ADVANCED CLAIM DENIALS

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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

Adjudication Errors

Claim / Service #	HIPAA Adj	Description	HIPAA Adj Remark	Description	EOB	Description
Service # 1	A1	Claim denied charges.	N115	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 www.cms.gov/mcd, or if you do not have web access, you may contact the contractor to request a copy	9998	CLAIM WAS PRICED IN ACCORDANCE WITH CURRENT OKLAHOMA HEALTH COVERAGE PROGRAM PO
Service # 1	165	PAYMENT DENIED/REDUCED FOR ABSENCE OF, OR EXCEEDED REFERRAL.			4298	SPECIALIST REQUIRES REFERRAL
Service # 1	165	PAYMENT DENIED/REDUCED FOR ABSENCE OF, OR EXCEEDED REFERRAL.			4298	SPECIALIST REQUIRES REFERRAL
Service # 1			N190	Missing/incomplete/invalid contract indicator.	0096	PROVIDER NOT ELIGIBLE TO RENDER SERVICE ON THIS PROGRAM
Service # 1			N30	Recipient ineligible for this service.	0148	PROCEDURE NOT PAYABLE THIS RECIPIENT
Service # 1			N130	Consult plan benefit documents for information about restrictions for this service.	0630	DIAGNOSIS NOT IN SCOPE OF THE PROGRAM
Service # 1			N77	Missing/incomplete/invalid designated provider number.	0681	PROVIDER INELIGIBLE ON DATE OF SERVICE
Service # 1	165	PAYMENT DENIED/REDUCED FOR ABSENCE OF, OR EXCEEDED REFERRAL.			4298	SPECIALIST REQUIRES REFERRAL
Service # 1			N190	Missing/incomplete/invalid contract indicator.	0096	PROVIDER NOT ELIGIBLE TO RENDER SERVICE ON THIS PROGRAM
Service # 1			N77	Missing/incomplete/invalid designated provider number.	0681	PROVIDER INELIGIBLE ON DATE OF SERVICE
Service # 1	165	PAYMENT DENIED/REDUCED FOR ABSENCE OF, OR EXCEEDED REFERRAL.			4298	SPECIALIST REQUIRES REFERRAL

Diagnosis Codes

Service Details

Svc #	From Date	To Date	Place of Service	EMG	Procedure Code	Mod	Diag Code Ptrs	Units	EPSDT	Charge Amount	Allowed Amount	Co-pay Amount
1 Denied	10/01/2018	10/01/2018	22	Unknown	99214		1,2,3,4	1.00 Unit		$150.00	$0.00	$0.00

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 .00 0.00

SuzieS123

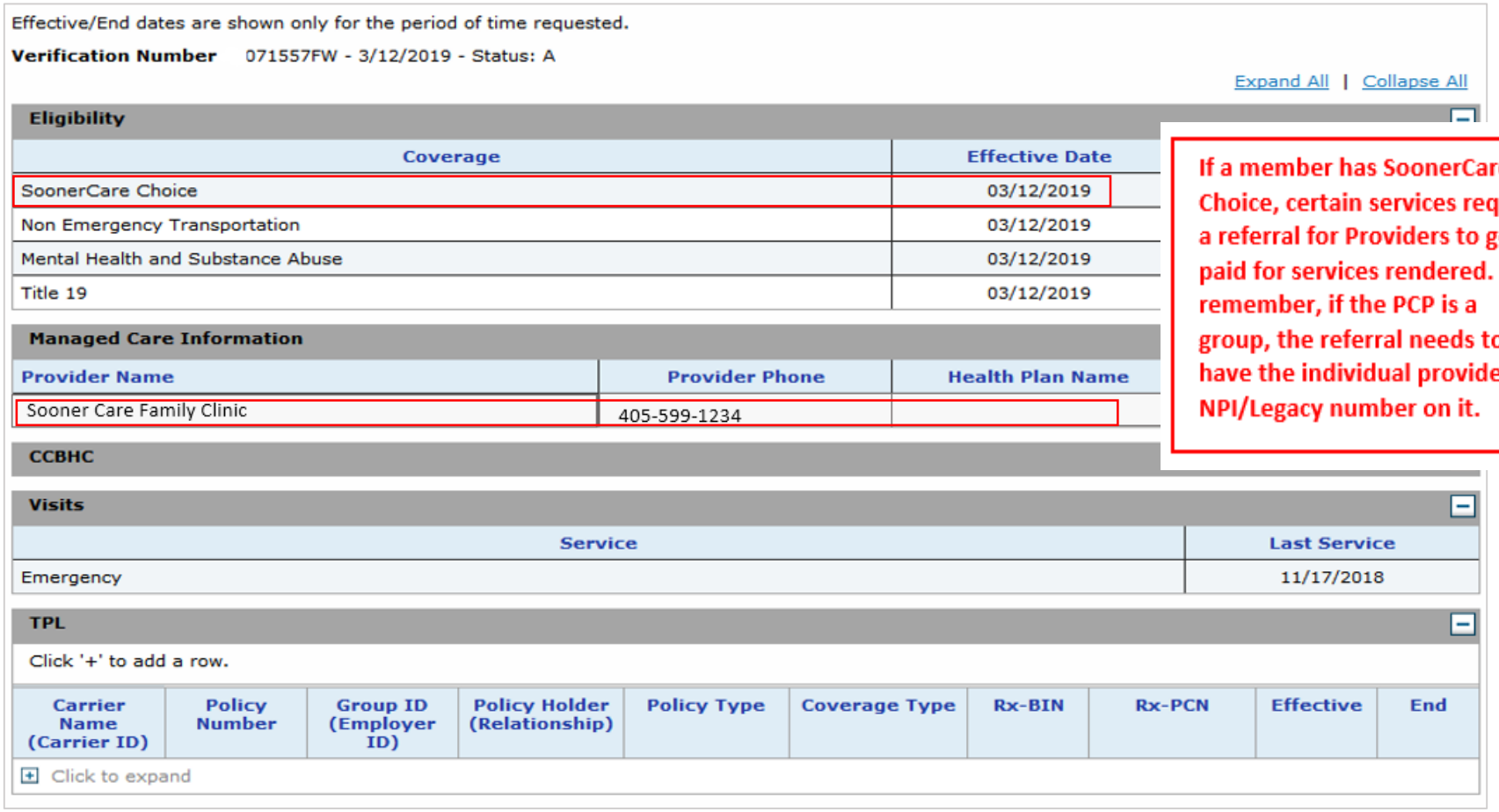
PL SERV	PROC CD	MODIFIERS	UNITS	SERVICE DATES FROM	SERVICE DATES THRU	RENDERING PROVIDER	BILLED AMOUNT	DETAIL EOBS
22	99214		1.00	100118	100118	100000010	150.00	185 96 167 B7 165 A1

These codes are explained at the end of your remittance advice.

This is what the Detail EOBS look like.

HIPAA REASON CODE/ EOB CODE	HIPAA ADJ REASON/EOB CODE DESCRIPTION.
185	THE RENDERING PROVIDER IS NOT ELIGIBLE TO PERFORM THE SERVICE BILLED.
96	NON-COVERED CHARGES (S).
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.
165	PAYMENT DENIED/REDUCED FOR ABSENCE OF, OR EXCEEDED REFERRAL.
A1	CLAIM DENIED CHARGES.

SPECIALIST REQUIRES REFERRAL - SOLUTION



Effective/End dates are shown only for the period of time requested.

Verification Number 071557FW - 3/12/2019 - Status: A

Expand All | Collapse All

Eligibility

Coverage	Effective Date
SoonerCare Choice	03/12/2019
Non Emergency Transportation	03/12/2019
Mental Health and Substance Abuse	03/12/2019
Title 19	03/12/2019

Managed Care Information

Provider Name	Provider Phone	Health Plan Name
Sooner Care Family Clinic	405-599-1234	

CCBHC

Visits

Service	Last Service
Emergency	11/17/2018

TPL

Click '+' to add a row.

Carrier Name (Carrier ID)	Policy Number	Group ID (Employer ID)	Policy Holder (Relationship)	Policy Type	Coverage Type	Rx-BIN	Rx-PCN	Effective	End

Click to expand

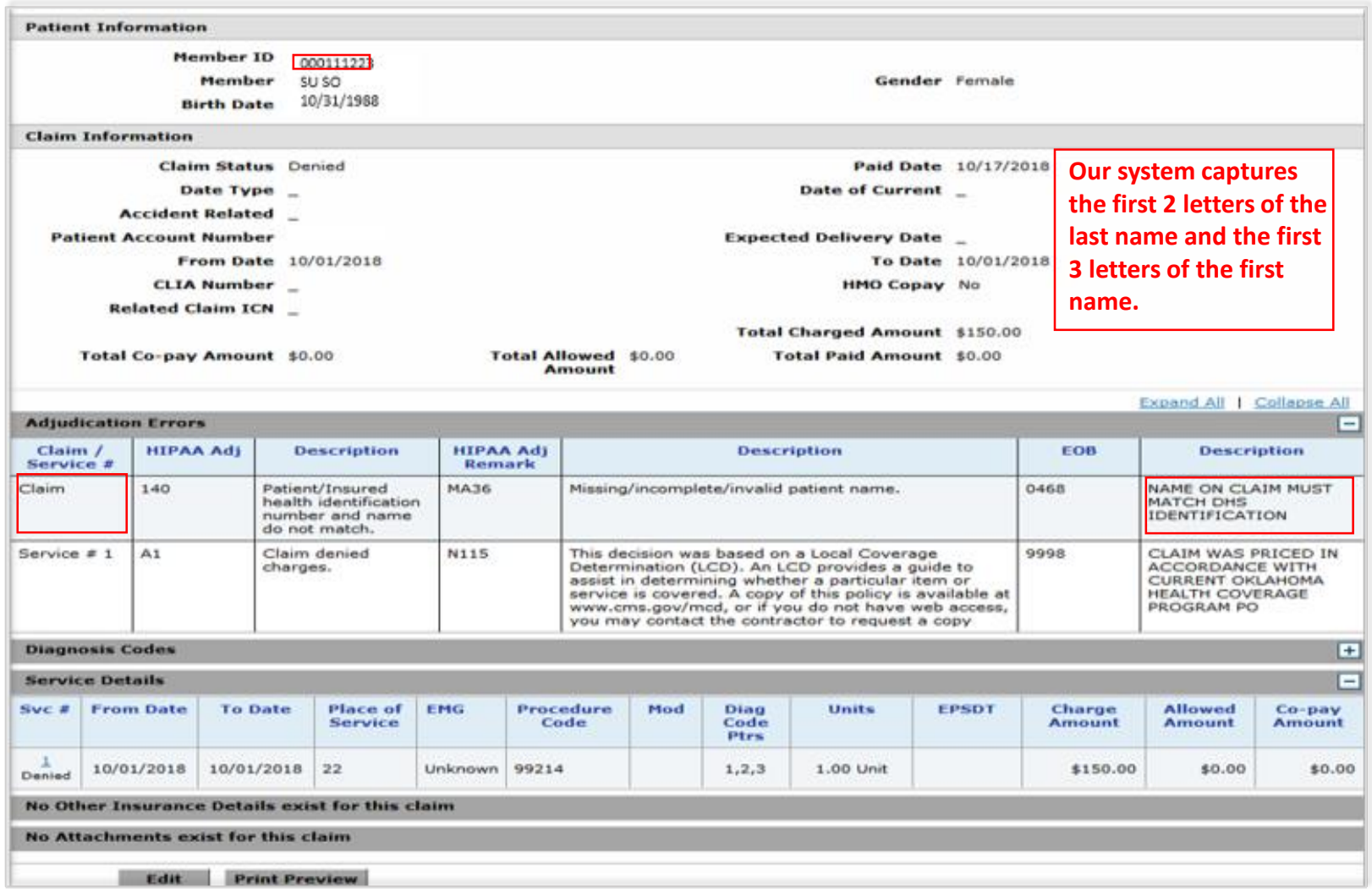
If a member has SoonerCare Choice, certain services require a referral for Providers to get paid for services rendered. And remember, if the PCP is a group, the referral needs to have the individual providers NPI/Legacy number on it.

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

NAME NUMBER MISMATCH



Patient Information

Member ID 00011122
Member SU SO
Birth Date 10/31/1988
Gender Female

Claim Information

Claim Status Denied
Date Type _
Accident Related _
Patient Account Number
From Date 10/01/2018
CLIA Number _
Related Claim ICN _
Paid Date 10/17/2018
Date of Current _
Expected Delivery Date _
To Date 10/01/2018
HMO Copay No
Total Charged Amount $150.00
Total Co-pay Amount $0.00
Total Allowed Amount $0.00
Total Paid Amount $0.00

Our system captures the first 2 letters of the last name and the first 3 letters of the first name.

