AlphaMCS

CLAIMS GUIDE

Written by:
Ross Inman, AlphaCM Support
Douglas Vann, AlphaCM Software Developer
Cheryl Mason, AlphaCM Customer

AlphaCM, Inc - 9-26-12; revised 2-6-13

Overview

The purpose of this guide is to assist you in understanding how a claim is validated in AlphaMCS. Claims in AlphaMCS are processed in batch on a nightly basis, and must undergo a series of validation checks, called adjudication, to ensure that the claim has correct data. After processing, a reason code is returned with the adjudication line that indicates whether the claim was approved, and if not, why the claim was adjusted.

This guide demonstrates the sequence of the validation and goes in depth about what conditions will cause an adjusted claim to return a reason code. For each possible reason code, the guide contains the following sections: 1) description of the reason code 2) a real-world example of when the reason code might occur 3) recommended action steps for both the MCO and Provider, and 4) an "in-depth look" (technical detail) at the validation process leading up to the reason code returned.

The "in-depth look" section shows in detail a series of checks that AlphaMCS has performed during the validation routine of a claim. An in-depth understanding of the validation routine can be useful when additional troubleshooting of a claim denial is required. Use the "in-depth look section" to backtrack through each step of the validation procedure and determine, with a little research, where data is missing or why specified data has caused the claim to become invalid.

After researching a claim, if you still cannot understand why a claim was denied, don't hesitate to contact support for assistance.

Providers can contact their MCO for support. MCO staff can contact AlphaCM directly about a denied claim. Provide the claim number, reason code, and any other information pertinent to the claim denial, and we will assist you in resolving the issue efficiently.

Validation Sequence

Clean claims that have been submitted to the AlphaMCS system through the MyMCSportal or 837 begin the claims adjudication process. In the first level of validation, the AlphaMCS system begins by checking the enrollment of the patient, as well matching the NPI number to the appropriate provider. In the event of a matching exception, a staff member has the option to manually match the client and/or provider and allow the claim to continue to be processed.

System-matched and manually-matched claims continue through the claims adjudication process to the second level of data verification. All codes on the claims are verified to be valid for services covered by the MCO. If the code combinations are invalid, the adjudication process stops, and the claim is denied and given the appropriate reason code.

Clean claims proceed to the third level of validation. In the third level of the validation, claims are validated for duplication, timely filing rules, medically unlikely edits (MUE), valid authorizations, client benefit plan coverage, provider contracts and budget limits, clinician based service information including verification of clinician credentials.

Clean claims proceed to the fourth level of claims processing that check for TPL information and referring provider requirements. If the claim is found to be invalid at this level the adjudication process stops and the claim is denied given the appropriate HIPAA standard reason and remark codes. Clean claims are approved and adjusted to the appropriate contracted rate with the appropriate HIPAA standard reason and remark codes.

During the MCO's standard auditing process of sample claims or denied claim level, the MCO needs to review the claim. The staff can find the claim using multiple search criteria including the line item control number submitted by the provider.

The MCO staff member selects the claim to review and the AlphaMCS system pulls the pertinent data that will assist the staff in reviewing the claim. The MCO staff can utilize the data presented to review the claim for appropriateness. If the reviewer decides that the claim is appropriate they can correct or request a correction to the data stored in the AlphaMCS system to allow the claim to process correctly. After the information in the AlphaMCS system is corrected, the MCO staff can reprocess the claim using the current data/rules.

Replacement/Reversal Claims

Before any claims are adjudicated, AlphaMCS processes reversal and replacement claims. Reversal and replacement claims can be thought of, in a sense, as new claim records that reference an original claim. As a result, they must undergo a series of initial checks. Reversal/replacement claims are identified by the system as having a billing type of 7 or 8, and a field in the claim header called resubmission reference number. The resubmission reference number contains the claim header id of the original claim.

The first validation that a replacement claim must undergo is whether or not the resubmission reference number (the original claim id) is valid. If the resubmission reference number is null, not a valid integer, or does not come from the same provider as the original claim number, the reason code returned is 93, Invalid DCN (Document Ctrl #) or resubmission ref #.

Next, AlphaMCS makes sure that the timing of the replacement or reversal claim is logical. The received date of the reversal/replacement claim is validated to ensure that it occurs in time after the original claim's date of service. If not, reason code 94 is returned.

Next, AlphaMCS checks replacement claims to verify that the resubmitted claim data is closely related to the original claim. The replacement claim must match the original claim for three out of six of the following criteria: 1) provider 2) patient 3) service rendered 4) place of service 5) date of service 6) principle diagnosis. If less than three of the criteria do not match then AlphaMCS returns reason code 95, Resubmitted claim does not match to referenced claim.

Next, AlphaMCS verifies that the resubmitted claim has not already been resubmitted. If a duplicate replacement/reversal claim is found or if the original claim has been voided, the reversal/replacement claim is denied with reason code 96, referenced claim has already been resubmitted.

If the reversal/replacement claim passes all of the above validation checks, then the original claim can then be safely reversed. The original claim is voided and stamped with reason code 86. Any amount paid for the original claim is credited back to the MCO via credit memo.

The following table shows the validation sequence specific to a reversal /replacement claim:

Validation	**Corresponding Denial Reason Code**
Does the reversal/replacement claim reference a valid original claim number?	93 - Invalid DCN (Document Ctrl #) or resubmission ref #
Was the reversal/replacement claim submitted after the orginial claim's date of service	94 - Resubmitted claim DOS is after original claim submission date
Does the resubmitted claim closely resemble the original claim based on at least 50% of the following criteria: 1) provider 2) patient 3) service rendered 4) place of service 5) date of service 6) principle diagnosis?	95 - Resubmitted claim does not match to with referenced claim
Has the referenced claim already been submitted?	96 - Referenced claim has already been resubmitted. Multiple resubmissions not allowed

All Claims

After AlphaMCS has completed processing reversal/replacement claims, the system then processes all claims in batch. Validation continues in the following sequence:

Validation	**Corresponding Denial Reason Code**
Was the patient inserted into the MCO database on the date of service?	19 - Incorrect Member -- Patient not enrolled on DOS
Was the claim submitted after the service date?	6 - Claim submitted before service date
Was the amount of units valid?	29 - Invalid Units
Was the amount of the claim valid?	22 - Invalid Amount
Was the provider's NPI number valid?	27 - Invalid provider NPI #
Was the rendering provider's NPI number valid?	28 - Invalid Rendering NPI
Was the service rendered recorded as a billable service in the MCO database?	33- Non billable Service
Was the service in the database, and was the date of service on the claim between the effective and end dates of the service?	14 - Discontinued Service
Was the patient enrolled in a benefit plan on the date of service?	18 Incorrect Member -- Patient not enrolled @ dt of srvc
Is there a provider listed in the claim header, and was the provider in the MCO database on the date of adjudication?	26 – Invalid Provider
Is the place of service valid for the service, and did the claim date of service fall between the effective and end dates of the service-to-place-of-service record?	25 - Invalid POS & Service combo
Is the service valid for the diagnosis? Did the claim date of service fall between the effective and end dates of the service-to-diagnosis group record in	24 - Invalid PC / DX Combo

the MCO database?	
Is the service valid for the age group of the patient? Did the claim date of service fall between the effective and end dates of the service-to-age-group record in the MCO database?	21 - Invalid Age Group & PC combo
Does the provider have a valid contract, and is the service being performed listed in the contract details? Did the claim date of service fall between the effective and end dates of the contract details?	37 – Service not in provider profile
When a claim is resubmitted, the original claim header number is stamped on the resubmission. In this validation, does the claim header have a reference to an original claim, showing that it is a resubmission?	34 - Re-submission already processed
Have we exceeded the number of days since the date of service allowed to approve a claim, as specified in the provider contract? If it's a replacement, or resubmission, add 90 more days.	5 - Claim received after billable period
Was the patient enrolled in a benefit plan of the date of service?	18 - Incorrect Member -- Patient not enrolled @ dt of srvc
If the benefit plan is state insurance, then was the patient enrolled in a target population of the date of service? Does the date of service fall between the effective and end dates of the patient-to-target-population record?	101 - Patient does not have a valid Target Pop. on DOS
Is the target population valid for the diagnosis? Did the claim date of service fall between the effective and end date of the target-pop-to-diagnosis record in the MCO database?	102 - Patient does not have a valid Target Pop. for DX submitted in claim
Is the target population valid for the service rendered? Did the claim date of service fall between the effective and end dates of the service-to-target-pop record in the MCO database?	103 - Patient does not have a valid Target Pop. for service submitted in claim

