TEXAS
Department of Aging
and Disability Services

COMMISSIONER
Chris Traylor

March 22, 2012

To: Adult Foster Care (AFC) Providers
Assisted Living Facilities (ALFs)
Community Attendant Services (CAS) Providers
Community Based Alternatives (CBA) Providers
Community Living Assistance and Support Services (CLASS) Providers
Consumer Directed Services (CDS) Providers
Consumer Managed Personal Attendant Services (CMPAS) Providers
Day Activity Home Services (DAHS) Providers
Deaf Blind with Multiple Disabilities (DBMD) Providers
Emergency Response Services (ERS) Providers
Family Care (FC) Providers
Home Delivered Meals (HDM) Providers
Hospice Providers
Intermediate Care Facilities for Persons with Intellectual Disabilities (ICF/ID)
Medically Dependent Children Program (MDCP) Providers
Nursing Facilities
Primary Home Care (PHC) Providers
Programs of All-Inclusive Care for the Elderly (PACE) Providers
Special Services to Persons with Disabilities (SSPD) Providers
Transition Assistance Services (TAS) Providers

Subject: Information Letter No. 12-08
Managing the Most Frequent Rejected and Denied Provider Claims

During the past calendar year (January-December 2011), the LTC Claims Management System (CMS) processed over 15 million claims. This included 423,185 rejected claims; another 456,967 claims were denied.

This letter provides guidelines to manage the most common errors that delay Long Term Care (LTC) provider claim processing and payment. Providers are encouraged to review and share this information with appropriate billing staff to reduce errors and maximize efficiency.

Providers can use the guidelines below to facilitate payment processing by reducing rejected and denied claims.

Rejected Claims
A rejected claim fails initial system edits, and is returned to the provider for correction without being submitted for processing. The claim is not entered in CMS and no Internal Control Number (ICN) is assigned. The majority of 2011 claim rejections were due to the following reasons, listed below by Explanation of Benefit (EOB) code:

1. **EOB F0077** *Billing code not submitted or cannot be determined*. Claims reject with EOB F0077 because the Healthcare Common Procedure Coding System (HCPCS) code entered on the claim does not match what is on the consumer's service authorization.

   To resolve this issue:
   - Check Medicaid Eligibility and Service Authorization Verification (MESAV) to ensure that there is an established Resource Utilization Group (RUG) level, if needed, and a valid service authorization for the entire timeframe billed.
   - Check MESAV to ensure that the correct LTC service group, service code, and procedure code are used. Refer to the most recent Long Term Care (LTC) Bill Code Crosswalk located at www.dads.state.tx.us/providers/hipaa/billcodes/.

2. **EOB F0155** *Unable to determine appropriate fund code for service billed, verify Medicaid eligibility*. This error occurs when a consumer loses eligibility, has no eligibility, or has the wrong Medicaid coverage.

   To resolve this issue:
   - If the consumer has no eligibility for the service billed, contact the Medicaid Eligibility Worker.
   - If the consumer has eligibility for the service billed, all information on the claim is correct and the error persists, contact the Texas Medicaid & Healthcare Partnership (TMHP) at 1-800-626-4117, Option 1 for assistance.

3. **EOB F0147** *Level of Service (LOS) type and level does not match service group and billing code requirements*. Claims reject with EOB F0147 because the claim has an incorrect billing code for the consumer's RUG level, or the consumer is missing a valid LOS record. LOS is the level of effort necessary to provide service to a consumer.

   To resolve this issue:
   - Verify on the MESAV that the consumer has a valid, active LOS for the dates of the claim:
     - Nursing facility and Hospice providers – (Note: This form is submitted by the nursing facility, not the Hospice provider.) If no LOS exists, submit a Minimum Data Set (MDS) assessment to the federal CMS database and initiate a valid, active LOS and resubmit the claim once this is complete.
     - Community Services Waivers Programs providers – contact your Department of Aging and Disability Services (DADS) caseworker.
   - Check if the LOS dates are split. If the dates are split, bill the dates on a separate line and resubmit the claim.
   - If all information on the claim is correct, the consumer has a valid, active LOS for the dates of the claim and the error persists, contact TMHP at 1-800-626-4117, Option 1 for assistance.

Denied Claims

A denied claim passes initial system edits, is processed and assigned an ICN, but payment is denied. Denied claims appear on the Remittance & Status (R&S) Report in the Non-Pending section. The majority of 2011 claims were denied due to the following reasons:

1. **EOB F0165** *This service has already been paid. Please do not file for duplicate services.* Claims deny with EOB F0165 because a claim has already been paid for the same dates of service.

While no action is needed to resolve a duplicated claim, providers can confirm previous payments by reviewing the MESAV record and the consumer Remittance and Status (R&S) Report for the consumer.

2. **EOB F0138** *A valid service authorization for this consumer for this service on these dates is not available.* Claims deny with the EOB F0138 because the consumer does not have a valid, active service authorization for the service dates of the claim and for the service group or service code.

   To resolve this issue:
   - Verify all of the claim information especially the dates of service and the service code(s). If information submitted on the claim is incorrect, correct the erroneous entries and resubmit the claim.
   - If all information submitted on the claim is correct, verify that the consumer has a valid, active service authorization on the MESAV:
     - If all information on the claim is correct and the consumer has a valid, active service authorization for the service dates of the claim and for the service group and service code billed, contact TMHP at 1-800-626-4117, Option 1 for assistance.

   If provider is a nursing facility:
     - If there is not a valid, active service authorization, review Form Status Inquiry on the LTC Online Portal to determine if a Form 3618/3619 has been submitted; if so, allow up to three business days for the form to process and service authorization to appear on the MESAV. If there is not a current Form 3618/3619 on file, submit the appropriate admission form and resubmit the claim when a valid, active service authorization is on the MESAV.
     - Is the appropriate Form 3618/3619 in Processed/Complete status but not on the MESAV? Contact DADS Provider Claims Services (PCS) Hotline at (512) 438-2200, Option 1.

3. **EOB F0269** *Claim Detail is an Exact Duplicate of History Claim Detail*. Claims deny with EOB F0269 because the claim is exactly the same as a previously paid claim.

While no action is needed to resolve a duplicated claim, providers can confirm previous payments by reviewing the MESAV record and the consumer Remittance and Status (R&S) Report for the consumer.

For additional assistance regarding claim rejections or denials, as well as other billing questions except for other more specific contact information provided above, please contact Texas Medicaid & Healthcare Partnership (TMHP) at 1-800-626-4117, Option 1.

Sincerely,

[*Signature on file*]

Gordon Taylor
DADS Chief Financial Officer

GT:nmp