Expand All | Collapse All

Adjudication Errors

Claim / Service #	HIPAA Adj	Description	HIPAA Adj Remark	Description	EOB	Description
Claim	140	Patient/Insured health identification number and name do not match.	MA36	Missing/incomplete/invalid patient name.	0468	NAME ON CLAIM MUST MATCH DHS IDENTIFICATION
Service # 1	A1	Claim denied charges.	N115	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 www.cms.gov/mcd, or if you do not have web access, you may contact the contractor to request a copy	9998	CLAIM WAS PRICED IN ACCORDANCE WITH CURRENT OKLAHOMA HEALTH COVERAGE PROGRAM PO

Diagnosis Codes

Service Details

Svc #	From Date	To Date	Place of Service	EMG	Procedure Code	Mod	Diag Code Ptrs	Units	EPSDT	Charge Amount	Allowed Amount	Co-pay Amount
1 Denied	10/01/2018	10/01/2018	22	Unknown	99214		1,2,3	1.00 Unit		$150.00	$0.00	$0.00

No Other Insurance Details exist for this claim

No Attachments exist for this claim

Edit | Print Preview

NAME NUMBER MISMATCH - REMITTANCE ADVICE DENIAL

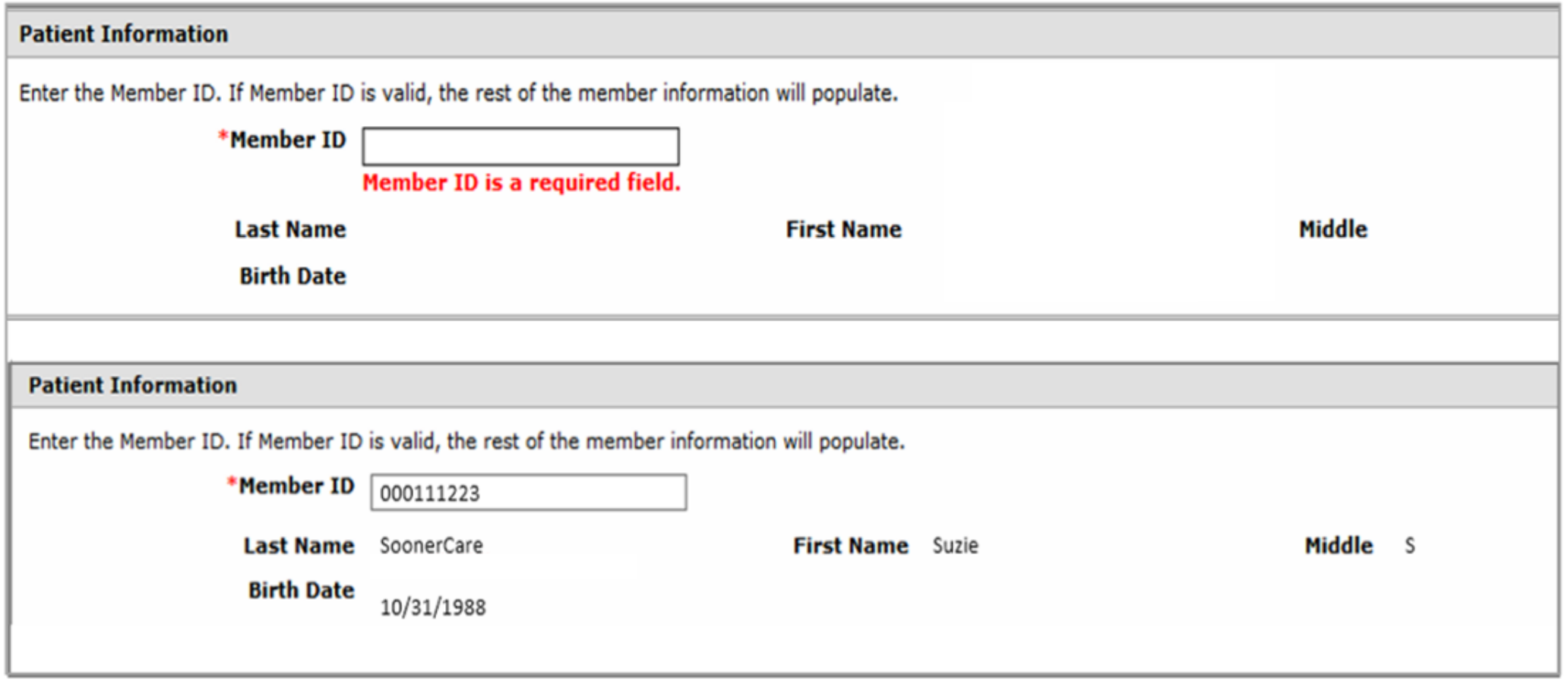
CLIENT NAME: SUZIE SOONERCARE CLIENT NO.: 000000123

2018001002222			100118	100118	150.00	.00	0.00

PL SERV	PROC CD	MODIFIERS	UNITS	SERVICE DATES FROM	SERVICE DATES THRU	RENDERING PROVIDER	BILLED AMOUNT	DETAIL EOBS
22	99214		1.00	100118	100118	100000010	150.00	A1

HIPAA REASON CODE/ EOB CODE	HIPAA ADJ REASON/EOB CODE DESCRIPTION.
A1	CLAIM DENIED CHARGES.

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

ORDERING/REFERRING REQUIRED

Adjudication Errors

Claim / Service #	HIPAA Adj	Description	HIPAA Adj Remark	Description	EOB	Description
Service # 1	A1	Claim denied charges.	N115	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 www.cms.gov/mcd, or if you do not have web access, you may contact the contractor to request a copy	9998	CLAIM WAS PRICED IN ACCORDANCE WITH CURRENT OKLAHOMA HEALTH COVERAGE PROGRAM PD
Service # 1	183	THE REFERRING PROVIDER IS NOT ELIGIBLE TO REFER THE SERVICE BILLED.	N265	MISSING/INCOMPLETE/INVALID ORDERING PROVIDER PRIMARY IDENTIFIER.	1138	HCPCS OR CPT CODE REQUIRES AN ORDERING/REFERRING NPI
Service # 1			N30	Recipient ineligible for this service.	0148	PROCEDURE NOT PAYABLE THIS RECIPIENT
Service # 1	183	THE REFERRING PROVIDER IS NOT ELIGIBLE TO REFER THE SERVICE BILLED.	N265	MISSING/INCOMPLETE/INVALID ORDERING PROVIDER PRIMARY IDENTIFIER.	1138	HCPCS OR CPT CODE REQUIRES AN ORDERING/REFERRING NPI
Service # 1			N190	Missing/incomplete/invalid contract indicator.	0096	PROVIDER NOT ELIGIBLE TO RENDER SERVICE ON THIS PROGRAM
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Service # 1			N130	Consult plan benefit documents for information about restrictions for this service.	0630	DIAGNOSIS NOT IN SCOPE OF THE PROGRAM
Service # 1			N77	Missing/incomplete/invalid designated provider number.	0681	PROVIDER INELIGIBLE ON DATE OF SERVICE
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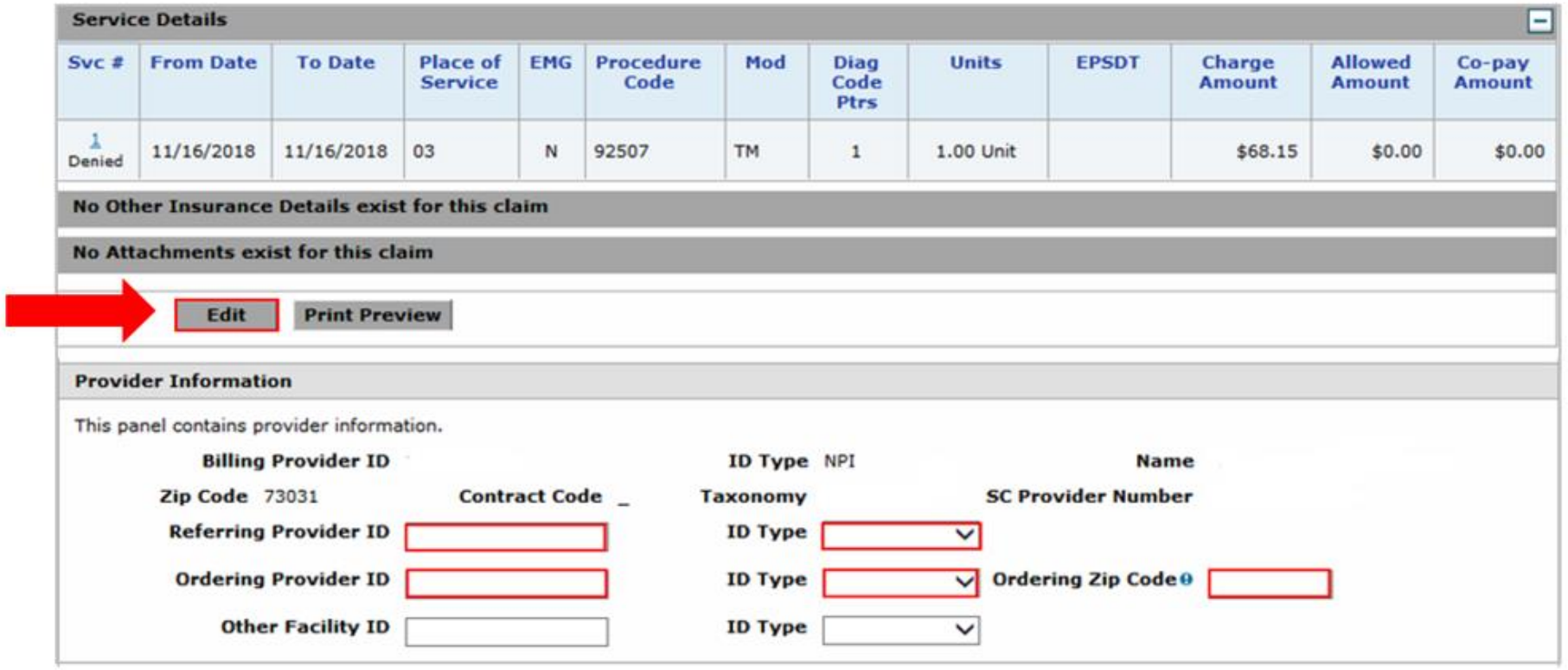
Diagnosis Codes

Service Details

Svc #	From Date	To Date	Place of Service	EMG	Procedure Code	Mod	Diag Code Ptrs	Units	EPSDT	Charge Amount	Allowed Amount	Co-pay Amount
1 Denied	11/16/2018	11/16/2018	03	N	92507	TM	1	1.00 Unit		$68.15	$0.00	$0.00

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



Service Details

Svc #	From Date	To Date	Place of Service	EMG	Procedure Code	Mod	Diag Code Ptrs	Units	EPSDT	Charge Amount	Allowed Amount	Co-pay Amount
Denied	11/16/2018	11/16/2018	03	N	92507	TM	1	1.00 Unit		$68.15	$0.00	$0.00

No Other Insurance Details exist for this claim

No Attachments exist for this claim

Edit | Print Preview

Provider Information

This panel contains provider information.

Billing Provider ID | ID Type NPI | Name

Zip Code 73031 | Contract Code _ | Taxonomy | SC Provider Number

Referring Provider ID | ID Type

Ordering Provider ID | ID Type | Ordering Zip Code

Other Facility ID | ID Type

Edit the claim, make the corrections on step 1, go to step 3 and resubmit the claim.