For non-basic services that require authorization, do we have an approved authorization on file? Is the authorization active and did the claim date of service fall between the effective and end dates of the authorization?	35- Service is not authorized
Does the patient have pending insurance to cover the service? Of, is there a COB (other insurance) amount in the claim line?	7 - Patient has other insurance which covers the service
Note: all of the above validation errors will deny the full claim amount.	
Is there a patient-specific contract showing an approved insurance for the given patient and service? Does the claim date of service fall between the effective and end dates of the active patient-specific contract?	8 – Client not covered by contract
Can we find a contract rate for the clinician, after looking for all the following: a patient-specific contract, in the provider contract, or in the standard rate schedule? If it's a clinician-based service did we find the contract rate based on the above checks? Does the clinician's license belong to a license group that is authorized to provide the service, as recorded in the license-to-license group relationship? Did the date of service on the claim fall between the effective and end dates of the clinician license, the license-to-license group relationship, and the effective and end dates of the provider contract or patient-specific contract?	9 - Clinician not licensed to provide the service
After all of the above checks, did we find a contract rate?	32 - No rates available
Does a concurrent service exist for the service on the claim line?	11 - Concurrent service has already been approved. Cannot bill another one.
Did we adjust the claim amount, based on the amount of payment provided by another insurance? This would set any adjusted amount to the existing adjusted amount + COB amount and deduct the COB amount from the adjudicated	10 - Coinsurance Amount

amount.	
Did we find a duplicate claim, meaning that another claim exists with the same service, place of service, provider, and patient?	15 - Duplicate Claim
Did the provider exceed the daily limit for the number of units, as specified in patient authorization details?	13 - Daily limit exceeded
Did the provider exceed the weekly limit for the number of units, as specified in patient authorization details?	40 - Weekly limit exceeded
Did the provider exceed the monthly limit for the number of units, as specified in patient authorization details?	31 - Monthly limit exceeded
Did the provider exceed the allowed number of basic units consumed for the patient specified in the claim?	4- Basic units
Did the provider exceed the allowed number of authorized units consumed for the patient specified in the claim?	3- Authed units exceeded

DRG Claims

DRG claims are treated by AlphaMCS with special attention. A DRG claim is identified by the “is DRG” flag in the service that is in the claim line and an “IP” bill type in the UB04.

Like other claims, DRG claims must pass the following validation, using the identical rules from other types of claims: 1) patient enrolled on date of service 2) claim submitted before the service date 3) valid number of total units 4) claim received during the billable period 5) a valid contract rate 6) non-duplicate claim

In addition, drug claims must pass additional validation rules:

Validation	**Corresponding Denial Reason Code**
Does the revenue code in the claim line match a service code?	91 - Invalid Revenue Code
Does the service code contain ‘100’ or ‘0100’? Could a contract rate be found for the DRG? Does the claim date of service fall between the effective and end dates of the provider contract, contract details and contract rates?	89 - No DRG exists or rate is not set up yet
Was the service provided at an ICF site?	90 - Non-Covered Ancillary Services

ED Claims

ED claims are another type of claim that is treated with special care in AlphaMCS. An ED claim is a claim for an emergency service rendered in an environment such as a hospital emergency room. ED claims have special rates, as defined in the provider's contract rate for service code 'HRCCR,' which stands for Hospital Ratio of Cost to Charge Rate.

The rate specified at the contract level for an HRCCR is adjusted with a multiplier (normally .812) when determining the rate an MCO should pay the provider. All ED claims, with the exception of lab, pharmacy, and professional services are to be paid by Ratio of Cost to Charge (RCC). The claims are still manually reviewed, however, so this is a suggested rate.

During the claim adjudication process, all ED claims are identified as being UB04 claims with a bill type starting with '13,' that identifies the place of service as being a hospital outpatient claim, and a revenue code corresponding with an ED service.

The validation process ensures that the patient is enrolled in the Medicaid benefit plan, and if not, denies the claim with reason code 18 (Incorrect Member -- Patient not enrolled on DOS).

The validation looks for the base contract rate in the contract rates for procedure code 'HRCCR' and ensures that the claim date of services falls between the effective and end dates of the contract rate record.

At the end of the adjudication process, the claims are stamped with a status id of 9, meaning that a manual review is required. All ED claims must undergo a manual review process. A staff member with appropriate rights must approve the claim with documented justification. The manual approval is recorded and appears on claims audit reports as manually approved.

1 Adjusted – Above Contract Rate

Description

The rate charged in the claim was higher than the rate that is in the provider's contract.

Corresponding HIPAA reason code

45-- Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).

Example

New Day Therapy charges $110 for a service, but in their contract, the rate the MCO agreed to pay is $100.

Recommended Action Steps

MCO

The claim will be paid at the rate that's in the provider contract.

If the MCO or provider determines that the higher rate is correct, the MCO can adjust the rate in the Maintain Provider Info module. To adjust the contract rate, follow these steps:

1) Click Menu → Provider → Main Provider
2) Click the Contracts tab.
3) Open the Contract Details tile and search for the service code on the claim
4) Open the Contract Rates tile and adjust the rate.

Provider

Do not re-submit the claim.

2 Approved

Description

The claim has passed all validation checks and has been approved for payment.

Corresponding HIPAA reason code

92--Approved

Recommended Action Steps

MCO

No action needed.

Provider

Post payment for the claim.

In-Depth Look

The claim record has undergone all possible validation checks and all data is accurate and complete. The full amount of the claim is adjudicated and approved.

3 Authed Units Exceeded

Description

The service on the claim was authorized; however, the provider has gone over the amount of units on the auth.

Corresponding HIPAA reason code

198-- Payment Adjusted for exceeding precertification/ authorization. This change to be effective 4/1/2008: Precertification/authorization exceeded.

Example

New Day Therapy has an auth for John Doe for 50 units of H2022. However, all 50 units have been used. When New Day enters another claim for John Doe, H2022, they will receive this denial.

Recommended Action Steps

MCO

MCO staff can confirm this error is correct by going to the Clinical modules, Utilization Management, Authorizations.

Provider

Verify units authorized and provided. The provider will need to enter a new SAR for this service. Contact MCO if applicable. Do not refile if authed units are truly exceeded.

In-Depth Look

The validation routine tests to see if the total consumed units is greater than the number of authorized units. The test is done only for procedures codes with the authorization required field set.

4 Basic units exceeded

Description

The total number of basic units has been exceeded. For certain services, usually evaluations and outpatient therapy, adults get 8 units covered without an authorization; children get 16. Basic units are renewed at the beginning of every fiscal year. They follow the patient across providers.

Corresponding HIPAA reason code

96-- Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)

Example

New Day Therapy used 6 basic units and Number One Therapy used 2; if New Day tries to enter another claim with a basic unit, it will get this denial.

Recommended Action Steps

MCO

MCO staff can confirm this error is correct by going to the Clinical modules, Utilization Management, Authorizations.

Provider

Providers will need to enter a SAR for the service they're trying to get approved.

