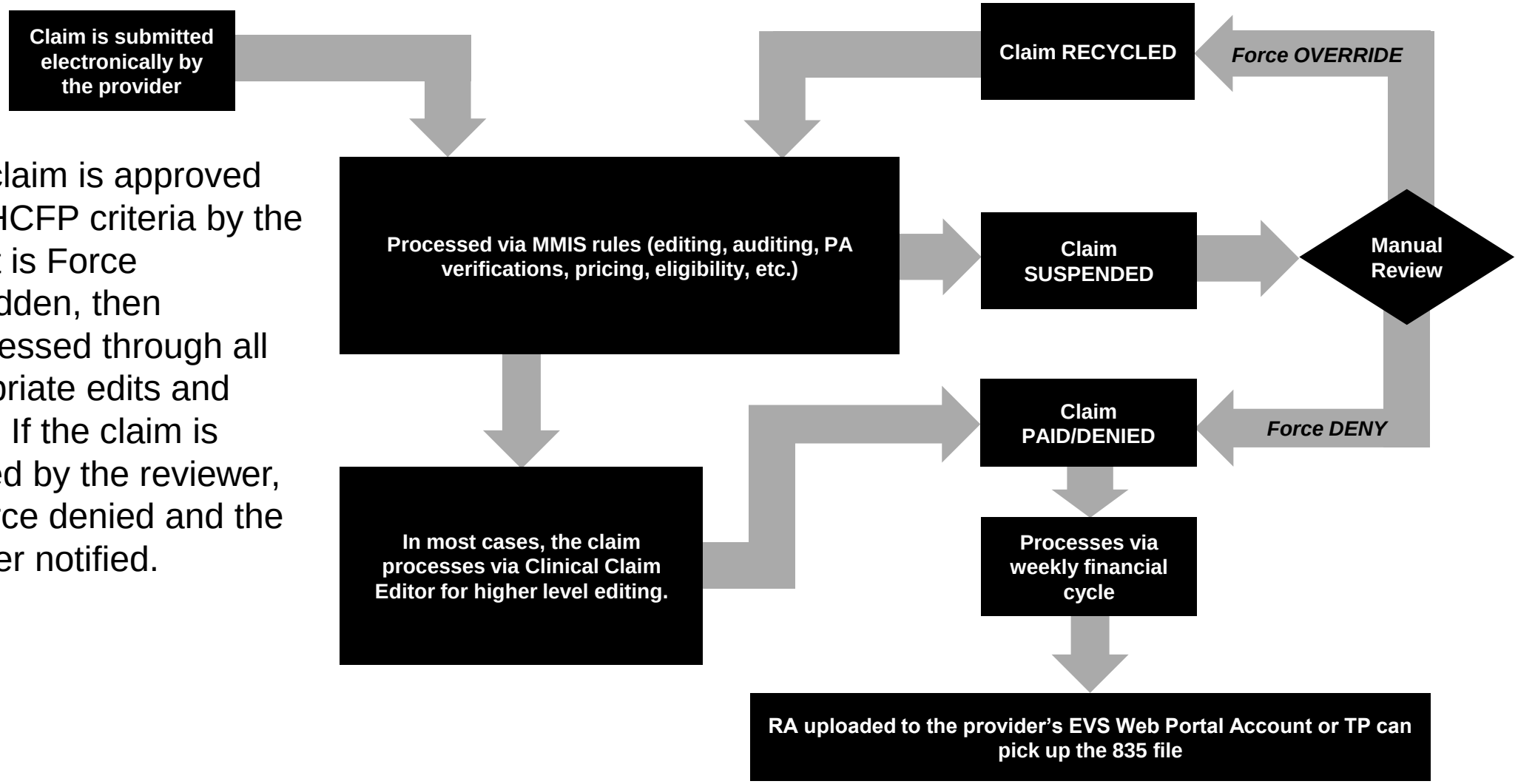




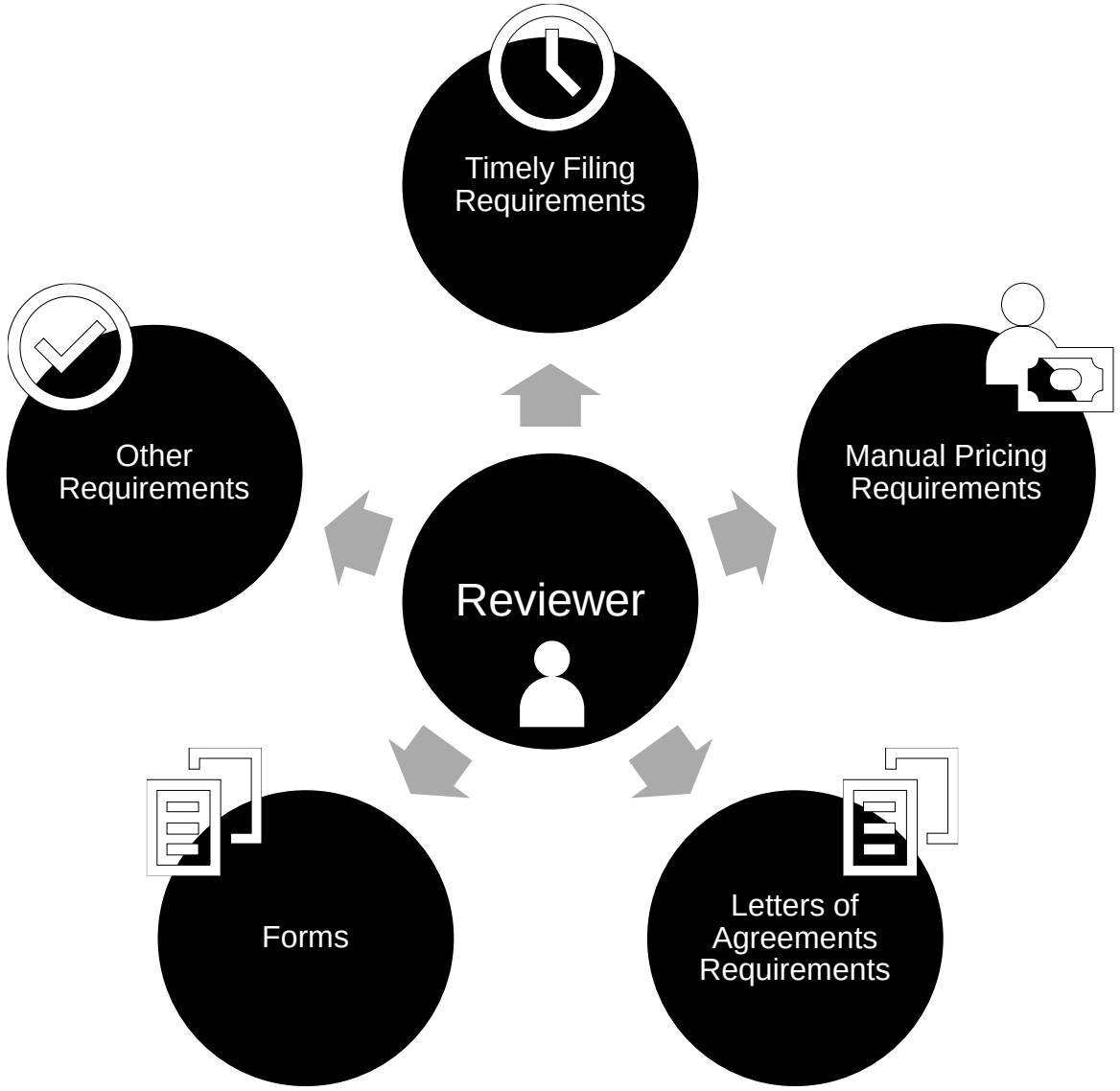
In some cases, a claim requires review once it is processed through the system edits. In such cases, the claim is suspended and submitted for manual review before it will continue through the claim cycle.

Suspended Claims

If the claim is approved per DHCFP criteria by the user, it is Force Overridden, then reprocessed through all appropriate edits and audits. If the claim is rejected by the reviewer, it is force denied and the provider notified.



Suspended Claims



A claim may suspend for a variety of reasons, including:

- timely filing requirements
- manual pricing requirements
- letters of agreement (LOAs)
- hysterectomy and abortion sterilization forms

In such cases, an auditor will review the claim against the DHCFP criteria to determine if all requirements have been met to ensure that everything is in order. If the reviewer finds that something is missing or out of order, such as a required form, the reviewer will deny the claim and the provider will be notified of the decision. If the reviewer finds that everything is in order, the claim will be reprocessed via the MMIS edits and audits.

Thank you