REFERRING PROVIDER NOT CONTRACTED

REFERRING PROVIDER NOT CONTRACTED

Adjudication Errors

Claim / Service #	HIPAA Adj	Description	HIPAA Adj Remark	Description	EOB	Description
Claim	183	THE REFERRING PROVIDER IS NOT ELIGIBLE TO REFER THE SERVICE BILLED.			4250	REFERRING PROVIDER NOT CONTRACTED
Service # 1	A1	Claim denied charges.	N115	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 www.cms.gov/mcd, or if you do not have web access, you may contact the contractor to request a copy	9998	CLAIM WAS PRICED IN ACCORDANCE WITH CURRENT OKLAHOMA HEALTH COVERAGE PROGRAM PO
Service # 1	97	Payment is included in the allowance for another service/procedure.	M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	7260	MORE THAN 100 LINES WERE ELIGIBLE FOR CLAIMCHECK PROCESSIN

Diagnosis Codes

Service Details

Svc #	From Date	To Date	Place of Service	EMG	Procedure Code	Mod	Diag Code Ptrs	Units	EPSDT	Charge Amount	Allowed Amount	Co-pay Amount
1 Denied	09/01/2017	09/01/2017	11	Unknown	99214		1	1.00 Unit		$202.00	$0.00	$0.00

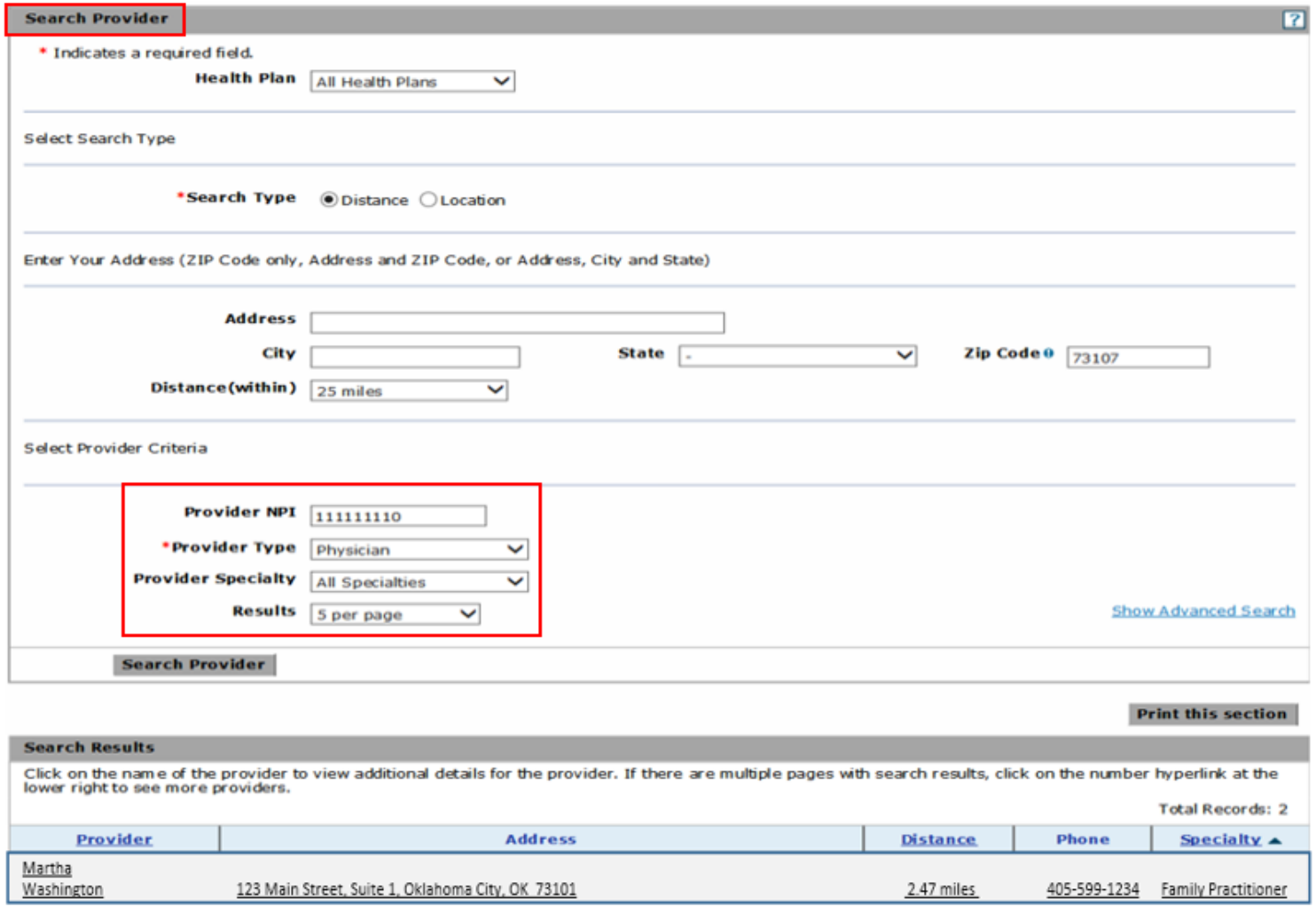
No Other Insurance Details exist for this claim

No Attachments exist for this claim

Edit | Print Preview

All referring providers must have a current SoonerCare contract.

REFERRING PROVIDER NOT CONTRACTED - SOLUTION



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

DATES OF SERVICE

Claim Information

Claim Status	Denied	**Paid Date**	12/19/2018
Covered Dates	11/02/2018 - 12/01/2018	**Covered Days**	0
Admission Date/Hour	_	**Discharge Hour**	_
Admission Type	_	**Admission Source**	_
Admitting ICD Version	_	**Admitting Diagnosis**	_
Patient Status	_	**Type of Bill**	331
Patient Account Number	_	**Related Claim ICN**	_
		Total Charged Amount	$600.00
Total Co-pay Amount	$0.00	**Total Allowed Amount**	$0.00
		Total Paid Amount	$0.00

Expand All | Collapse All

Adjudication Errors

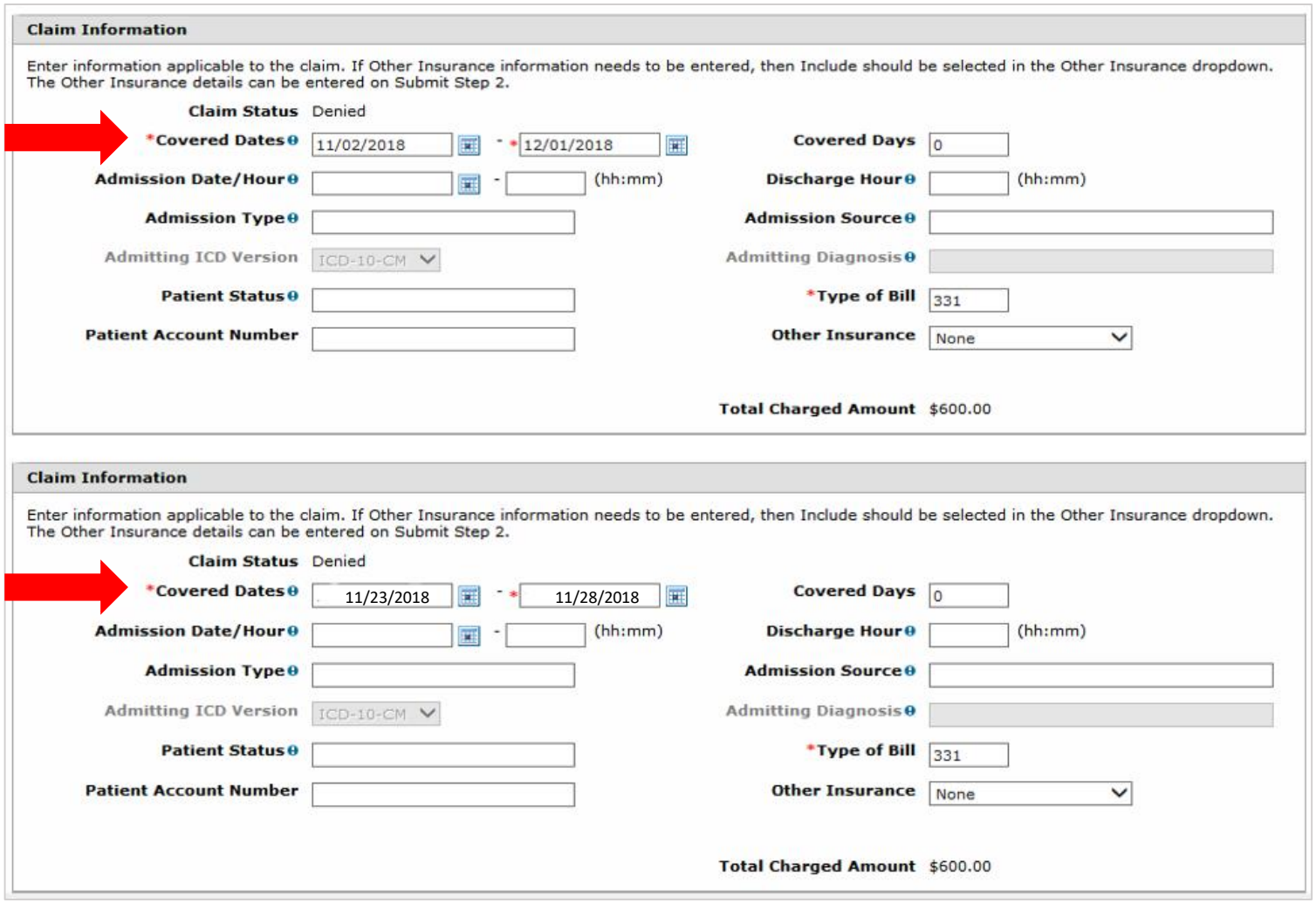
Claim / Service #	HIPAA Adj	Description	HIPAA Adj Remark	Description	EOB	Description
Claim	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N300	MISSING/INCOMPLETE/INVALID OCCURRENCE SPAN DATE(S).	0223	SERVICE DATES ARE NOT IN SAME MONTH
Service # 1	A1	Claim denied charges.	N115	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 www.cms.gov/mcd, or if you do not have web access, you may contact the contractor to request a copy	9998	CLAIM WAS PRICED IN ACCORDANCE WITH CURRENT OKLAHOMA HEALTH COVERAGE PROGRAM PO
Service # 2	A1	Claim denied charges.	N115	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 www.cms.gov/mcd, or if you do not have web access, you may contact the contractor to request a copy	9998	CLAIM WAS PRICED IN ACCORDANCE WITH CURRENT OKLAHOMA HEALTH COVERAGE PROGRAM PO

Service Details

Svc #	Revenue Code	HCPCS/Proc Code	Mod	From Date	To Date	Units/Type	Charge Amount	Allowed Amount	Co-pay Amount
1 Denied	551			11/23/2018	11/23/2018	3.00 Unit	$200.00	$0.00	$0.00
2 Denied	551			11/28/2018	11/28/2018	3.00 Unit	$200.00	$0.00	$0.00

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.

Claim Status Denied

***Covered Dates** 11/02/2018 - *12/01/2018 **Covered Days** 0

Admission Date/Hour - (hh:mm) **Discharge Hour** (hh:mm)

Admission Type **Admission Source**

Admitting ICD Version ICD-10-CM **Admitting Diagnosis**

Patient Status ***Type of Bill** 331

Patient Account Number **Other Insurance** None

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.

Claim Status Denied

***Covered Dates** 11/23/2018 - *11/28/2018 **Covered Days** 0

Admission Date/Hour - (hh:mm) **Discharge Hour** (hh:mm)