In-Depth Look

AlphaMCS looks at the procedure code in the claim line to look up data about the procedure code that was performed. If the procedure code is flagged as “basic,” AlphaMCS sums the basic units of claim lines that have been adjudicated for the patient prior to the claim line currently being adjudicated. If the sum of the basic units is great than the number of allowed basic units, the claim is denied for this reason. The allowed basic units is 8 units for adults and 16 for children.

5 Claim received after billable period

Description

A provider's contract specifies a certain number of allowable days to bill for a claim after the date of service. The provider did not submit the claim in time.

Corresponding HIPAA reason code

29-- The time limit for filing has expired.

Example

New Day Therapy's contract specifies that they have 30 days to submit a claim, following the date of service. The rendering provider renders service on 1/1/2012, but the claim gets submitted on 2/12/2012.

Recommended Action Steps

MCO

Verify that the claim was received within the number of days specified in the provider contract, plus a three day grace period. Verify that for reversal/replacement or COB claims, the period has been extended 90 days.

Provider

Write off charges as non-billable. Do not rebill.

In-Depth Look

AlphaMCS looks at the provider id in the claim header to look up the provider contract. The system determines the number of days allowed to submit a claim by checking the claim days field in the provider contract.

The following checks are also performed during this operation: 1) the provider contract is verified to be active 2) the claim date of service falls between the effective date and end date of the provider contract.

Next the system adds the number of allowed claim days to the claim date of service, plus 3 (each claim has a 3-day grace period) and checks that this value is greater than or equal to the insert date on the claim header.

Next, the system checks if the claim is a replacement claim. If it is a replacement claim, an additional 90 days past the insert date of the claim is allowed for processing, provided that the original claim was not denied for being received after the billing period.

Next, the system checks for the existence of a COB amount and COB reason in the claim line, and if those exist, the billable period is extended 90 days.

6 Claim submitted before service date

Description

The date of service (DOS) is later than the date the claim was submitted.

Corresponding HIPAA reason code

110-- Billing date predates service date.

Example

New Day Therapy submits a claim on 8/1, but the DOS on the claim is 8/4.

Recommended Action Steps

MCO

MCO staff can confirm this error by going to the Finance modules, Claims Maintenance. The Claims Maintenance tile will show the date the claim was submitted and the Claim Line tile will show the DOS for the particular claim line.

Provider

Check DOS for accuracy. Refile only if incorrect. Do not bill service prior to service date.

In-Depth Look

AlphaMCS looks at the date of service on the claim header. It verifies that the date and time on which the claim was inserted into the system (an internal timestamp) occurs after the date and time of service in the claim header.

7 Client has other insurance which covers the service

Description

The client has another insurance that should pay for this service.

Corresponding HIPAA reason code

22-- Payment adjusted because this care may be covered by another payer per coordination of benefits. This change to be effective 4/1/2008: This care may be covered by another payer per coordination of benefits.

Example

New Day Therapy puts in a claim for H2022. BCBS covers this service and should pay for it, as opposed to the state insurance.

Recommended Action Steps

MCO

MCO staff can confirm this error by going to the Patient module, Finance tab, and looking at the Insurance and COB tiles.

Provider

Check DOS for accuracy. Resubmit only if incorrect. Do not bill service prior to service date.

In-Depth Look

AlphaMCS retrieves the patient id from the claim header and the procedure code, claim date of service, and COB amount from the claim line. The patient id is used to retrieve COB insurance data. If the patient is enrolled in COB, and the claim date is between the effective and end dates of the COB, and there is no COB amount or COB reason in the claim line, then the claim is denied.

8 Patient not covered by contract

Description

A client-specific contract exists but the client is not included in the contract.

Corresponding HIPAA reason code

181-- Payment adjusted because this procedure code was invalid on the date of service. This change to be effective 4/1/2008: Procedure code was invalid on the date of service.

Example

The service on the claim wasn't in the providers contract on the DOS.

Recommended Action Steps

MCO

To confirm a client specific contract, do the following:

1. Click Menu→Provider→Maintain Provider Info
2. Click the provider name in the Providers tile
3. Click the Contract tab
4. Click the contract in the Contract Details tile
5. Patient-specific contracts will then be listed in the Patient-Specific contract tile

Provider

Check criteria listed in provider contract for patient eligibility. Confirm patient eligibility through Enrollment and Eligibility.

In-Depth Look

You can think of the provider contract and the client-specific contract as being in a hierarchy, with the client specific contract being stored beneath the provider contract.

AlphaMCS maintains a list of client-specific contracts that are tied to the provider contract. During the adjudication process, AlphaMCS looks at the provider id in the claim header to look up the provider

contract. The provider contract is then compared to the list of client-specific contracts. If a client-specific contract is found not to have a provider contract associated with it (a so-called orphan record), then the claim is denied.

9 Clinician not licensed to provide the service

Description

The clinician who performed the service doesn't have the license required to perform the service.

Corresponding HIPAA reason code

52-- The referring/prescribing/rendering provider is not eligible to refer/prescribe/order/perform the service billed.

Example

Nurse Jones performs a triage when she admits a patient to inpatient therapy. The claim is billed under clinician Dr. Bob Jones, the patient's therapist. The state insurance guidelines specify that only an LPN can perform the service.

Recommended Action Steps

MCO

MCO staff can confirm the error by going to Provider Network, Clinician Maintenance, and looking at the Licenses tile for that clinician. Also ensure that the clinician's license group has a contract rate associate with the procedure code in the claim line.

Provider

Check claim for accuracy and if no errors exist, claim cannot be billed. No action needed. If billed in error, correct and refile claim.

In-Depth Look

AlphaMCS looks at the provider id in the claim header in order to retrieve the provider contract, provider contract details, contract rates. The claim line is used to look up the procedure code and clinician id. The clinician id is used to find a corresponding clinician license, wich is mapped to a license group. So, in this validation, not only does AlphaMCS look at the provider contract rates, but also the license belonging to the clinician. If the contract rate in the adjudication line is null or zero, and the claim is for a clinician-based service, then the claim is denied.

10 Coinsurance Amount

Description

This reason code is set when AlphaMCS is adjusting a claim that has a COB Amount. The adjudicated amount is subtracted from the cob amount and the difference is the adjusted amount.

Corresponding HIPAA reason code

2—Coinsurance Amount

11 Concurrent service has already been approved. Cannot bill another one.

Corresponding HIPAA reason code

59-- Charges are adjusted based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.) This change to be effective 4/1/2008: Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.)

In-Depth Look

AlphaMCS looks for claim lines that been adjudicated and stamped with reason code 1 - Adjusted – Above Contract Rate or 30 – monthly case rate already paid. AlphaMCS then denies a claim if two procedures are performed by the same provider on the same date of service, as defined in non-concurrent procedure code definition.

NOT CURRENTLY IN USE

12 Correction to prior claim

Description

Corresponding HIPAA reason code

63-- Correction to a prior claim.

NOT CURRENTLY IN USE

13 Daily limit exceeded

Description

The service has a limit on the amount of units that can be billed per day. Either the claim has exceeded that limit OR that claim in addition to other claims (for that same day and service) has exceeded the limit.

Corresponding HIPAA reason code

198-- Payment Adjusted for exceeding precertification/ authorization. This change to be effective 4/1/2008: Precertification/authorization exceeded.

Example

A clinician at New Day Therapy submits a claim for 1 unit for a service. Another clinician at New Day then submits another claim for 1 unit for that same service. They both bill but the second is denied because only 1 unit is allowed per day for that service.

Recommended Action Steps

MCO

MCO staff can confirm this error by going to the Master modules, Benefit Plans, then checking the Service/Proc Codes tile. This will tell you any limits on the service.

Provider

Only one occurrence of service is billable per day. Adjust off charges and do not refile. Only if service is billed as daily summary of units, file adjusted claim.

