



Department of Health
and Human Services

*Maine People Living
Safe, Healthy and Productive Lives*

MaineCare Technical Advisory Group



Hospital-Specific TAG

May 10, 2012

Agenda



- Adjustments**
- Wait Rev**
- RA's**
- Secondary Billing**
- Other Known Issues**

Adjustments



The following issues were previously identified and have been reprocessed:

- **APC Claims Pricing** - APC claims adjudicated between 9/15/10 and 11/30/10 had line items that paid at zero.
- **DRG Claims** – Due to an incorrect version of MicroDyn, DRG claims with an admit date of 10/1/10 or later did not get DRG allocated. Claims processed and paid at zero.
- **APC Fall-out Codes** – APC Status Indicators B and E did not have rates assigned to CPT/HCPCS codes.
- **Revenue Code/CPT Conflict** – CAH's experienced line item denials. Bill type 0851 was not set up accurately in MIHMS.

Adjustments



- **Claims Adjustment Reason Code 204-** During the week of 3/21/11, hospitals experienced an increase in denials for CARC 204.
- **Claims Adjustment Reason Code 505 and 304 –** Hospitals received a volume of line item denials on their RA's.
- **Claims Adjustment Reason Code 11 –** Claim denials caused by PCCM issue.
- **Lab Fee Schedule –** Claims were processed at the wrong rate.

Wait Rev



- ✓ 20,132 claims have been in a “WAITREV” status for more than 30 days
- ✓ 19,114 of that total have gone through the Flexi Financial but were not finalized in QNXT, the system that adjudicates the claim
- ✓ The RAs didn’t occur because the system was set to NOT produce an RA when there were no positive QNXT transactions
 - Tied to cash payments (bridge or PIP payments etc.)
 - Most occurred during the 11/5 and 3/5 payment cycles
- ✓ Defect #TR1005935 change the system and to perform the necessary data remediation
- ✓ With approval from the State, a report will be produced for each provider that is equivalent to the missing RA

RA's Example from Week # 1



Report Number: FNCL0001-HPAS
Paper Remittance Advice

Remittance Advice #:

Check #:

Summarized Disbursement of Fund

Site Name

NP WAP I-3

Paid Claims		\$74.18
Denied Claims		\$0.00
Reversal Claims	Reversed and Adjusted Total (Net)	(\$126.83)
Total		(\$52.65)

$$138.11 - 126.83 = 11.28$$

Non-Claim Payments

NO DATA TO REPORT

Offsets

Forward Balance	Reversals Only	\$138.11
Claim Recoupment	Claims to be paid- that can be recouped	(\$85.46)
Total		\$52.65

$$74.18 + 11.28 + 85.46$$

Location Total \$0.00

RA's Example from Week # 2



Report Number: FNCL0001-HPAS
Paper Remittance Advice

Remittance Advice #:

Check #:

Summarized Disbursement of Fund

Site Name

NP VAP H-3

Paid Claims

Denied Claims

Reversal Claims

Total

Sum of Paid Claim Section

\$6,674.76

Sum of the Reversed and Adjusted Section

\$0.00

(\$1,106.26)

\$5,568.50

Non-Claim Payments

NO DATA TO REPORT

Offsets

Forward Balance

Claim Recoupment

Total

Sum of the Reversed Claims (only)

\$1,106.26

(\$1,158.91)

(\$52.65)

Sum of the Reversed Claims (only)

Owed from prior RA

\$5,515.85

Location Total

Secondary Billing



At the beginning of March, training was provided to all hospitals for billing MaineCare secondary to other payors. Part of the training included the use of a tool called the EOB Splitting Worksheet. This tool was created to assist hospitals with splitting their secondary claims to MaineCare.

After extensive testing and discussion with hospitals and MaineCare Management, the decision was made to not utilize the tool. MaineCare recognized this process as being too complex and understands the need to simplify.

Secondary Billing



For secondary billing, hospitals will submit claims to MaineCare in the same manner submitted to the primary commercial payor.

Example: Hospital submits primary claim to Anthem on a UB-04. Hospitals will submit the secondary claim to MaineCare on the UB-04 and attach the Anthem EOB.

This instruction does not change the way hospitals submit claims to MaineCare as primary. Primary claims will continue to be split billed (UB/1500) in the same manner that mirrors Medicare.

Secondary Billing



Billing Instructions/Paper Claims

CMS 1500	
Appendix A: Box 24F	Box 24F: Charges must be the lower of the provider's charge or the allowed amount that the provider and the insurance company agreed to, as shown on the insurance company's Explanation of Benefits (EOB). The allowed amount should equal the amount paid plus the patient responsibility.
Appendix A: Box 29	Box 29: Enter the amount paid by the insurance company/third party.
UB04	
Box 54	If there are one or more other payers listed in FL 50, enter the prior payments and/or discounts/contractual adjustments received from other third party payers, except MaineCare.

Secondary Billing



My HealthPAS (DDE)	
Charge	Charges must be the lower of the provider's charge or the allowed amount that the provider and the insurance company agreed to, as shown on the insurance company's Explanation of Benefits (EOB). The allowed amount should equal the amount paid plus the patient responsibility.
COB Information:	When possible, enter detail at the line level for more accurate claims processing.

Other Known Hospital Issues



- ❑ Duplicate denials for CAH's when billing their ER/Admissions separately.
- ❑ Duplicate denials for room & board charges when using the same revenue code on separate lines.
- ❑ RA/835 does not balance due to rounding issue.
- ❑ NDC Code on out patient hospital claims not required for most hospitals. Per Policy, the only hospitals that are required to submit NDC codes on their out patient claims are CAH's that have not enrolled under the 340b program.
- ❑ Some crossovers taking copays
- ❑ Medicare exempt codes given crossover attribute.
- ❑ Reversal claim populating the wrong CARC. When reversing an original claim that had denied lines, the reversal piece populates a CARC 45 which is a contractual adjustment. On the original claim the line had denied. This is causing the provider to overstate their contractual obligation.

Other Known Hospital Issues



- ❑ System is not creating secondary claims. Example: when a crossover claim is processed and MaineCare responsibility is for coinsurance/deductible and denied line items, the system will only process the coinsurance/deductible portion. The fix that is in process will allow a second claim to be generated in order to process the denied line from Medicare.
- ❑ Crossover issue where Edit 6024 is firing in error. This is causing hospital secondary claims to process and pay zero. It is applying RARC M46 and CARC 192 in error.
- ❑ Some crossover claims are being charged copays (where Part A or Part B attribute has effective dates that do not encompass the claim from DOS). Cause: Research revealed that the system is referring to effective and term dates of the Medicare attribute and limiting the crossover exemption to the date range found on the Medicare attribute. Those dates are not involved in the determination whether the claim is Medicare or not.
- ❑ The system is not correctly linking service locations to rendering and pay-to providers on Medicare Crossover claims.

Other Known Hospital Issues



- ❑ Copay exemption is not working properly on claims that have an AJ occurrence code.
- ❑ Hospital Cost Settlement Reports
- ❑ WAITREV Issue – new issue with claim getting stuck in WAITREV status. The total amounts for those WAITREV claims were reflected on a prior remittance advice.
- ❑ Crossover claims paid more than once. There is a gap in dupe logic that prevents a crossover claim from denying if submitted a second time.
- ❑ Copays applied to psychiatric hospital claims in error. This is currently being reviewed and we suspect that the system is not choosing the correct benefit when processing.
- ❑ Lab services were paid at zero. Molina is reviewing to determine if it is related to PCCM scoring issue.



Questions?