Admission Type **Admission Source**

Admitting ICD Version ICD-10-CM **Admitting Diagnosis**

Patient Status ***Type of Bill** 331

Patient Account Number **Other Insurance** None

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

Adjudication Errors

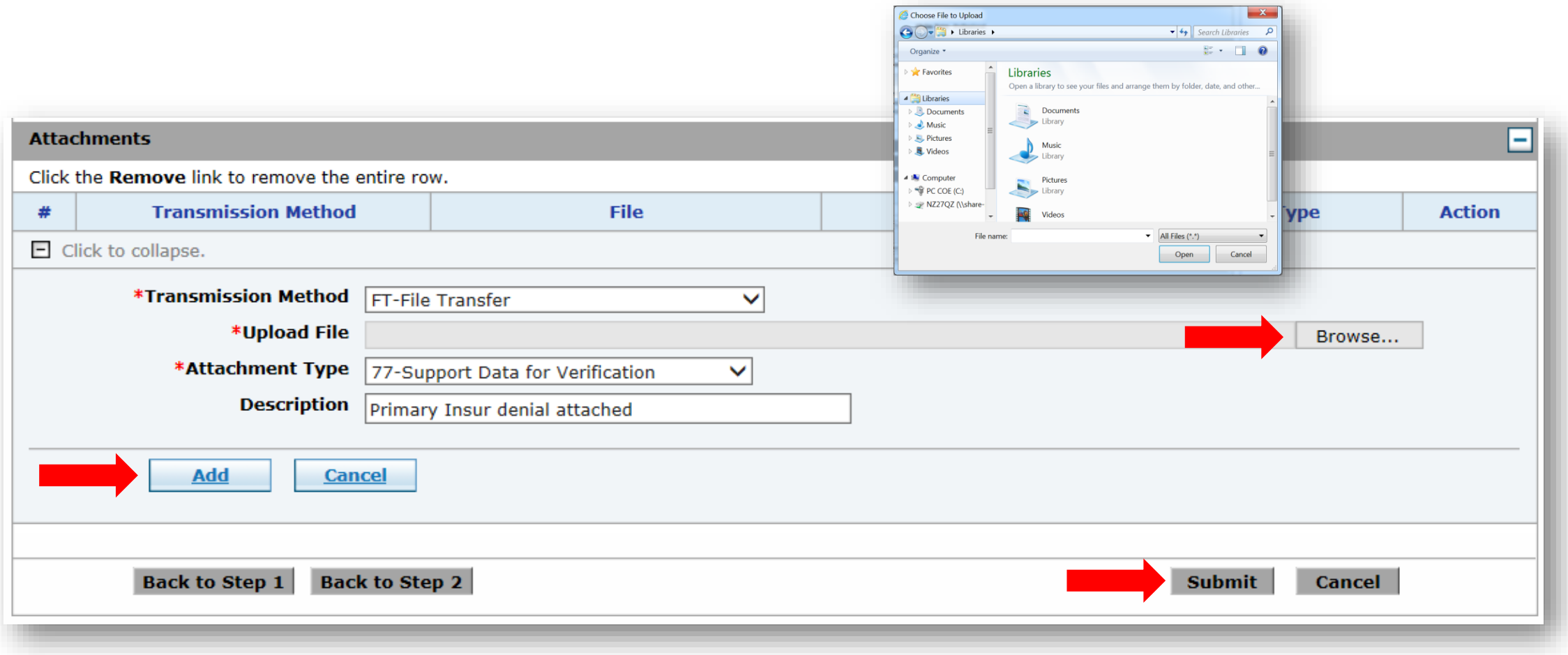
Claim / Service #	HIPAA Adj	Description	HIPAA Adj Remark	Description	EOB	Description
Claim	50	These are non-covered services because this is not deemed a `medical necessity' by the payer.			0723	SERVICES REQ DOCUMENTATION FOR MEDICAL NECESSITY
Claim	A1	Claim denied charges.	N115	This decision was based 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 www.cms.gov/mcd, or if you do not have web access, you may contact the contractor to request a copy	9998	CLAIM WAS PRICED IN ACCORDANCE WITH CURRENT OKLAHOMA HEALTH COVERAGE PROGRAM PO
Claim	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate			9667	NO ATTACHMENT HAS BEEN RECIEVED
Claim	45	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.			9928	PRICING ADJUSTMENT - DRG PRICING APPLIED

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.

ATTACHMENT REQUIRED - SOLUTION



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

Adjudication Errors

Claim / Service #	HIPAA Adj	Description	HIPAA Adj Remark	Description	EOB	Description
Service # 1	A1	Claim denied charges.	N115	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 www.cms.gov/mcd, or if you do not have web access, you may contact the contractor to request a copy	9998	CLAIM WAS PRICED IN ACCORDANCE WITH CURRENT OKLAHOMA HEALTH COVERAGE PROGRAM PO
Service # 1	18	Duplicate claim/service.	M86	SERVICE DENIED BECAUSE PAYMENT ALREADY MADE FOR SAME/SIMILAR PROCEDURE WITHIN SET TIME FRAME.	5001	THIS IS A DUPLICATE OF ANOTHER CLAIM.
Service # 1	45	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.			9918	PRICING ADJUSTMENT - MAX FEE PRICING APPLIED
Service # 1	35	Benefit maximum has been reached.	M139	Denied services exceed the coverage limit for the demonstration.	0003	LIMIT FOR THIS SERVICE IS EXCEEDED
Service # 1	18	Duplicate claim/service.	M86	SERVICE DENIED BECAUSE PAYMENT ALREADY MADE FOR SAME/SIMILAR PROCEDURE WITHIN SET TIME FRAME.	0807	POSSIBLE DUPLICATE OF ANOTHER CLAIM
Service # 1			N30	Recipient ineligible for this service.	0148	PROCEDURE NOT PAYABLE THIS RECIPIENT
Service # 1			N190	Missing/incomplete/invalid contract indicator.	0096	PROVIDER NOT ELIGIBLE TO RENDER SERVICE ON THIS PROGRAM

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

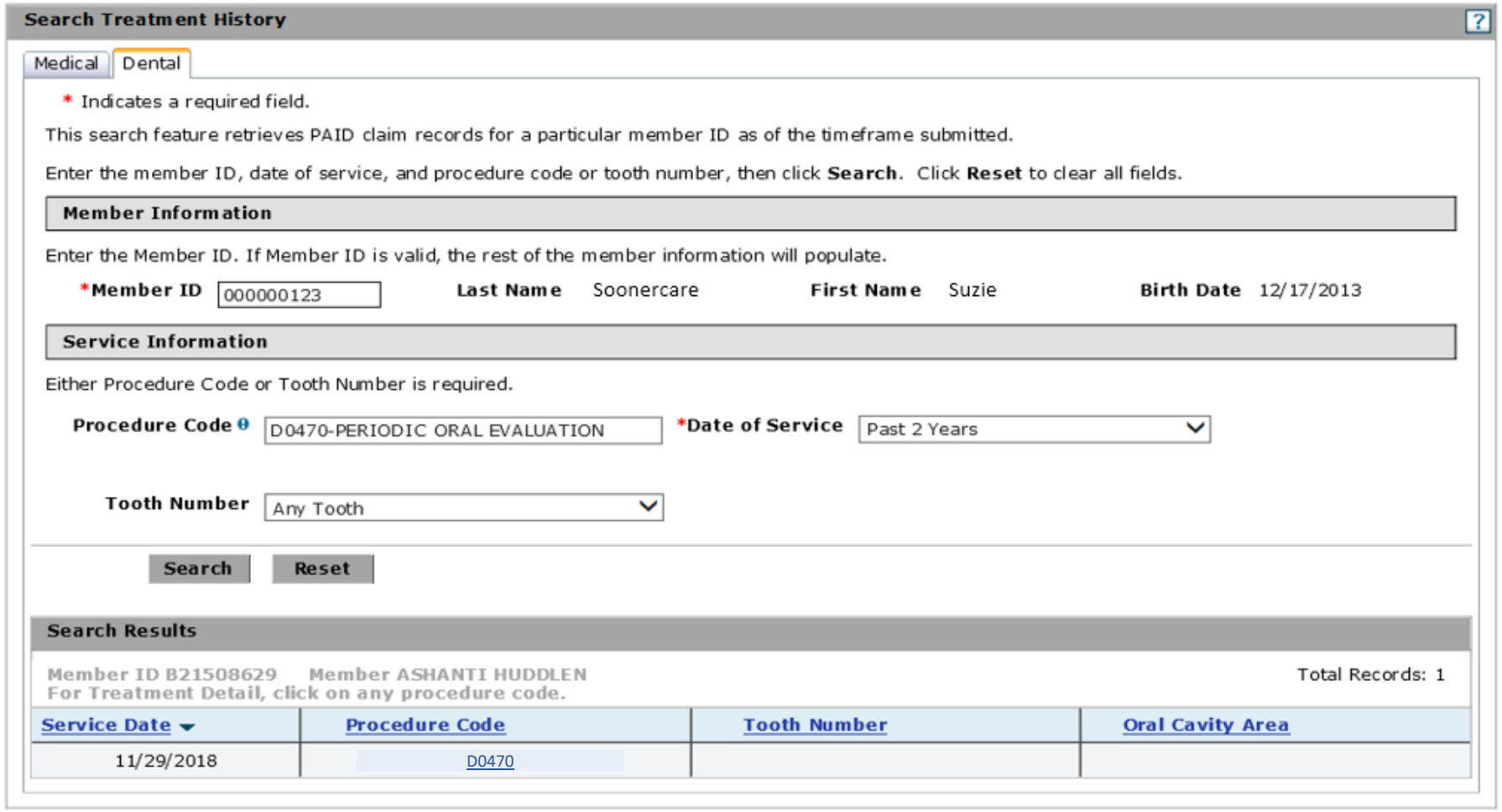
---ICN---	RENDERING PROVIDER	SERVICE DATES FROM	THRU	BILLED AMOUNT	TPL AMOUNT	SPENDDOWN AMOUNT
CLIENT NAME: SUZIE SOONERCARE			CLIENT NO. 000000123			
2018001003333	100000000Z	112918	112918	165.00	0.00	0.00

PL SERV	PROC CD	TOOTH	SURFACE	DATE SVC PERF	BILLED AMOUNT	DETAIL EOBS	
11	D0120			112918	75.00	119 185 96 B7 18 A1	0.00
11	D1120			112918	75.00	119 185 96 B7 18 A1	

TOTAL DENTAL CLAIMS DENIED:	165.00	0.00	0.00

HIPAA REASON CODE/ EOB CODE	HIPAA ADJ REASON/EOB CODE DESCRIPTION
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 (S).
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
  - Provider > Claim Tools > Fee Schedule
    - Scroll down to the most recent fee schedule
    - Dental fee schedule 01/01/19

Procedure Code	Amount	Effective Date	Prior Authorize	Tooth # Required	Additional Criteria
D0470	36.30	1/1/2019	N		Once per 2 yrs

As you can see, the code we billed is only payable once per every 2 years.

THIRD PARTY LIABILITY (TPL)

THIRD PARTY LIABILITY - TPL

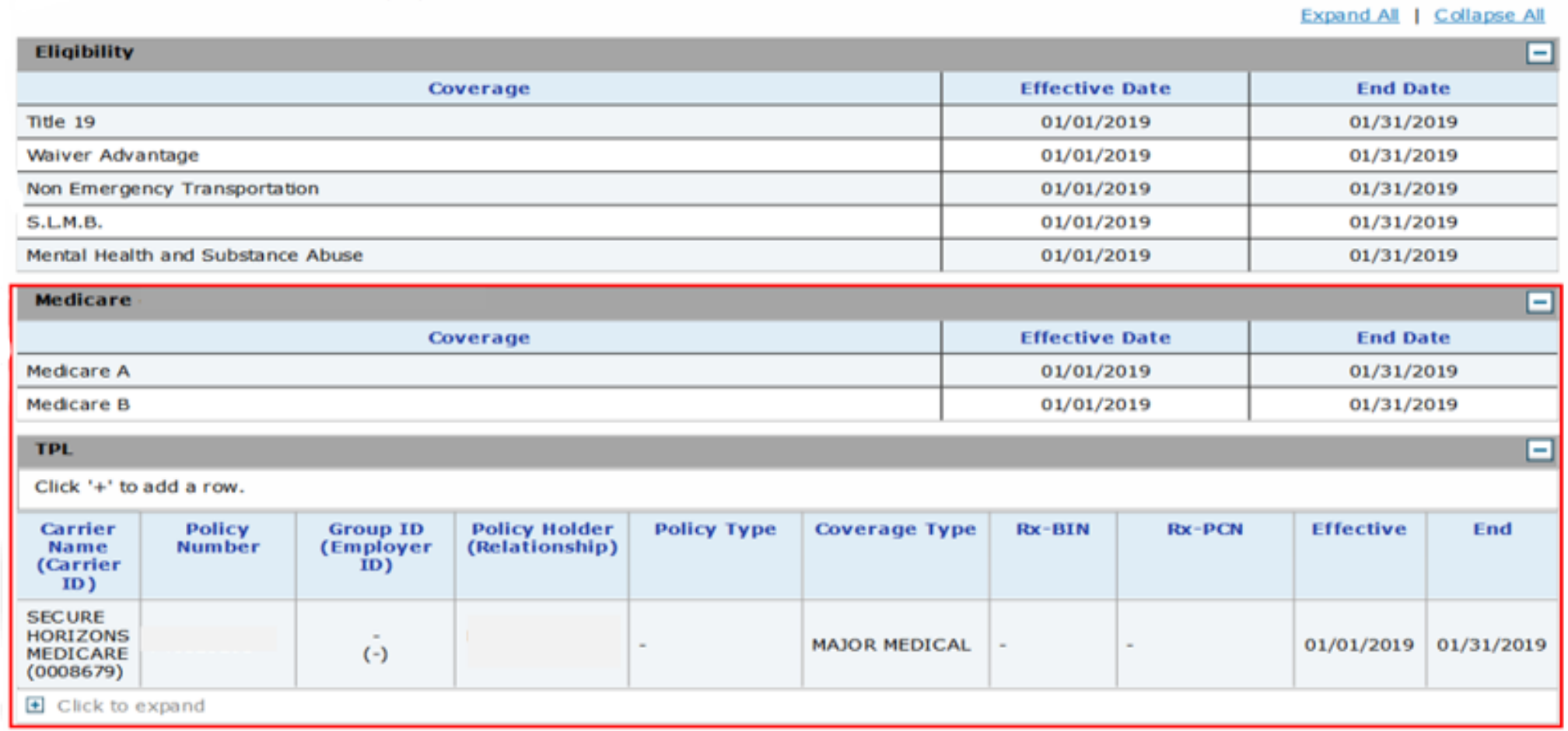
Adjudication Errors

Claim / Service #	HIPAA Adj	Description	HIPAA Adj Remark	Description	EOB	Description
Service # 1	A1	Claim denied charges.	N115	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 www.cms.gov/mcd, or if you do not have web access, you may contact the contractor to request a copy	9998	CLAIM WAS PRICED IN ACCORDANCE WITH CURRENT OKLAHOMA HEALTH COVERAGE PROGRAM PO
Service # 1	129	Payment denied - Prior processing information appears incorrect.	N4	Missing/incomplete/invalid prior insurance carrier EOB.	0233	INSURANCE DENIAL REQUIRED
Service # 1	6	The procedure code is inconsistent with the patient's age.	N129	This amount represents the dollar amount not eligible due to the patients age.	0328	PROCEDURE NOT IN SCOPE OF PROGRAM FOR THIS AGE
Service # 1	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	N4	Missing/incomplete/invalid prior insurance carrier EOB.	0502	FILE CLAIM WITH MEDICARE
Service # 1			N77	Missing/incomplete/invalid designated provider number.	0681	PROVIDER INELIGIBLE ON DATE OF SERVICE

How can they have SoonerCare and other insurance?