In-Depth Look

AlphaMCS calculates the daily limits for procedure codes that require authorization by looking up the daily limit in the procedure-code-to-benefit plan record. The units for the adjudicated claim lines for that day are summed, and if the daily amount is greater than the daily limit, the claim is denied.

14 Discontinued Service

Description

The MCO is no longer reimbursing providers for performing this service.

Corresponding HIPAA reason code

204-- This service/equipment/drug is not covered under the patient's current benefit plan

Example

Recommended Action Steps

MCO

MCO staff can confirm this by going to the Master modules, Benefit Plans. Choose the benefit plan that applies, then the appropriate service definition. The services that fall under that definition will show. The DOS of the claim should outside the end date of the service.

Provider

Service has been lapsed/removed from benefit plan and is no longer billable. Confirm through Provider Network.

In-Depth Look

AlphaMCS looks at the procedure code in the claim line. It first validates that the procedure code in the claim line exists in the known procedure codes located in the database. Next, AlphaMCS verifies that the claim date of service falls between the effective date and end date of the procedure code.

15 Duplicate Claim

Description

An identical claim has already been processed.

Corresponding HIPAA reason code

18-- Duplicate claim/service.

Example

New Day Therapy sends in the same claim twice. Either accidentally in the same batch or in two separate batches. Also, a claim could have been sent in an 837 and someone also entered a CMS 1500.

Recommended Action Steps

MCO

MCO staff can confirm this error by going to the Claims Header Base and filtering for the claim using the search fields. Two claims with the same data should come up.

Provider

Claim has previously been submitted and adjudicated. Do not refile.

In-Depth Look

AlphaMCS considers a claim to be a duplicate if the following data matches another claim: procedure code id, place of service, provider id, patient id, and date of service. In the event that a duplicate is found, the claim that will be processed further will be the one that was adjudicated prior to the duplicate.

16 *DX code is invalid for service/insurance combo*

Description

The diagnosis on the claim is part of a dx group that isn't mapped to that service.

Corresponding HIPAA reason code

11-- The diagnosis is inconsistent with the procedure.

17 FFS claim pended for 14 days wait

Description

Corresponding HIPAA reason code

96-- Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)

NOT CURRENTLY IN USE

18 Incorrect Member -- Patient not enrolled @ dt of srvc

Description

The client either wasn't enrolled in the insurance on the date of service (DOS) or they were never enrolled in it.

Corresponding HIPAA reason code

31-- Claim denied as patient cannot be identified as our insured. This change to be effective 4/1/2008: Patient cannot be identified as our insured.

Example

New Day Therapy bills a claim for Jane Doe with a DOS of 8/1/12 to state insurance. However, Jane only had Medicaid until 8/5/12, so she wasn't covered under state at the time the service was performed.

Recommended Action Steps

MCO

MCO staff can confirm this error by going to the Patient module, Finance tab, and looking at the Insurances and COB's tiles. Check the existence of a patient insurance record and that the claim date of service falls between the effective and end dates of the patient insurance.

Provider

Verify that all patient information is correct on claim. If no errors exist, contact MCO.

In-Depth Look

AlphaMCS looks at the patient id in the claim header. The patient id in the header maps to the patient-to-insurance record. AlphaMCS validates the existence of the patient-to-insurance record and that the date of service on the claim falls between the effective and end dates of the patient's insurance record.

In a subsequent validation routine, AlphaMCS identifies the approved insurance by looking up the provider id in the claim header and the procedure code in the claim line. AlphaMCS uses these fields to look up the provider contract and the provider contract details, which maps a provider contract to procedure code.

Next, AlphaMCS selects the plan under which the claim is going to be adjudicated by looking at the procedure code in the claim line. The procedure code is used to look up a corresponding record in the procedure-code-to-benefit plan mapping. In this way, the system determines the types of insurances

that cover the procedure code.

Next, AlphaMCS checks the patient id in the claim line to see if the patient is enrolled in the correct benefit plan at the date of service. In this check we look up the patient's type of insurance and ensure that the claim date of service falls between the effective and end date of the patient's insurance record.

19 Incorrect Member -- Patient not enrolled @ dt of srvc

Description

The client either wasn't enrolled in the insurance on the date of service (DOS) or they were never enrolled in it.

Corresponding HIPAA reason code

140-- Patient/Insured health identification number and name do not match.

Example

A claim is received via an 837 file. The system checks the patient's name and DOB, but cannot locate a patient id.

Recommended Action Steps

MCO

MCO staff can confirm this error by going to the Patient module, Finance tab, and looking at the Insurances and COB's tiles.

Provider

Verify that all patient information is correct on claim. If no errors exist, contact MCO.

In-Depth Look

This reason code description is the same as reason code 18, however, the validation rule is different. In this check, AlphaMCS verifies the existence of a patient id in the claim header. A patient id is an internal field that uniquely identifies each patient. If the patient id cannot be found, the system returns reason code 19.

20 Incorrect Service -- Service not in database

Description

The service on the claim is not in the AlphaMCS database.

Corresponding HIPAA reason code

181-- Payment adjusted because this procedure code was invalid on the date of service. This change to be effective 4/1/2008: Procedure code was invalid on the date of service.

Example

New Day Therapy bills for a service code '17765327'. This service doesn't exist in the MCO's database.

Recommended Action Steps

MCO

MCO staff can confirm this by going to the Master modules, Benefit Plans. Choose the benefit plan that applies, then the appropriate service definition. The services that fall under that definition will show. The DOS of the claim should fall within the effective and end dates of the service, OR there aren't any dates at all for the service.

Provider

Verify that all service information is correct on claim. If no errors exist, contact SMC Provider Network.

In-Depth Look

AlphCMS uses the procedure code id in the claim line to search for the existence of the procedure in the database. If no results are found, the claim is denied for this reason.

21 Invalid Age Group & PC combo

Description

The age group that the client falls into shouldn't be receiving that service.

Corresponding HIPAA reason code

6-- The procedure/revenue code is inconsistent with the patient's age.

Example

John Doe is 35 years old but the provider is billing for a child service.

Recommended Action Steps

MCO

MCO staff can confirm this by going to the Master modules, Service Matrix. Filter for the service on the Base tile, highlight it, then go to the Others tab. The Age Group tile will tell you which age groups are acceptable for this service.

Provider

Verify that consumer age corresponds with procedure code billed and that all information is submittted correctly. Refile only if incorrect.

In-Depth Look

AlphaMCS looks at the procedure code id and patient id in the claim line, and the claim date of service in the claim header. It uses the patient id to look up the patient date of birth. In the system, each procedure code is mapped to an age group. Alpha CMS validates the following 1) the relationship of the procedure code to the age group is valid OR the procedure code is mapped to all age groups 2) the date of service on the claim line falls between the patients date of birth + the lower age limit and the patient's date of birth + the upper age limit. 3) the claim date of service falls between the effective date and end date of the procedure-code-to-age group mapping.

22 Invalid Amount

Description

The amount billed on the claim is blank, $0, or less than $0.

Corresponding HIPAA reason code

96-- Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)

Example

An provider submits an incoming 837 file, but the data is missing or formatted incorrectly and the claim amount cannot in the file. AlphaMCS stores, yet denies the claim, giving the provider a chance to re-enter the missing data.

Recommended Action Steps

MCO

MCO staff can confirm this by going to the Claim Line tile and viewing the Amount column.

Provider

Enter charge information for service. Refile Claim.

In-Depth Look

AlphaMCS checks that the claim amount being adjudicated is not null and greater than 0.

24 Invalid PC / DX Combo

Description

The diagnosis code submitted on the claim is invalid for the service.

Corresponding HIPAA reason code

11-- The diagnosis is inconsistent with the procedure.

Example

The claim is for a DD service but the client only has an SA diagnosis.

