Claims Validation Process for Providers (Alpha MCS)

Providers have requested to know the validation sequence their claims go through in the AlphaMCS system. Below is the documentation that the MCO staff use for this purpose.

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 PBHM 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.

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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

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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 the MCO database?	24 - Invalid PC / DX Combo
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

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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 amount.	10 - Coinsurance 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

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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