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



Expand All | Collapse All

Eligibility

Coverage	Effective Date	End Date
Title 19	01/01/2019	01/31/2019
Waiver Advantage	01/01/2019	01/31/2019
Non Emergency Transportation	01/01/2019	01/31/2019
S.L.M.B.	01/01/2019	01/31/2019
Mental Health and Substance Abuse	01/01/2019	01/31/2019

Medicare

Coverage	Effective Date	End Date
Medicare A	01/01/2019	01/31/2019
Medicare B	01/01/2019	01/31/2019

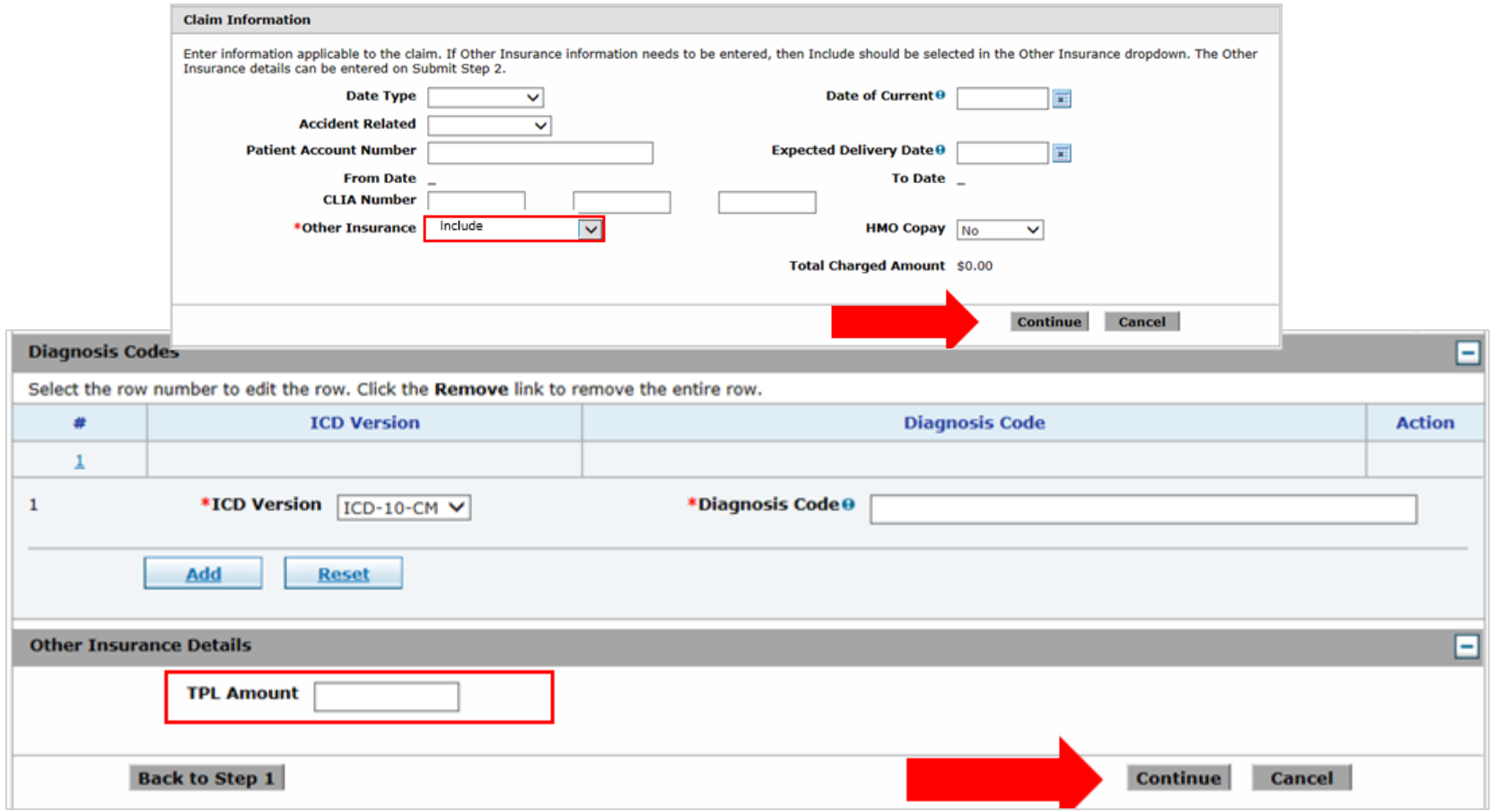
TPL

Click '+' to add a row.

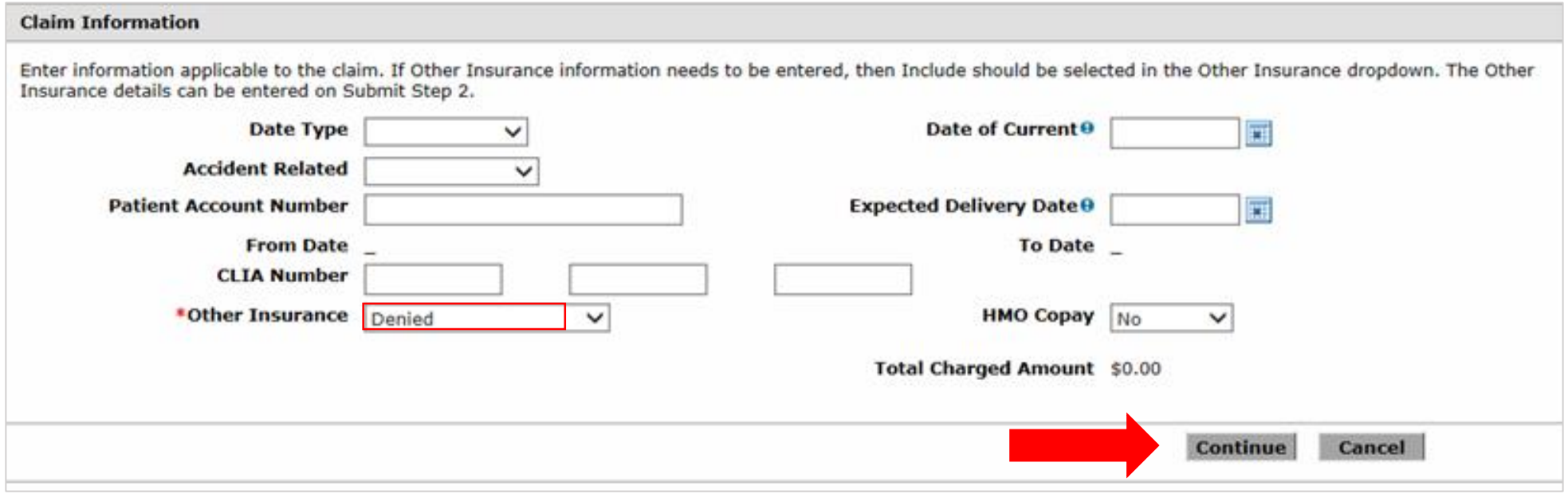
Carrier Name (Carrier ID)	Policy Number	Group ID (Employer ID)	Policy Holder (Relationship)	Policy Type	Coverage Type	Rx-BIN	Rx-PCN	Effective	End
SECURE HORIZONS MEDICARE (0008679)		- (-)		-	MAJOR MEDICAL	-	-	01/01/2019	01/31/2019