Recommended Action Steps

MCO

MCO staff can confirm this by going to the Master modules, Service Matrix. Filter for the service on the Base tile, highlight it, then go to the Others tab. The Diagnosis Group of the client should not be showing on that tile.

Provider

Verify that Procedure code corresponds with Dx and that all information is submittted correctly. Refile only if incorrect.

In-Depth Look

AlphaMCS looks at the procedure code, diagnostic code, benefit plan, from date, to date, and insert date of in the claim line. Alpha CMS validates that the procedure code has a matching record in the procedure-to-diagnostic-group relationship. It verifies that, for that procedure, that the diagnostic code has a mapping to the diagnostic-code-to- diagnostic-groups relationship. It verifies that the procedure-to-diagnostic-group relationship has a record for the given benefit plan. It verifies that the from date – to date of the claim line falls between the effective and end dates of the procedure-to-diagnostic-group relationship and the diagnostic-code-to-diagnostic-group relationship.

25 Invalid POS & Service combo

Description

The place of service (POS) submitted on the claim is invalid for the serivce.

Corresponding HIPAA reason code

5-- The procedure code/bill type is inconsistent with the place of service.

Example

The claim is for an Intensive In-Home service but the POS is "Office".

Recommended Action Steps

MCO

MCO staff can confirm this by going to the Master modules, Service Matrix. Filter for the service on the Base tile, highlight it, then go to the Others tab. The POS on the claim will not be showing on that tile if the POS is invalid.

Provider

Verify place of service used for billing and that it is appropriate for the service billed. If incorrect, refile under a valid place of service.

In-Depth Look

AlphaMCS looks at the procedure code id, place of service id, from date, and to date in the claim line. AlphaMCS validates the following conditions: 1) the procedure code in the claim line has a matching record in the procedure-code-to-place-of-service mapping 2) that the place of service is valid for the procedure code or that the procedure code permits ALL places of service 3) That the procedure-code-to-place-of-service mapping is active and that the from and to dates on the claim line fall between the mapping's effective and end dates.

26 Invalid Provider

Description

The provider isn't active in the MCO's network.

Corresponding HIPAA reason code

208-- NPI denial - not matched. This change to be effective 4/1/2008: National Provider Identifier - Not matched.

Example

New Day Therapy is still under credentialing with the MCO.

Recommended Action Steps

MCO

MCO staff can confirm this by going to Provider Network, Maintain Provider Info and filtering for that provider. The provider should not have an status of Active.

Provider

Verify that provider information is correct on claim and is valid for the service billed. Contact MCO to update, then refile.

In-Depth Look

AlphaMCS looks at the provider id in the claim header. It first invalidates any records that do not have a provider id at all. Next it checks that the provider id in the claim header has a corresponding match to the providers in the MCO's database.

27 Invalid provider NPI

Description

The NPI on the claim either isn't in the system or isn't associated with the main site on the claim for the date of service.

Corresponding HIPAA reason code

206-- NPI denial - Missing. This change to be effective 4/1/2008: National Provider Identifier - missing.

Example

AlphaMCS receives a claim via an 837 file. The NPI number on the claim does not match an NPI number in the MCO's database.

Recommended Action Steps

MCO

MCO staff can confirm this by going to Provider Network, Maintain Provider Info and filtering for that provider. Go to the Site tab and choose the appropriate site. Then go to the Site Mapping tab, Numbers tile, and see if that NPI shows there.

Provider

Verify that provider NPI is correct on claim and is valid NPI for the service billed. Contact SMC Provider Network to update, then refile.

In-Depth Look

AlphaMCS looks at the provider id, and provider npi number in the claim header. It checks that the provider id in the claim header is matched to a site. AlphaMCS checks that the provider npi number in the header is matched to a site. AlphaMCS checks that the provider id and provider npi number in the header has a matching provider in the database.

28 Invalid Rendering NPI

Description

The rendering NPI submitted on the claim either isn't in the system, isn't associated with the site or clinician on the claim for the date of service.

Corresponding HIPAA reason code

206-- NPI denial - Missing. This change to be effective 4/1/2008: National Provider Identifier - missing.

Example

The provider submits a claim for Dr. Bob Jones, who is a new practitioner at New Day Therapy. However, the provider has mistakenly entered the effective date of Dr. Jones's employment to one month later than the claim date of service.

Recommended Action Steps

MCO

MCO staff can confirm this by going to Provider Network, Maintain Provider Info and filtering for that provider. Go to the Site tab and choose the appropriate site. Then go to the Site Mapping tab, Numbers tile, and see if that NPI shows there. If the rendering NPI is for a clinician, go to Provider Network, Clinician Maintenance and filter for that clinician. The clinician's NPI will show on the 2 and 3 view.

Provider

Verify that rendering NPI is correct on claim and is valid NPI for the service billed. Contact SMC Provider Network to update, then refile.

In-Depth Look

AlphaMCS looks at the provider id, procedure code id (to determine a clinician-based procedure), rendering provider, from date, and site id in the claim line. If clinician based, AlphaMCS verifies that the provider in the header exists in the database and is matched to a site. It then validates that the rendering provider is matched to the same site. For other records, the rendering npi number in the claim line is matched to a clinician, the clinician is matched to a provider, the "from date" in the claim line falls between the effective and end dates of the clinic-to-provider relationship.

29 Invalid Units

Description

The units submitted for the claim is blank, 0 or less than 0.

Corresponding HIPAA reason code

96-- Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)

Example

A claim is received on an 837 and the claim amount was inadvertently left out.

Recommended Action Steps

MCO

MCO staff can confirm this by going to the Claim Line tile and viewing the Units column.

Provider

Verify that the units are correct for service billed, and refile claim.

In-Depth Look

AlphaMCS checks the units field in the adjudication record and verifies that it is not null and is greater than 0. In subsequent checks, the allowable number of basic units and authorized units is compared to the acceptable limit. This validation routine is the most basic of the units validation routines, in that it simply checks for the existence of a numerical value in the units field.

30 Monthly case rate already paid (TCM)

Description

There is a monthly limit for TCM. Any claims beyond this set limit will deny for this reason.

Corresponding HIPAA reason code

96-- Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)

Example

New Day Therapy can bill four TCM services a month to the MCO. They bill a fifth and get this denial.

Recommended Action Steps

MCO

Look at the Benefit Plan and see what the monthly limit is. Then look at Claim Maintenance and filter for claims for that patient for that month.

Provider

You can look at RA's or the Claims Dump to see how many services have been billed for a patient in a given period of time.

31 Monthly limit exceeded

Description

The amount of units on the claim, along with units on other claims for the same patient and service during that same month, exceed what is allowed by the MCO.

Corresponding HIPAA reason code

198-- Payment Adjusted for exceeding precertification/ authorization. This change to be effective 4/1/2008: Precertification/authorization exceeded.

Example

New Day Therapy has submitted 8 units for John Doe during June. This is maximum that the MCO has allowed New Day to bill for this service in a month. When they try to bill a ninth unit, they will get this denial reason.

Recommended Action Steps

MCO

MCO staff can confirm this by going to the Master modules, Benefit Plans. Choose the benefit plan that applies, then the appropriate service definition. The services that fall under that definition will show. The monthly limit for the service will show on the far right hand side of the 1 view.

Provider

Units for monthly service were exceeded. Do not refile claim.

In-Depth Look

AlphaMCS calculates the monthly limits for procedure codes that require authorization by looking up the monthly limit in the procedure-code-to-benefit plan record. The units for the adjudicated claim lines for that month are summed, and if the monthly amount is greater than the monthly limit, the claim is denied.

32 No rates available

Description

A contract rate was not found for the provider.

Corresponding HIPAA reason code

147-- Provider contracted/negotiated rate expired or not on file.

Example

New Day Therapy bills a claim for a service that the MCO hasn't said how much they're going to pay for it, if at all.

Recommended Action Steps

MCO

Confirm this by going to Finance, Rates Schedule. Search for the appropriate Contract, then find the service and check if it has rates connected to it.

