37.10 CLAIMS PROCESSING/PAYMENTS

Overview

Introduction

Claims for Medicaid reimbursement are processed by the Medicaid fiscal intermediary. This Section describes claims processing and gives the provider information about the remittance advice as well as how to obtain help with claims processing problems.

In This Section

This Section Contains:

37.10.1 CLAIMS PROCESSING

Claim Entry

Point of Sale (POS) claims enter the claims processing system directly through a telecommunications network and adjudicate in real time. Paper claims are keyed directly into the system for adjudication. Paper claims should be submitted to:

Molina
P. O. Box 91020
Baton Rouge, LA 70821

Claim Adjudication

The system edits the claim information and determines the status or disposition of the claim. This process is known as claim adjudication.

Disposition of Claim

A claim disposition can be:

- Paid: payment is approved in accordance with program criteria; or
- Denied: payment cannot be made because the information supplied indicates the claim does not meet program criteria, or information necessary for payment was either erroneous or missing.

Processing Time Frames

Payments are made on a weekly basis.

POS claims submitted by end of day Thursday are typically paid the following Tuesday. Paper claims are processed for adjudication within ten to thirty days.

37.10.2 POINT OF SALE CLAIMS

Pharmacy claims are processed through a DHH approved switch vendor through the Point of Sale System. The POS System is designed to work under the general framework of standards and protocols established by the National Council for Prescription Drug Programs (NCPDP). It uses methods of communication which are in place for other pharmacy Point of Sale processing.

Note: Refer to Appendix D of the Point of Sale User Guide for comprehensive information.

37.10.3 PAPER CLAIMS

A received paper claim is screened for missing information. If information is missing, the claim will not be entered into the system. It will be returned to the provider. The provider needs to correct the error, attach any missing documentation, and return the claim for processing.

Pharmacy providers should verify payment or denial of paper claims on their weekly remittance advice. Pharmacy providers should resubmit these paper claims if the services meet the criteria for payment.

37.10.4 DENIED CLAIM FACSIMILES

In some instances, denied claim facsimiles are generated for both Point of Sale and paper claims. Pharmacy providers should correct and submit these claim facsimiles to the fiscal intermediary for processing if necessary. Some corrected claims may be submitted Point of Sale if applicable.

37.10.5 REMITTANCE ADVICE

The Remittance Advice (RA) plays an important communication role between the provider, the Medicaid Program, and Molina. Aside from providing a record of transactions, the Remittance Advice assists providers in resolving and correcting possible errors and reconciling paid claims. The RA also serves as a bulletin board for messages from the Medicaid Program.

The RA is the control document which informs the provider of the current status of submitted claims. It is sent out each week when the provider has adjudicated claims.

On the line immediately below each claim, a code will be printed representing denial reasons and payment reduction reasons. Messages explaining all codes found on the RA will be found on a separate page following the status listing of all claims. The only type of claim status which will not have a code is one which is paid as billed.

If the provider uses a medical record number (which may consist of up to sixteen alpha and/or numeric characters), it will appear on the line immediately following the recipient's number.

Internal Control Number (ICN)

At the end of each claim line is the thirteen-digit internal control number (ICN) assigned to that claim line. Each separate claim line is assigned a unique ICN for tracking and audit purposes. Following is a breakdown of the thirteen digits of the ICN and what they represent:

Position 1	Last Digit of Current Year
Positions 2-4	Julian Date - ordinal day of 365-day year
Position 5	Media Code - 0 = paper claim with no attachments 1 = electronic batched claim 3 = system adjustment 4 = system void 5 = paper claim with attachments 6 = resubmission 7 = pharmacy POS electronic claim
Positions 6-8	Batch Number - for Molina internal purposes
Positions 9-11	Sequence Number - for Molina internal purposes
Positions 12-13	Number of Lines within Claim - 00 = first line 01 = second line 02 = third line, etc.

In situations where providers choose to contract with outside billing or collection agencies to bill claims and reconcile accounts, it is the provider's responsibility to provide the contracted agency with copies of the RA's or other billing related information in order to bill the claims and reconcile the accounts.

When providers or contractors are attempting to reconcile old accounts, if RA's are not available through the provider, it is necessary for the provider to order a claims history, which is available through Molina Provider Relations.

Electronic Remittance Advice (ERA)

The EMC Department now offers Electronic Remittance Advices (ERA) in the ANSI X12 835 format. The 835 would be in addition to the NCPDP response. This allows providers to have their Remittance Advices transmitted from the fiscal intermediary and posted to accounts electronically. There is a minimal fee for this service. Further information may be obtained by calling the Molina EMC Coordinator at 225-216-6335.