Click to expand

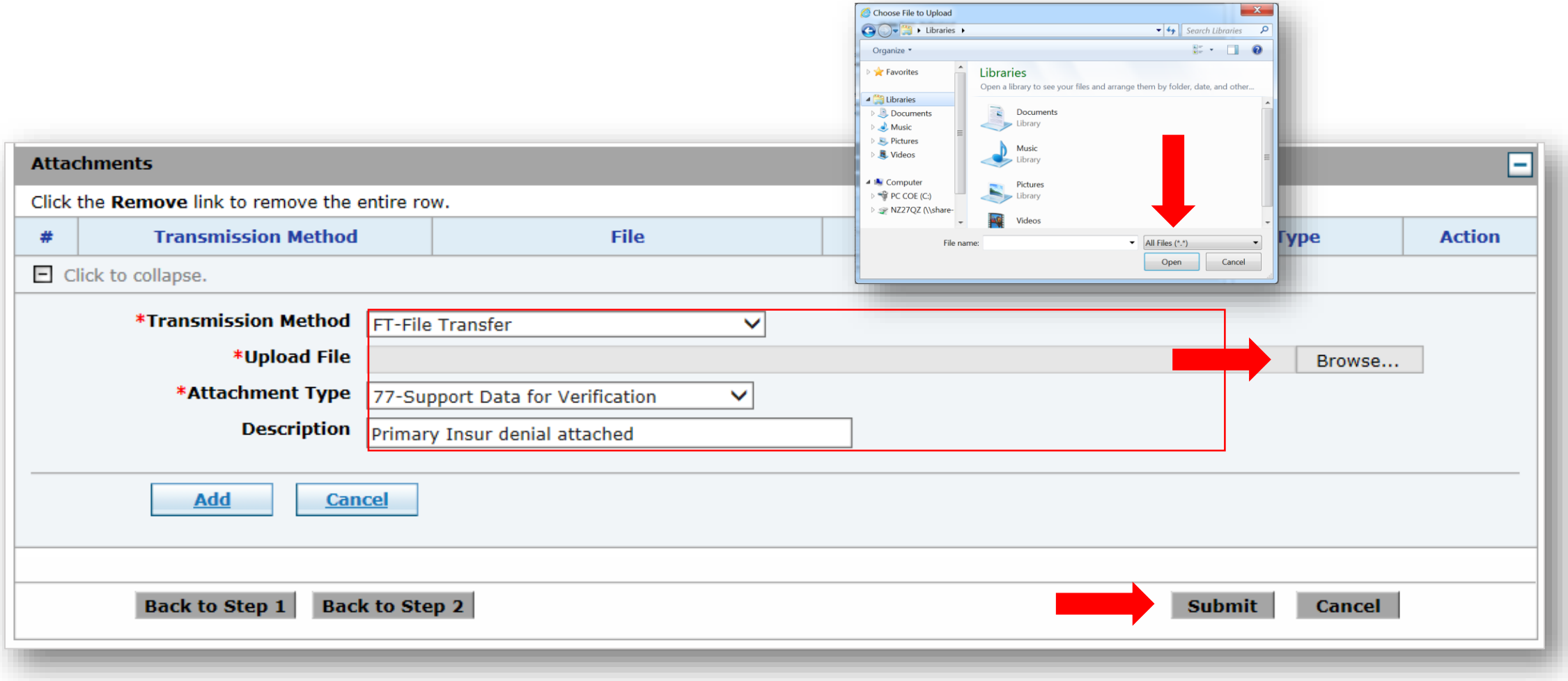
THIRD PARTY LIABILITY – SOLUTION PRIMARY PAID



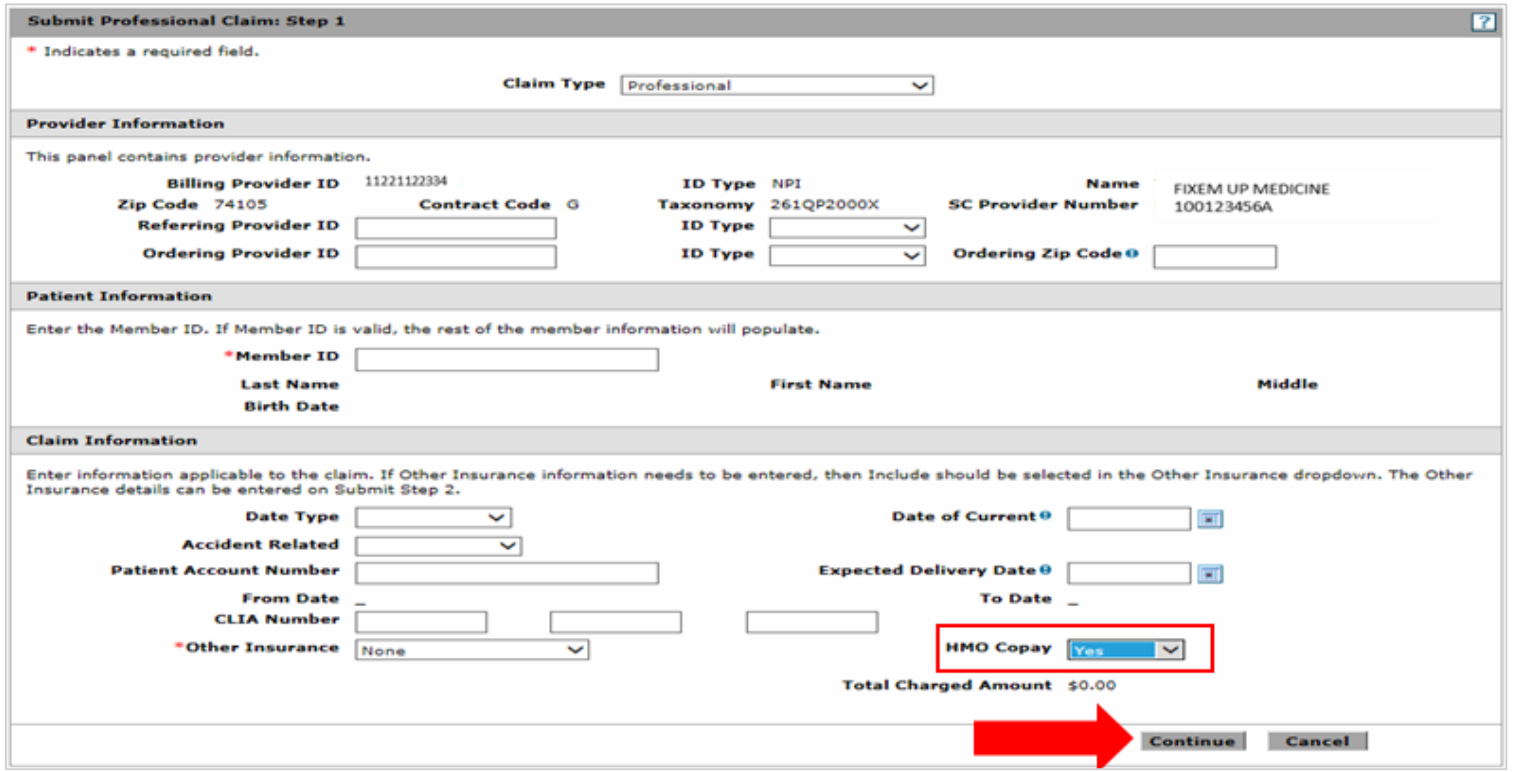
THIRD PARTY LIABILITY – SOLUTION PRIMARY DENIED



THIRD PARTY LIABILITY - SOLUTION PRIMARY DENIED



THIRD PARTY LIABILITY – SOLUTION HMO COPAY



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

NO PRIOR AUTHORIZATION ON DATABASE

Claim / Service #	HIPAA Adj	Description	HIPAA Adj Remark	Description	EOB	Description
Service # 1	A1	Claim denied charges.	N115	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 www.cms.gov/mcd, or if you do not have web access, you may contact the contractor to request a copy	9998	CLAIM WAS PRICED IN ACCORDANCE WITH CURRENT OKLAHOMA HEALTH COVERAGE PROGRAM PO
Service # 1			M62	Missing/incomplete/invalid treatment authorization code.	0178	PROCEDURE REQUIRES PRIOR AUTHORIZATION
Service # 1			N30	Recipient ineligible for this service.	0148	PROCEDURE NOT PAYABLE THIS RECIPIENT
Service # 1			N77	Missing/incomplete/invalid designated provider number.	0681	PROVIDER INELIGIBLE ON DATE OF SERVICE
Service # 1	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M50	Missing/incomplete/invalid revenue code(s).	4227	REVENUE CODE NOT COVERED BY PROGRAM
Service # 2	A1	Claim denied charges.	N115	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 www.cms.gov/mcd, or if you do not have web access, you may contact the contractor to request a copy	9998	CLAIM WAS PRICED IN ACCORDANCE WITH CURRENT OKLAHOMA HEALTH COVERAGE PROGRAM PO
Service # 2			N30	Recipient ineligible for this service.	0148	PROCEDURE NOT PAYABLE THIS RECIPIENT
Service # 2			N30	Recipient ineligible for this service.	0148	PROCEDURE NOT PAYABLE THIS RECIPIENT
Service # 2			N77	Missing/incomplete/invalid designated provider number.	0681	PROVIDER INELIGIBLE ON DATE OF SERVICE
Service # 2	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M50	Missing/incomplete/invalid revenue code(s).	4227	REVENUE CODE NOT COVERED BY PROGRAM

Diagnosis Codes [+]

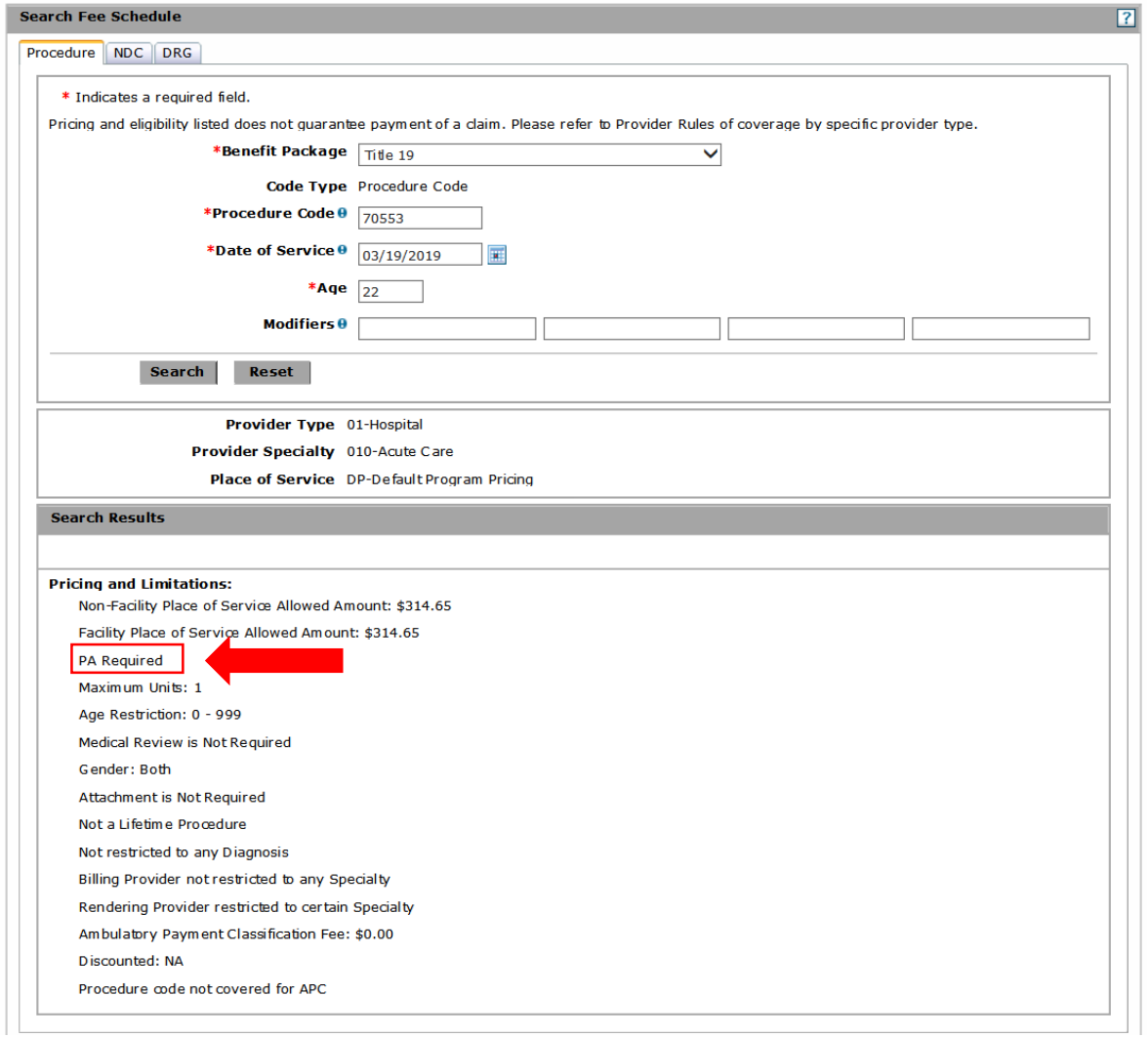
Service Details [−]

Svc #	Revenue Code	HCPCS/Proc Code	Mod	From Date	To Date	Units/Type	Charge Amount	Allowed Amount	Co-pay Amount
1 Denied	611	70553	TC	01/07/2019	01/07/2019	1.00 Unit	$4,401.00	$0.00	$0.00

How am I supposed to know that a code needs a prior authorization?

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

Claim / Service #	HIPAA Adj	Description	HIPAA Adj Remark	Description	EOB	Description
Service # 1	29	The time limit for filing has expired.	M139	Denied services exceed the coverage limit for the demonstration.	0125	TIMELY FILING
Service # 1	A1	Claim denied charges.	N115	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 www.cms.gov/mcd, or if you do not have web access, you may contact the contractor to request a copy	9998	CLAIM WAS PRICED IN ACCORDANCE WITH CURRENT OKLAHOMA HEALTH COVERAGE PROGRAM PO