Provider

Rate not established in rate schedule. Contact SMC Provider Network.

In-Depth Look

AlphaMCS first stamps all of the claim lines that belong to subcapitated contracts for special processing. AlphaMCS looks at the provider id in the claim header in order to retrieve the provider contract, provider contract details, contract rates. The claim line is used to look up the benefit plan, the site, procedure code and clinician id. The clinician id is used to find a corresponding clinician license, wich is mapped to a license group. So, in this validation, not only does AlphaMCS look at the provider contract rates, but also the license belonging to the clinician.

33 Non billable Service

Description

The MCO does not reimburse providers for performing this service.

Corresponding HIPAA reason code

46-- This (these) service(s) is (are) not covered.

Example

Clinician Bob Roberts submits a claim for accompanying John Doe to a court date. The MCO has this as an service in their benefit plan but they will not pay for it.

Recommended Action Steps

MCO

MCO staff can confirm this by going to the Master modules, Service Matrix. Filter for the service on the Base tile. On the 3 view, you're able to look at the "Is Billable?" checkbox.

Provider

Service is not covered under the benefit plan. Confirm correct service billed, and contact the provider network if disputing denial.

In-Depth Look

AlphaMCS gets the procedure code in the claim line. It looks up the procedure record in the database, and checks to see if the procedure is billable by looking for a value in the Billable column.

34 Re-submission already processed

Description

A claim that has been resubmitted and the re-submitted claim has already been adjudicated.

Corresponding HIPAA reason code

96-- Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)

Example

Clinician Bob Roberts submits a claim for a service but inadvertently enters the incorrect number of units. After receiving the RA, he realizes his mistake and submits a replacement claim after correcting the number of units.

Recommended Action Steps

MCO

Check the Resub/Ref # in the resubmission to verify that it references an original claim. The duplicate resubmission will contain the same reference.

Provider

Duplicate claim. Do not refile claim. Contact SMC Claims Specialist.

In-Depth Look

When a claim is re-submitted, a new claim is created and the new claim gets stamped with the claim header id of the old claim. AlphaMCS uses this data to verify that a re-submitted claim gets processed only once.

35 Service is not authorized

Description

The service peformed by the provider was not authorized.

Corresponding HIPAA reason code

62-- Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.

Example

Clinician Bob Roberts enters a claim for therapy that he's doing with John Doe but the SAR he submitted hasn't been approved yet.

Recommended Action Steps

MCO

To verify if a service is authorized for a procedure code for a particular provider, to do the following

1. Click Menu→Clinical → Utilitzation Management → SAR
2. Search by Patient or Procedure Code

Provider

Verify Service Authorization for consumer. Contact SMC Service Management.

In-Depth Look

Alpha CMS looks at the claim header for the provider id and and uses that to look up, in the provider contract details, if authorization is required for the procedure in the claim line. A list of authorization codes is generated for each procedure performed, based on the data taken from the provider contract details. If authorization is required for the procedure code for that site and the authorization code is not found in the database, the claim is denied. The validation rules for the reason code do not apply to procedures flagged as basic or institutional.

36 Service not in contract

Description

The patient is enrolled with a particular type of insurance plan, such as State or Medicaid, but the provider contract does not specify that the provider can render the service.

Corresponding HIPAA reason code

181-- Payment adjusted because this procedure code was invalid on the date of service. This change to be effective 4/1/2008: Procedure code was invalid on the date of service.

Example

New Day Therapy bills for H2022. However, they're only contracted to do therapy with the MCO.

Recommended Action Steps

MCO

Confirm this by going to Provider Network, Maintain Provider Info, search for that provider and go to the Contracts tab. Find the appropriate contract in the Contracts tile, then go to the Contract Details tile and try to find that service. You shouldn't be able to.

Provider

Review your contract with the Provider Network prior to refiling claim.

In-Depth Look

AlphaMCS looks at the provider id in the claim header to look up the provider contract. The provider contract identifies the approved types of insurance for that provider. Next AlphaMCS determines whether the claim is going to be adjudicated as a claim going to the State, Medicaid B, Medicaid C, or Medicaid FFS. If the approved types of insurance for that provider do not cover the type of service being rendered, then the service is not in the provider's contract and the claim is denied.

37 Service not in provider profile

Description

A provider's contract details what procedure codes the provider can render. The procedure code in the claim line is not a procedure that can be rendered by the provider.

Corresponding HIPAA reason code

181-- Payment adjusted because this procedure code was invalid on the date of service. This change to be effective 4/1/2008: Procedure code was invalid on the date of service.

Example

New Day Therapy bills for H2022. However, they're only contracted to do therapy with the MCO.

Recommended Action Steps

MCO

Verify that service is included in provider profile.

Provider

Confirm through your Provider Network prior to refiling claim.

In-Depth Look

AlphaMCS looks at the provider id, procedure code id, and claim date of service, in order to look up the provider contracts in the database. In Alpha CMS, each provider is mapped to a contract, and each provider's contract is matched to a set of procedure codes. AlphaMCS checks the provider contract to validate the following: 1) that a contract exists with the provider 2) that the procedure code exists in the provider contract details 3) that the claim date of service is between the effective and end dates of the provider contract and contract details.

38 Subcapitated Provider/Service

Description

Provider has already been paid, so this will not be paid even if it's approved.

Corresponding HIPAA reason code

24-- Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan. This change to be effective 4/1/2008: Charges are covered under a capitation agreement/managed care plan.

Example

New Day is a provider who has subcapitated services—they are regularly paid by the MCO regardless of the claims that come in—so when a claim is approved, it's still not going to pay since it's already been paid once.

Recommended Action Steps

MCO

Check the contract of the provider. Go to **Contract Details**, find the service that was on the claim, and click the 3 view to see if the **Subcapitated** checkbox is checked.

Provider

Refer to your contract with the MCO and call them with any questions.

39 The procedure code is inconsistent with the provider type/specialty (taxonomy).

Description

The MCO doesn't have on file that the provider uses the taxonomy entered for the claim, OR the MCO doesn't have that taxonomy associated with the site specified on the claim.

Corresponding HIPAA reason code

8-- The procedure code is inconsistent with the provider type/specialty (taxonomy).

Example

New Day Therapy bills using taxonomy 101TXNMY but the MCO doesn't have this taxonomy on file as one that New Day uses.

Recommended Action Steps

MCO

Confirm this by going to Provider Network, Maintain Provider Info, search for the provider, then go to the Site tab to select the site that was billed. Then go to Site Mapping tab, Taxonomy tile. Look for the taxonomy there.

Provider

Verify the Taxonomy code filed for the claim. If incorrectly submitted, correct and refile. Contact SMC Provider Network to add taxonomy code.

40 Weekly limit exceeded

Description

The service has a limit on the amount of units that can be billed per week. Either the claim has exceeded that limit OR that claim in addition to other claims (for that same week and service) has exceeded the limit.

Corresponding HIPAA reason code

198-- Payment Adjusted for exceeding precertification/ authorization. This change to be effective 4/1/2008: Precertification/authorization exceeded.

Example

A clinician at New Day Therapy submits a claim for 1 unit for a service on Monday. Another clinician at New Day then submits another claim for 1 unit for that same service on Tuesday. They both bill but the second is denied because only 1 unit is allowed per week for that service.

Recommended Action Steps

MCO

MCO staff can confirm this error by going to the Master modules, Benefit Plans, then checking the Service/Proc Codes tile. This will tell you any limits on the service. If a SAR was submitted for this patient and service, staff can go to Clinical, Utilization Management, SAR, search for the patient and find the SAR for this service, then go to the Service tile to view if any exceptional limits were put on the service just for this patient.

Provider

Limit to occurrence of service billable per week. If necessary, submit a SAR for service authorization. Adjust off charges and do not refile. Only if service is billed in error, file adjusted claim.