Remittance Advice Breakdown

Claims presented on the RA can appear under one of several headings: Approved Original Claims (paid claims); Denied Claims; Claims in Process; Adjustment Claims; Previously Paid Claims; and Voided Claims. When reviewing the RA, please look carefully at the heading under which the claims appear. This will assist with your reconciliation process.

Always remember that claims appear under the heading "Claims in Process" to let the provider know that the claim has been received by the fiscal intermediary, and should not be worked until they appear as either "Approved Original Claims" or "Denied Claims."

Remittance Summary

"Approved Original Claims" may appear with zero (0 dollar) payments. These claims are still considered paid claims. Claims pay a zero amount legitimately, based on other insurance payments, maximum allowable payments, etc.

When providers choose to return checks to adjust or void a claim rather than completing an adjustment/void form, the checks will initially appear as a financial transaction on the front of the RA to acknowledge receipt of that check. The provider's check number and amount will be indicated, as well as an internal control number (ICN) which is assigned to the check. If claims associated with the check are processed immediately, they will appear on the same RA as the check financial transaction, under the heading of "adjustment or void" as appropriate, as well as the corresponding "previously paid claim." The amount of the check posted to the RA should offset the amount recouped from the RA as a result of the adjustment/void, and other payments should not be affected. However, if the adjustments/voids cannot be processed on the same RA, the check will be posted and appear on the financial page of the RA under "Suspense Balance Brought Forward" where it will be carried forward on forthcoming RA's until all adjustments/voids are processed. As the adjustments/voids are processed, they will appear on the RA and the amount of money being recouped will be deducted from the "Suspense Balance Brought Forward" until all claims payments returned are processed.

It is the provider's responsibility to track these refund checks and corresponding claims until they are all processed.

When providers choose to submit adjustment/void forms for refunds, the following is an important point to understand. As the claims are adjusted/voided on the RA, the monies recouped will appear on the RA appropriately as "Adjustment Claims" or "Voided Claims." A corresponding "Previously Paid Claim" will also be indicated. The system calculates the difference between what has already been paid ("Previously Paid Claim") and the additional amount being paid or the amount being recouped through the adjustment/void. If additional money is being paid, it will be added to the provider's check and the payment should be posted to the appropriate recipient's account. If money is being recouped, it will be deducted from the provider's check amount. This process means that when recoupments appear on the RA, the paid claims must be posted as payments to the appropriate recipient accounts through the bookkeeping process and the recoupments must be deducted from the accounts of the recipients for which adjustment or voids appear. If the total voided exceeds the total original payment, a negative balance occurs, and money will be recouped out of future checks. This also includes state recoupments, SURS recoupments and cost settlements.

Below are the summary headings which may appear on the financial summary page and an explanation of each.

- **Suspense Balance Brought Forward** - A refund check or portion of a refund check carried forward from a previous RA because all associated claims have not been processed;
- **Approved Original Claim -** Total of all approved (paid) claims appearing on this RA;
- **Adjustment Claims -** Total of all claims being adjusted on this RA;
- **Previously Paid Claim -** Total of all previously paid claims which correspond to an adjustment or void appearing on this RA;
- **Void Claims -** Total of all claims being voided on this RA;
- **Net Current Claims Transactions -** Total number of all claims related transactions appearing on t his RA (approved, adjustments, previously paid, voided, denied, claims in process);
- **Net Current Financial Transactions -** Total number of all financial transactions appearing on the RA;
- **Prior Negative Balance -** If a negative balance has been created through adjustments or voids processed, the negative balance is carried forward to the next RA. (This also includes state recoupments, SURS recoupments and cost settlements.);
- **Recoupment Bypassed by DHH**;
- **Withheld for Future Recoveries -** Difference between provider checks posted on the RA and the deduction from those checks when associated claims are processed on the same RA as the posting of the check. (This is added to Suspense Balance Brought Forward on the next RA.);
- **Total Payments This RA -** Total of current check;
- **Total Copayment Deducted This RA -** Total pharmacy co-payments deducted for this RA;
- **Suspense Balance Carried Forward -** Total of Suspense Balance Brought Forward and withheld for future recoveries;
- **Y-T-D Amount Paid -** Total amount paid for the calendar year;
- **Denied Claims -** Total of all denied claims appearing on this RA; and
- **Claims in Process -** Total of all pending claims appearing on this RA.

Messages

Important messages appear on the RA pertinent to the pharmacy program. Updates to program policy as well as changes in participating manufacturers in the federal rebate program are included. Changes in the Federal Upper Limits (FULs) and Louisiana Maximum Allowable Costs (LMACs) are also listed.

37.10.6 HELP DESK

Point of Sale information is available to Pharmacy providers between 8am and 5pm Monday through Friday by contacting the Molina POS Helpdesk at 800-648-0790 or 225-216-6381.