Diagnosis Codes

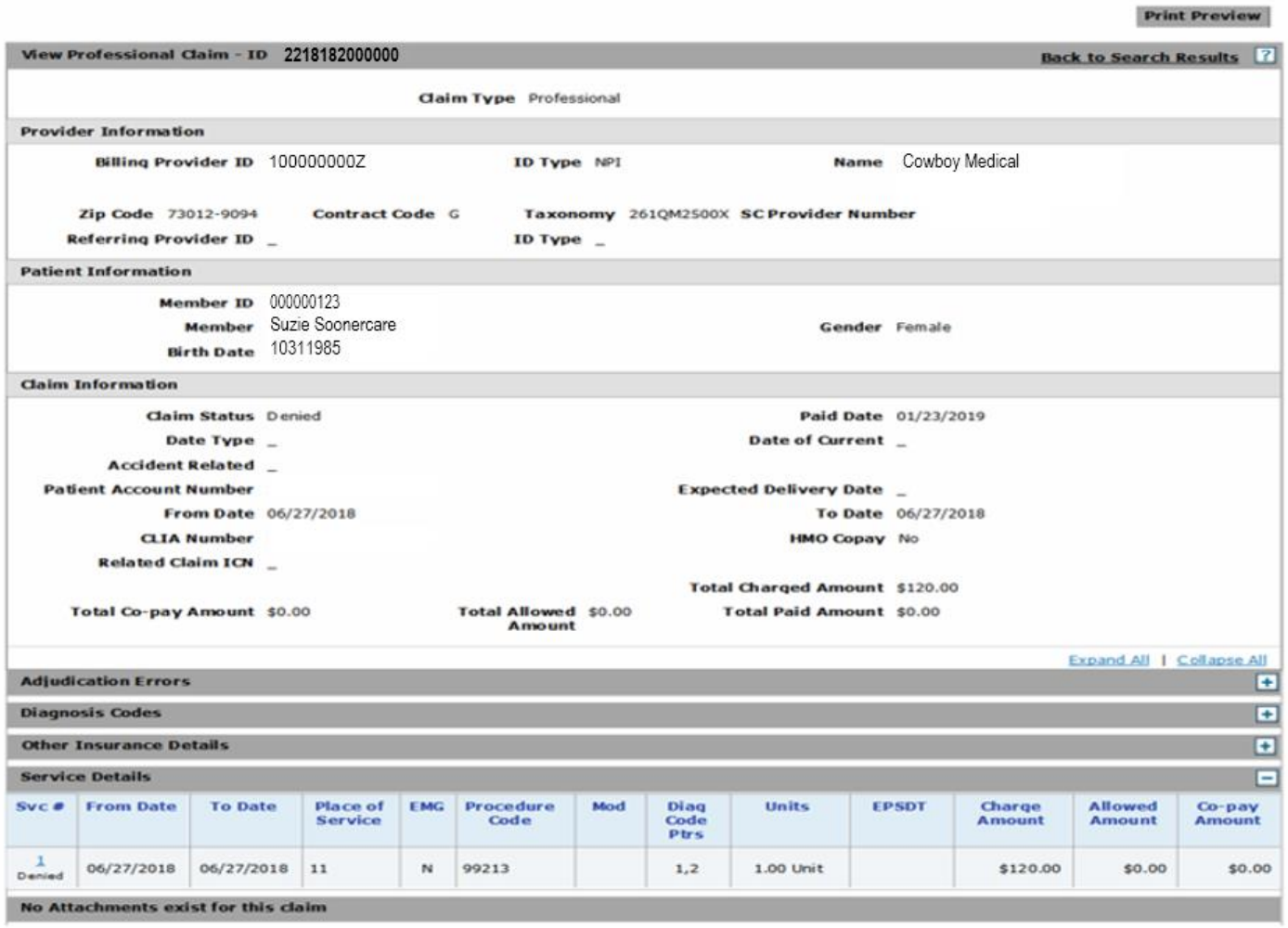
Other Insurance Details

Service Details

Svc #	From Date	To Date	Place of Service	EMG	Procedure Code	Mod	Diag Code Ptrs	Units	EPSDT	Charge Amount	Allowed Amount	Co-pay Amount
1 Denied	06/27/2018	06/27/2018	11	N	99213		1,2	1.00 Unit		$120.00	$0.00	$0.00

No Attachments exist for this claim

TIMELY FILING – SOLUTION



Print Preview

View Professional Claim - ID 2218182000000 — Back to Search Results

Claim Type Professional

Provider Information

Billing Provider ID	100000000Z	ID Type	NPI	Name	Cowboy Medical
Zip Code	73012-9094	Contract Code	G	Taxonomy	261QM2500X
Referring Provider ID	_	ID Type	_		

SC Provider Number

Patient Information

Member ID	000000123		
Member	Suzie Soonercare	Gender	Female
Birth Date	10311985		

Claim Information

Claim Status	Denied	Paid Date	01/23/2019
Date Type	_	Date of Current	_
Accident Related	_		
Patient Account Number		Expected Delivery Date	_
From Date	06/27/2018	To Date	06/27/2018
CLIA Number		HMO Copay	No
Related Claim ICN	_		
		Total Charged Amount	$120.00
Total Co-pay Amount	$0.00	Total Allowed Amount	$0.00
		Total Paid Amount	$0.00

Expand All | Collapse All

Adjudication Errors

Diagnosis Codes

Other Insurance Details

Service Details

Svc #	From Date	To Date	Place of Service	EMG	Procedure Code	Mod	Diag Code Ptrs	Units	EPSDT	Charge Amount	Allowed Amount	Co-pay Amount
1 Denied	06/27/2018	06/27/2018	11	N	99213		1,2	1.00 Unit		$120.00	$0.00	$0.00

No Attachments exist for this claim

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

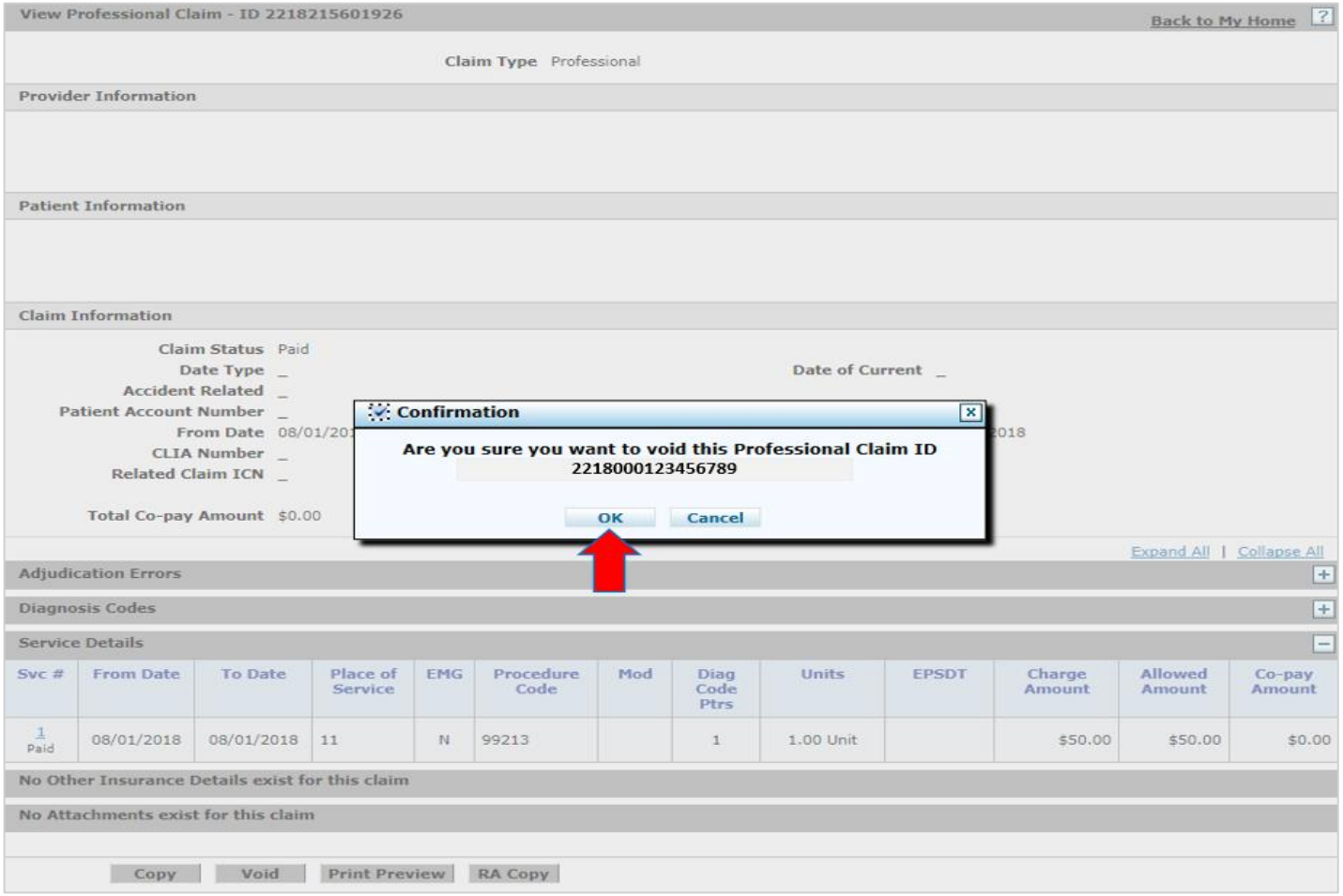
DUPLICATE CLAIM SERVICE

Adjudication Errors

Claim / Service #	HIPAA Adj	Description	HIPAA Adj Remark	Description	EOB	Description
Claim	18	Duplicate claim/service.	M86	SERVICE DENIED BECAUSE PAYMENT ALREADY MADE FOR SAME/SIMILAR PROCEDURE WITHIN SET TIME FRAME.	5000	THIS IS A DUPLICATE OF ANOTHER CLAIM.
Service # 1	18	Duplicate claim/service.	M86	SERVICE DENIED BECAUSE PAYMENT ALREADY MADE FOR SAME/SIMILAR PROCEDURE WITHIN SET TIME FRAME.	0806	EXACT DUPLICATE OF ANOTHER CLAIM
Service # 1	A1	Claim denied charges.	N115	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 www.cms.gov/mcd, or if you do not have web access, you may contact the contractor to request a copy	9998	CLAIM WAS PRICED IN ACCORDANCE WITH CURRENT OKLAHOMA HEALTH COVERAGE PROGRAM PO
Service # 1	18	Duplicate claim/service.	N111	No appeal right except duplicate claim/service issue. This service was included in a claim that has been previously billed and adjudicated.	7236	DENIED DUPLICATE - CAN ONLY BE DONE XX TIMES IN A DAY
Service # 1	45	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.			9920	PRICING ADJUSTMENT - RBRVS PRICING APPLIED
Service # 1			N190	Missing/incomplete/invalid contract indicator.	0096	PROVIDER NOT ELIGIBLE TO RENDER SERVICE ON THIS PROGRAM
Service # 1			N30	Recipient ineligible for this service.	0148	PROCEDURE NOT PAYABLE THIS RECIPIENT
Service # 1			N77	Missing/incomplete/invalid designated provider number.	0681	PROVIDER INELIGIBLE ON DATE OF SERVICE

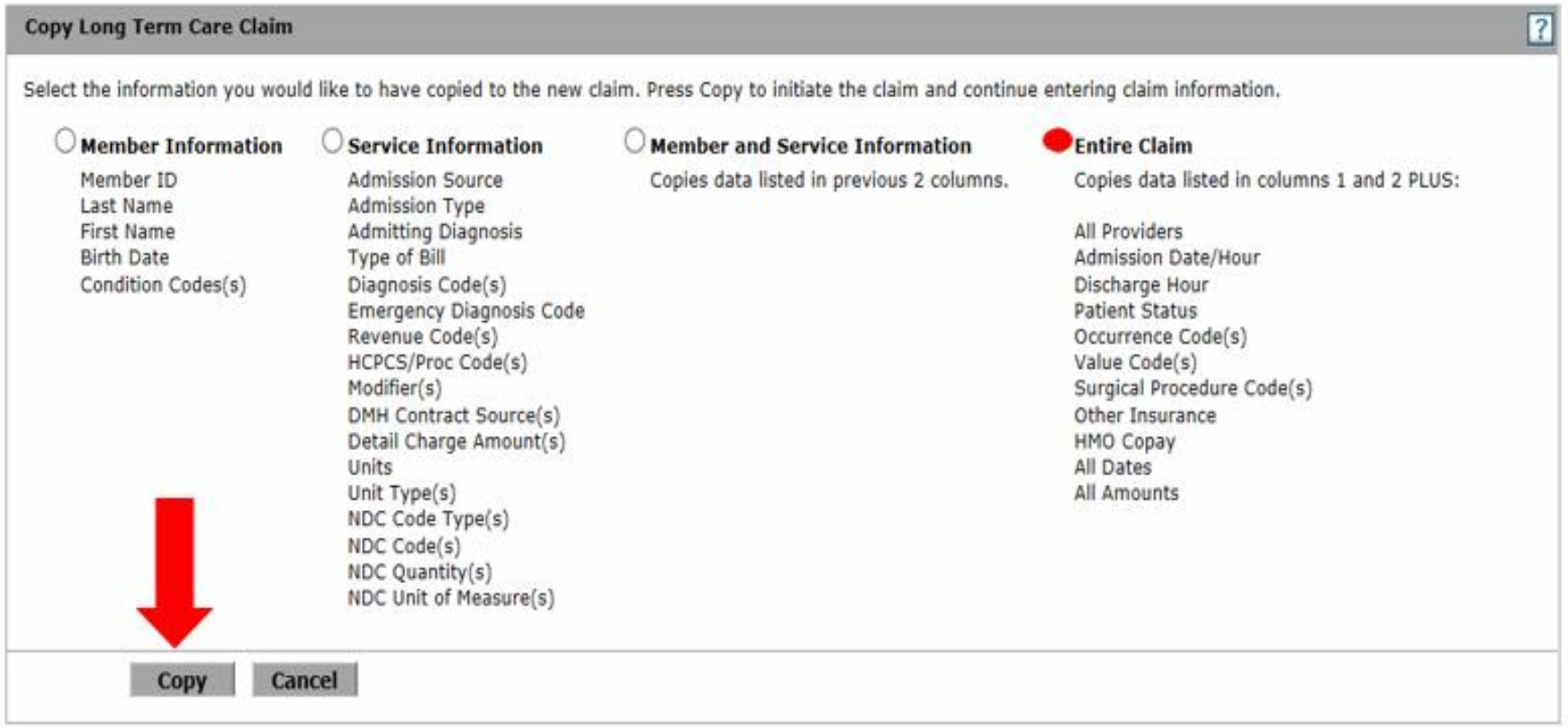
Duplicate claim means there is another claim with the same dates of service.