In-Depth Look

AlphaMCS calculates the weekly limits for procedure codes that require authorization by looking up the weekly limits in the procedure-code-to-benefit plan record. The units for the adjudicated claim lines for that week are summed, and if the daily amount is greater than the weekly limit, the claim is denied.

87 Adjusted Against Co-Insurance

Description

The adjudicated amount has been adjusted by subtracting the amount paid by the patient's co-insurance.

Corresponding HIPAA reason code

142-- Claim adjusted by the monthly Medicaid patient liability amount. This change to be effective 4/1/2008: Monthly Medicaid patient liability amount.

Example

John Doe has BCBS, who pays $100 for a service, then the claim goes to Medicaid, which is administered by the state in this case. Medicaid is going to adjust off what BCBS paid.

Recommended Action Steps

MCO

Look at patient's Insurances or COB's in the Patient module to ensure they have other payors that were active during the DOS.

Provider

Look at patient's Insurances or COB's in the Patient module to ensure they have other payors that were active during the DOS.

88 Invalid DRX DX Code

Description

DRG R&B codes should accompany a set of diagnosis codes. ***But this validation has been removed and hence this reason is not being used currently.***

Corresponding HIPAA reason code

11-- The diagnosis is inconsistent with the procedure.

Example

Recommended Action Steps

MCO

Provider

89 No DRG exists or rate is not set up yet

Description

If code 100 is not in the contract or a rate is not set up for 0100, claims will be denied for this reason.

Corresponding HIPAA reason code

147-- Provider contracted/negotiated rate expired or not on file.

Example

New Day Therapy bills a DRG service but this isn't in their contract.

Recommended Action Steps

MCO

Check the provider's contract for a code 100, this covers all DRG services.

Provider

Refer to your contract and call the MCO with any questions.

90 Non-Covered Ancillary Services

Description

A claim is identified as a drug claim by revenue code '100' or '0100', but it wasn't administered at an ICF site.

Corresponding HIPAA reason code

48-- This (these) procedure(s) is (are) not covered.

Example

New Day Therapy bills 0100 for a patient being seen at a site that isn't marked as ICF.

Recommended Action Steps

MCO

Go to Provider Network, Sites, and look at the 3 view for the site on the claim to see if the "ICF Site" checkbox is checked.

Provider

Go to Provider Network, Sites, and look at the 3 view for the site on the claim to see if the "ICF Site" checkbox is checked.

91 Invalid Revenue Code

Description

An invalid revenue code was provided for a drug claim. For these types of claims, the revenue code and procedure code must match.

Corresponding HIPAA reason code

199—Revenue code and Procedure code do not match.

Example

Recommended Action Steps

MCO

Provider

92 Excess amount over allowed medicare copayment

Description

The adjudicated amount has been adjusted by subtracting the Medicare copayment.

Corresponding HIPAA reason code

99-- Medicare Secondary Payer Adjustment Amount.

Example

John Doe has Medicare, who pays $100 for a service, then the claim goes to Medicaid, which is administered by the state in this case. Medicaid is going to adjust off what Medicare paid.

Recommended Action Steps

MCO

Look at patient's Insurances or COB's in the Patient module to ensure they have other payors that were active during the DOS.

Provider

Look at patient's Insurances or COB's in the Patient module to ensure they have other payors that were active during the DOS.

93 Invalid DCN (Document Ctrl #) or resubmission ref

Description

This is for replacement and reversal claims. The claim number entered for the original claim that the replacement/reversal claim is referencing is invalid.

Corresponding HIPAA reason code

125-- Payment adjusted due to a submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.) This change to be effective 4/1/2008: Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)

Example

New Day Therapy submits a replacement claim but the reference number (the original claim number that the new claim is replacing) doesn't exist in the MCO's system because New Day entered it incorrectly.

Recommended Action Steps

MCO

Go to Claims Maintenance and look up the reference number to see if it exists. You can also look at all past claims for a patient to see if you can find that number.

Provider

Look at your RA with the original claim number and make sure you entered it correctly.

94 Resubmitted claim DOS is after original claim submission date

Description

This is for replacement claims. The original claim was submitted earlier than the DOS on the resubmitted claim.

Corresponding HIPAA reason code

125-- Payment adjusted due to a submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.) This change to be effective 4/1/2008: Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)

Example

New Day Therapy submits a claim for the 1st of the month (DOS) on the 5th (submission date). They then send a replacement claim on the 15th (second submission date) but the DOS on that claim is the 6th.

Recommended Action Steps

MCO

Check in Claims Maintenance to view the original claim's submission date.

Provider

Check your RA to view the original claim's submission date.

95 Resubmitted claim does not match with the reference claim

Description

A replacement claim must match the original claim for three out of six of the following criteria: 1) provider 2) patient 3) service rendered 4) place of service 5) date of service 6) principle diagnosis. If less than three of the criteria do not match then AlphaMCS returns reason code 95.

Corresponding HIPAA reason code

125-- Payment adjusted due to a submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.) This change to be effective 4/1/2008: Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)

Example

New Day Therapy sends in a claim to replace a previous claim because the POS was wrong in the original. However, the replacement claim has a different POS, date of service and principal diagnosis. This differs too greatly from the original claim.

Recommended Action Steps

MCO

Go to Claims Maintenance and search for the original claim. The Claim Line tile will have the information you'll need to compare and contrast to the replacement claim.

Provider

In your claims dump and in your RA, you can see the information from the original claim that you need to compare and contrast to the replacement claim.

96 Referenced claim has already been resubmitted. Multiple resubmissions not allowed

Description

This for replacement and reversal claims. The original claim being referenced has already been resubmitted. A claim can only be resubmitted once.

Corresponding HIPAA reason code

125-- Payment adjusted due to a submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.) This change to be effective 4/1/2008: Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)

Example

New Day Therapy enters a replacement claim (eg, claim ID #3) for claim #1. However, New Day already entered a replacement, claim #2, for claim #1.

Recommended Action Steps

MCO

Go to Claims Maintenance and search by provider, DOS and patient to find all claims that are identical and when they were submitted. You can also look up the patient in the Patient module to find all claims entered for them.

Provider

You can look in the Patient module to find all claims entered for that patient and see which are identical and when they were submitted.

97 Exceeded budgeted amount

Description

There has been a cap placed on the provider/service/definition/age group/dx group/ benefit plan that has been reached. This claim would exceed that amount.

Corresponding HIPAA reason code

42-- Charges exceed our fee schedule or maximum allowable amount. (Use CARC 45)

Example

New Day Therapy has been given a $500,000 cap on H2022 by the MCO. They reach that cap, then submit a claim that asks the MCO to reimburse them over that amount and they receive this error.

Recommended Action Steps

MCO

Go to Finance, Funding Capitation and look up funding caps related to that claim (same service, provider, age group, service definition, etc.

Provider

Contact the MCO so they can review any funding caps that may apply to this claim.

100 Invalid date range/Invalid date for discharge claim

Description

For discharge claims (bill type ending in 1 or 4), if the day of discharge on the claim line matches the claim's date of service, the claim is denied. This is because the last date of discharge, the bed will be vacant. So the total billed units should be days minus 1. If total days in the date range are the same as the total units, the last date will be denied for this reason.

Corresponding HIPAA reason code

125-- Payment adjusted due to a submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.) This change to be effective 4/1/2008: Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)

Example

New Day enters a discharge claim for three days. As with all discharge claims, the last day won't pay.

101 Patient does not have a valid Target Pop. on DOS

Description

A claim is covered by state insurance for a particular procedure. However, the patient record has not been assigned to a target population, as required by the state.

