TEXAS
Department of Aging
and Disability Services

COMMISSIONER
Adelaide Horn

May 1, 2007

To: DADS Long Term Services and Supports Providers

Subject: Texas Department of Aging and Disability Services (DADS)
Chief Financial Services
Information Letter No. 07-24
Minimizing Claim Rejections

With the automated edits of the Claims Management System (CMS), Long Term Care claims can be paid quickly and efficiently when properly billed the first time. The purpose of this information letter is to share information with DADS Long Term Services and Supports providers to assist in expediting the troubleshooting process when claims are denied.

During the past few months, DADS has been monitoring reasons why regional staff are contacted about claim denials. Attached to this information letter is a document titled "Common Reasons Claims Deny". The attachment provides common reasons why regions are contacted about claim denials and the Explanation of Benefit (EOB) codes related to these situations that providers receive from the Texas HealthCare Partnership (TMHP).

Researching/Accessing Reports

Research has confirmed that many billing requests can be resolved by first accessing a Medicaid Eligibility Service Authorization Verification (MESAV) and/or a Remittance and Status (R&S) report. Using information from these two sources can resolve most billing issues. When a claim denies, before contacting the Regional Claims Management (CMS) Coordinator, providers should follow the steps below.

1) Access a MESAV for the period the claim denied.

2) Access the R&S report with the claim denial.

3) Using the attached "Common Reasons Claims Deny" chart, review the information on the MESAV and/or R&S report.

This research will help clarify whether any records are missing, determine whether information on the claim is correct, identify any gaps in services, and confirm that providers have specifically identified what needs to be resolved. In some cases, even if this step does not resolve the issue, accessing a MESAV or R&S report will help expedite resolution of the issue. In some cases, after reviewing the MESAV and/or R&S report, the provider may simply need to re-bill for services.

Contacting the CMS Coordinator

There are times when a request to the region is necessary. Examples of when to contact the CMS Coordinator include:

- the MESAV inquiry indicates there are not enough authorized units in the client's service authorization
- the service authorization has not been processed in the Service Authorization System (SAS)
- there is a gap in dates of the service authorization
- services and/or units have not been updated on the client's service authorization

We hope this information is helpful in expediting claim payments. Please contact your regional contract manager if you have any questions about this document.

Sincerely,

[signature on file]

Gordon Taylor
Chief Financial Office

GT:mgm

Common Reasons Claims Deny

Note:
The following table identifies the most common reasons providers contact the regions about claim denials and the reasons claims are denied at TMHP.

- The first column lists the reasons providers most often contact the CMS Coordinators about claim denials.
- The second column identifies the related Explanation of Benefit (EOB) code with an explanation of why these claims denied at TMHP.
- The third column provides steps providers can use to respond to and/or resolve errors identified by each EOB listed.

Common Reasons Regions are Contacted About Claim Denials	Related EOBs Caused by Situations in Column 1	Recommended Solutions: Before contacting TMHP or the CMS Coordinator, providers should access a MESAV and/or an R&S to resolve these issues to verify the following…
Medicaid Related ▪ Client not Medicaid eligible ▪ Client lost Medicaid eligibility	EOB F0155 - Unable to determine appropriate fund code for service billed, verify Medicaid eligibility Explanation: Claims deny with EOB F0155 because the client has lost eligibility, the wrong HCPCS code was entered on the claim, or an incorrect fund code was entered on the client's service authorization.	▪ The client is eligible for services during the period billed ▪ Eligibility, coverage code, category code, and program type code. Note: If eligibility has not been established for the dates entered in the MESAV inquiry, the Med Elig/Med Nec tab will be gray/disabled. Contact the CMS Coordinator to establish eligibility for the client.
Client Related ▪ Provider entered wrong client name/client number ▪ Provider misspelled client name ▪ Provider entered wrong contract/provider number ▪ Provider not authorized for client and/or period billed ▪ Provider billed for incorrect dates of service, i.e., before/past end date (client deceased/client in nursing facility/services terminated) ▪ Provider billed for more hours than authorized	EOB F0138 - A valid service authorization for this client for this service on these dates is not available. Explanation: Claims deny with EOB F0138 because the information provided on the claim does not match the information on the client's service authorization. Some examples of this occur when the client's case/Medicaid number does not match the number on the service authorization; the provider number is incorrect; the client was not eligible for services on the dates of service that were billed; or the service authorization does not cover all the dates of service that were billed.	▪ The client name matches the client number ▪ The client's name is spelled correctly ▪ The client's case/Medicaid number is correct ▪ The provider's contract/ provider matches the number on the MESAV and/or the contract/provider number includes all 9 digits The client is eligible for services during the entire period billed. If even one day of service that is not covered by a service authorization is billed, the entire claim will deny.

Common Reasons Regions are Contacted About Claim Denials	Related EOBs Caused by Situations in Column 1	Recommended Solutions: Before contacting TMHP or the CMS Coordinator, providers should access a MESAV and/or an R&S to resolve these issues to verify the following…
Client Related ▪ Missing or invalid codes (bill codes/HCPCS/modifiers) ▪ Level of service is not appropriate for the code being billed	EOB F0077 - Billing code not submitted or cannot be determined. Explanation: Claims deny with EOB F0077 because The Healthcare Common Procedure Coding System (HCPCS) code entered on the claim does not match the service code on the client's service authorization.	▪ The provider/contract number is correct and/or includes all nine digits ▪ The client's name is spelled correctly ▪ The client's case/Medicaid number is correct ▪ The client is eligible for services during the entire period billed. If even one day of service that is not covered by a service authorization is billed, the entire claim will deny. ▪ The client's level of service is appropriate for the code being billed The procedure codes billed are correct for the billing period. Note: Refer to the most current LTC Bill Code Crosswalk for a listing of procedure codes.
Claims Past 12 months	EOB F0250 - Late billing claims must be filed 12 months from the end of the month of service or 12 months from the end of the eligibility add date. Explanation: Claims deny with EOB F0250 when the claims is more than 12 months from the end of the service month.	Contact the CMS Coordinator assigned to the provider's region.