DUPLICATE CLAIM SERVICE - SOLUTION



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

Adjudication Errors

Claim / Service #	HIPAA Adj	Description	HIPAA Adj Remark	Description	EOB	Description
Claim			N30	Recipient ineligible for this service.	0285	RECIPIENT NOT ELIGIBLE FOR DATES OF SERVICE
Claim	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M76	Missing/incomplete/invalid diagnosis or condition.	3600	ADMITTING DIAGNOSIS MISSING
Service # 1	A1	Claim denied charges.	N115	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 www.cms.gov/mcd, or if you do not have web access, you may contact the contractor to request a copy	9998	CLAIM WAS PRICED IN ACCORDANCE WITH CURRENT OKLAHOMA HEALTH COVERAGE PROGRAM PO

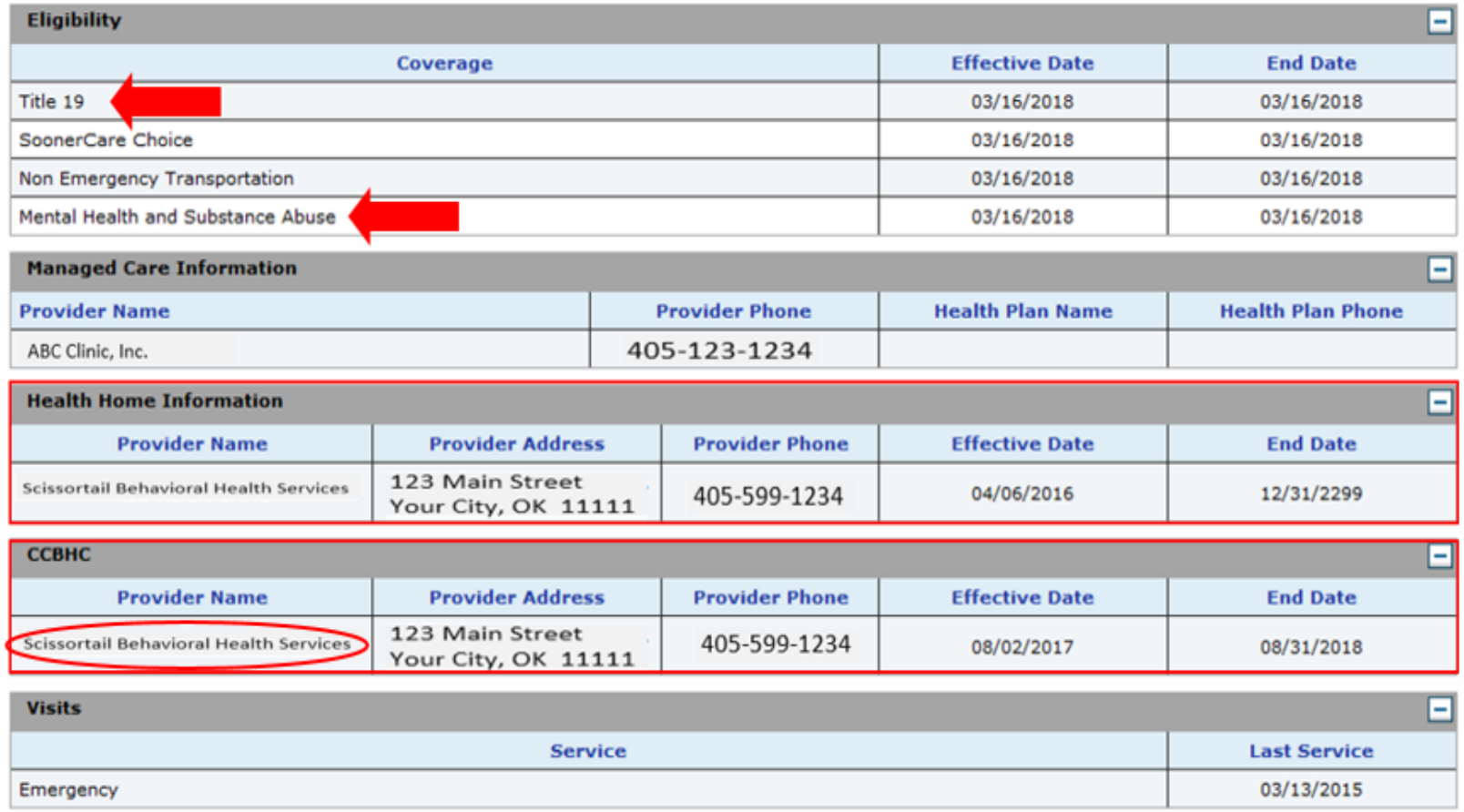
Diagnosis Codes

Service Details

Svc #	Revenue Code	HCPCS/Proc Code	Mod	From Date	To Date	Units/Type	Charge Amount	Allowed Amount	Co-pay Amount
1 Denied	120			10/01/2018	10/15/2018	15.00 Days	$2,381.85	$0.00	$0.00

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



Eligibility

Coverage	Effective Date	End Date
Title 19	03/16/2018	03/16/2018
SoonerCare Choice	03/16/2018	03/16/2018
Non Emergency Transportation	03/16/2018	03/16/2018
Mental Health and Substance Abuse	03/16/2018	03/16/2018

Managed Care Information

Provider Name	Provider Phone	Health Plan Name	Health Plan Phone
ABC Clinic, Inc.	405-123-1234		

Health Home Information

Provider Name	Provider Address	Provider Phone	Effective Date	End Date
Scissortail Behavioral Health Services	123 Main Street Your City, OK 11111	405-599-1234	04/06/2016	12/31/2299

CCBHC

Provider Name	Provider Address	Provider Phone	Effective Date	End Date
Scissortail Behavioral Health Services	123 Main Street Your City, OK 11111	405-599-1234	08/02/2017	08/31/2018

Visits

Service	Last Service
Emergency	03/13/2015

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.

RECIPIENT NOT ELIGIBLE ON DATES OF SERVICE – SOLUTION

Mental Health and Substance Abuse Only

Eligibility

Coverage	Effective Date	End Date
Mental Health and Substance Abuse	08/24/2018	08/24/2018

Insure Oklahoma

Eligibility

Coverage	Effective Date	End Date
PUBLIC PRODUCT O-EPIC IP	08/24/2018	08/24/2018

No Coverage

Effective/End dates are shown only for the period of time requested.

The member is not eligible for the date(s) of service requested.

Verification Number 98765SA5AAA 8/24/2018 - Status: A

There are no coverage details to show based on the search criteria selected.

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

Claim Information

Claim Status	Denied	**Paid Date**	11/07/2018
Covered Dates	10/02/2018	**Covered Days**	0
Admission Date/Hour	_ ' _	**Discharge Hour**	_
Admission Type	3-ELECTIVE	**Admission Source**	1-Physician Referral
Admitting ICD Version	_	**Admitting Diagnosis**	_
Patient Status	01-DISCHARGED TO HOME OR SELF CARE (ROUTINE DISCHARGE)	**Type of Bill**	141
Patient Account Number		**Related Claim ICN**	_
		Total Charged Amount	$88.00
Total Co-pay Amount	$0.00	**Total Allowed Amount**	$0.00
		Total Paid Amount	$0.00

Expand All | Collapse All

Adjudication Errors

Claim / Service #	HIPAA Adj	Description	HIPAA Adj Remark	Description	EOB	Description
Service # 1	A1	Claim denied charges.	N115	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 www.cms.gov/mcd, or if you do not have web access, you may contact the contractor to request a copy	9998	CLAIM WAS PRICED IN ACCORDANCE WITH CURRENT OKLAHOMA HEALTH COVERAGE PROGRAM PO
Service # 1	2	Coinsurance Amount	N245	INCOMPLETE/INVALID PLAN INFORMATION FOR OTHER INSURANCE.	4480	MISSING MEDICARE DATA

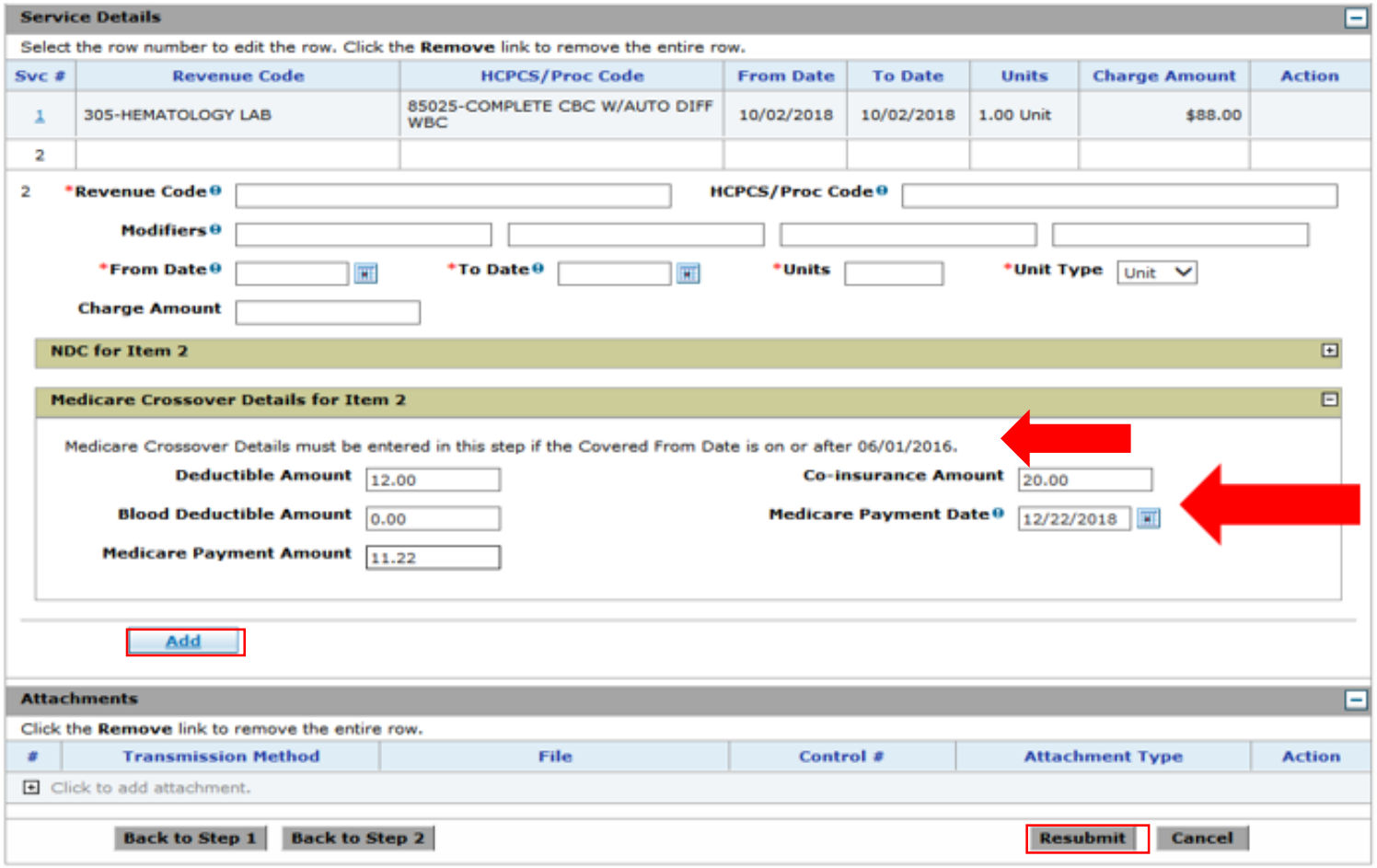
Diagnosis Codes

Service Details

Svc #	Revenue Code	HCPCS/Proc Code	Mod	From Date	To Date	Units/Type	Charge Amount	Allowed Amount	Co-pay Amount
1 Denied	305	85025		10/02/2018	10/02/2018	1.00 Unit	$88.00	$0.00	$0.00

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.

MISSING MEDICARE DATA - SOLUTION



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.
- OKMMIS Provider Billing & Procedures Manual.
- SoonerCare Provider Portal - Medicaid on the Web Guide.