Corresponding HIPAA reason code

125-- Payment adjusted due to a submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.) This change to be effective 4/1/2008: Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)

Example

The provider enters a claim for the 90801AH - CLINICAL INTAKE- CLINICAL PSYCH procedure for patient Jane Doe. However, Jane Doe has active insurance coverage with the state but has not been assigned to a Target Population.

Recommended Action Steps

MCO

You can verify that patient's Target Population by doing the following:

1. Go to Menu→Patient→Patient Search
2. Search for the patient by Last Name, First Name and other criteria
3. Select the patient in the search results.
4. Click the Doc, Assignment tab
5. In the IPRS Target Pops tile, you can verify the patient's assigned Target Pop(s)

Provider

Verify that consumer has a valid and current IPRS target population for the date of service billed. Contact MCO for assistance. If no errors exist, do not refile.

In-Depth Look

AlphaMCS looks at the patient id and date of service in the claim header. The system validates the following 1) the claim is covered by state insurance 2) the patient has been assigned to a target population 3) the claim date of service falls between patient-to-target-pop effective date and end date.

102 Patient does not have a valid Target Pop. for DX submitted in claim

Description

A claim is covered by state insurance; however the patient is in a target population and given a diagnosis that is not valid for that target population.

Corresponding HIPAA reason code

125-- Payment adjusted due to a submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.) This change to be effective 4/1/2008: Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)

Example

A female patient is diagnosed with Alzheimers Dimentia/Late Onset Uncomplicated and is not assigned to a valid target population, such as Adult Veteran or Adult MH Crisis.

Recommended Action Steps

MCO

You can verify that patient's Target Population by doing the following:

1. Go to Menu→Patient→Patient Search
2. Search for the patient by Last Name, First Name and other criteria
3. Select the patient in the search results.
4. Click the Doc, Assignment tab
5. In the IPRS Target Pops tile, you can verify the patient's assigned Target Pops

You can verify that Target Population to Diagnostic Code Relationship by doing the following:

1. Go to Menu→Master → Target Populations
2. Search for a target population
3. Verify that the diagnostic code has been assigned to that Target Pop.

Provider

Verify that consumer has a valid IPRS target population that corresponds with the diagnosis information on claim. Contact MCO for assistance. If no errors exist, do not refile.

In-Depth Look

AlphaMCS looks at the patient id, diagnosis code, and date of service in the claim header. The system validates the following 1) the claim is covered by state insurance 2) the patient has been assigned to a

target population 3) the target-population-to-diagnosis code relationship exists 4) the claim date of service falls between the effective and end dates of the target-population-to-diagnosis code relationship

103 Patient does not have a valid Target Pop. for service submitted in claim

Description

A claim is covered by state insurance for a particular procedure. However, the procedure performed is not valid for the patient's target population.

Corresponding HIPAA reason code

125-- Payment adjusted due to a submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.) This change to be effective 4/1/2008: Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)

Example

The provider enters a claim for the 90801AH - CLINICAL INTAKE- CLINICAL PSYCH procedure for patient Jane Doe. Jane Doe has active insurance coverage with the state but has not been assigned to a Target Population.

Recommended Action Steps

MCO

You can verify that patient's Target Population by doing the following:

1. Go to Menu→Patient→Patient Search
2. Search for the patient by Last Name, First Name and other criteria
3. Select the patient in the search results.
4. Click the Doc, Assignment tab
5. In the IPRS Target Pops tile, you can verify the patient's assigned Target Pops

You can verify that Target Population to Procedure Relationship by doing the following:

1. Go to Menu→Master → Target Populations
2. Search for a target population
3. Verify the procedure code has been assigned to that Target Pop

Provider

Verify that consumer has a valid IPRS target population that corresponds with the procedure on the claim. Contact MCO for assistance. If no errors exist, do not refile.

In-Depth Look

AlphaMCS looks at the patient id, diagnosis code, and date of service in the claim header. The system validates the following 1) the claim is covered by state insurance 2) the patient has been assigned to a target population 3) the target-population-to-diagnosis code relationship exists 4) the claim date of service falls between the effective and end dates of the target population.

104 Loaded from legacy system – No reason available

Description

The claim information was loaded into AlphaMCS during the initial data upload without a reason attached to it.

Corresponding HIPAA reason code

125-- Payment adjusted due to a submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.) This change to be effective 4/1/2008: Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)

Example

New Day Therapy has been working with the MCO for years before the MCO started using AlphaMCS. When the MCO made the transition to Alpha, they uploaded many New Day claims. Unfortunately, some did not have reason codes attached.

Recommended Action Steps

MCO

If the MCO still has access to the legacy system, they can look there and investigate as to what the reason could be.

Provider

Get in touch with the MCO.

105 Pended for manual review

Description

The system is not adjudicating the claim for some reason (eg, it's an ED claim or a claim that exceeds a dollar amount set by the MCO).

Corresponding HIPAA reason code

125-- Payment adjusted due to a submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.) This change to be effective 4/1/2008: Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)

Example

New Day sends in claim for $6k but the MCO has said they want to manually review all claims over $5k. MCO staff will have to look at the claim and manually adjudicate it.

Recommended Action Steps

MCO

Go into Claims Maintenance and search for Status "Manual Review Required". You can then see a list of claims that need to be manually adjudicated. To manually adjudicate a claim, go to the Adjudication Line tile and click "Adjudicate".

Provider

Get in touch with the MCO and ask for a timeframe around when the claim should be adjudicated.

106 Pended for COB since patient has no COB record

Description

The claim had a COB amount on it but the patient has no COB on record. For this reason, the claim has gone to "Manual Review Required" status and MCO staff must manually adjudicate it.

Corresponding HIPAA reason code

125-- Payment adjusted due to a submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.) This change to be effective 4/1/2008: Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)

Example

New Day bills a claim with a COB amount of $20. However, the MCO has no record of that patient having a COB.

Recommended Action Steps

MCO

Go to Patient, search for the patient, then go to the COB tile to view any other payors and effective dates.

Provider

Go to Patient, search for the patient, then go to the COB tile to view any other payors and effective dates.

107 The procedure code/bill type is inconsistent with the place of service

Description

The procedure code or bill type is inconsistent with the place of service, as defined in the procedure code-to-place-of-service mapping.

Corresponding HIPAA reason code

5-- The procedure code/bill type is inconsistent with the place of service.

Example

Examples of a place of service are: Office, Home, Inpatient Hospital, Emergency Room, etc. An invalid place of service for a particular procedure could be, for example, listing a clinical intake as taking place in someone's home.

Recommended Action Steps

MCO

Go to Service Matrix and search for the service, then look at the POS tile to see what places or services are mapped to it and will pay.

Provider

Contact your MCO.

108 No coverage available for Patient/Service/Provider combo

Description

A benefit plan could not be mapped to the claim since there's an inconsistency in the dates the patient had the benefit plan and the provider was contracted to perform that service.

Corresponding HIPAA reason code

Example

A provider is contracted for a service for State.

The client is covered by both State & Medicaid insurances.

The service is only eligible for Medicaid.

So...the claim is valid for the provider, the client and the service individually. But there is no single BP valid for all the three.

Recommended Action Steps

MCO

Go to Patient Module, Finance tab, Insurance tile to view when the patient was covered under what insurances. Then go to Provider Network, Contracts, Contract Details to see when the service is effective.

Provider

Contact your MCO.

109 Service is not authorized for the supplied site

Description

The service is in the provider's contract but for a different site than what was entered on the claim.

Corresponding HIPAA reason code

Example

New Day Therapy sends in a claim for 90832 done at Site A. However, this service is only in their contract for Site B.

Recommended Action Steps

MCO

Go to Provider Network, Contracts tab, Contracts. Select the appropriate contract then go to Contract Details. Here you can search for services and see which site they're attached to in the Site column.

Provider

Go to Provider Details, Contracts tab, Contracts. Select the appropriate contract then go to Contract Details. Here you can search for services and see which site they're attached to in the Site column.