Life of a Claim

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MEDICA®

Life of a Claim Agenda

- Claim Submission Requirements
- Data Entry Requirements
- EDI Claim Submission
- Rejected Claims
- Corrected/Replacement Claims
- Claim Edits
- Timely Filing/Claim Submission
- Coordination of Benefits
- Policies that Affect Claim Processing
- Claim Output
- Claim Adjustments

Claim Submission

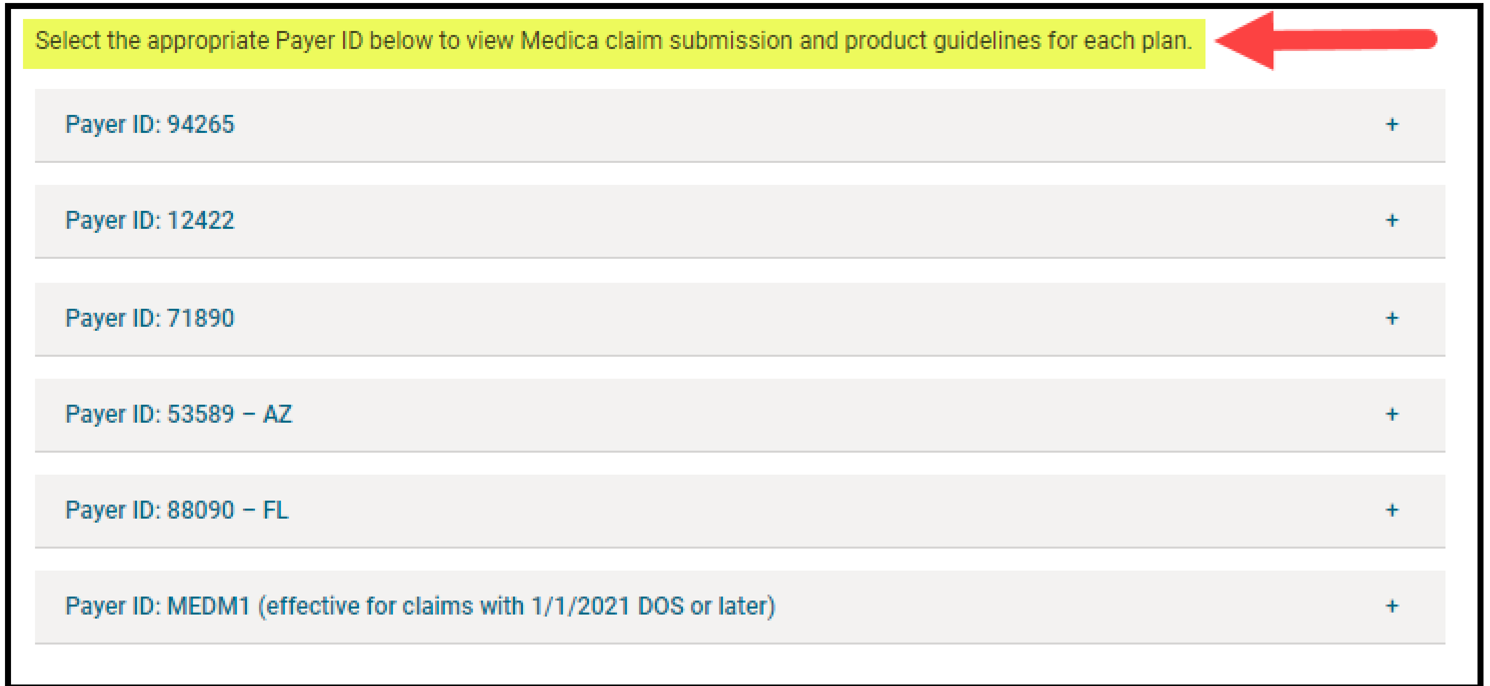
Claim Submission

Electronic Submission

- MN providers are required to submit all claims electronically in accordance with Administrative Uniformity Committee (AUC) guidelines
- Electronic claims are accepted through clearinghouse vendors
- Refer to the MN Administrative Uniformity Committee website for guidelines and billing resources
- All claims are submitted through either Optum Financial Services or Availity (depending on line of business) before they reach Medica

Billing Information

[medica.com->For Providers ->Administrative Resources-> Claim Tools->Claim Submission and Product Guidelines]

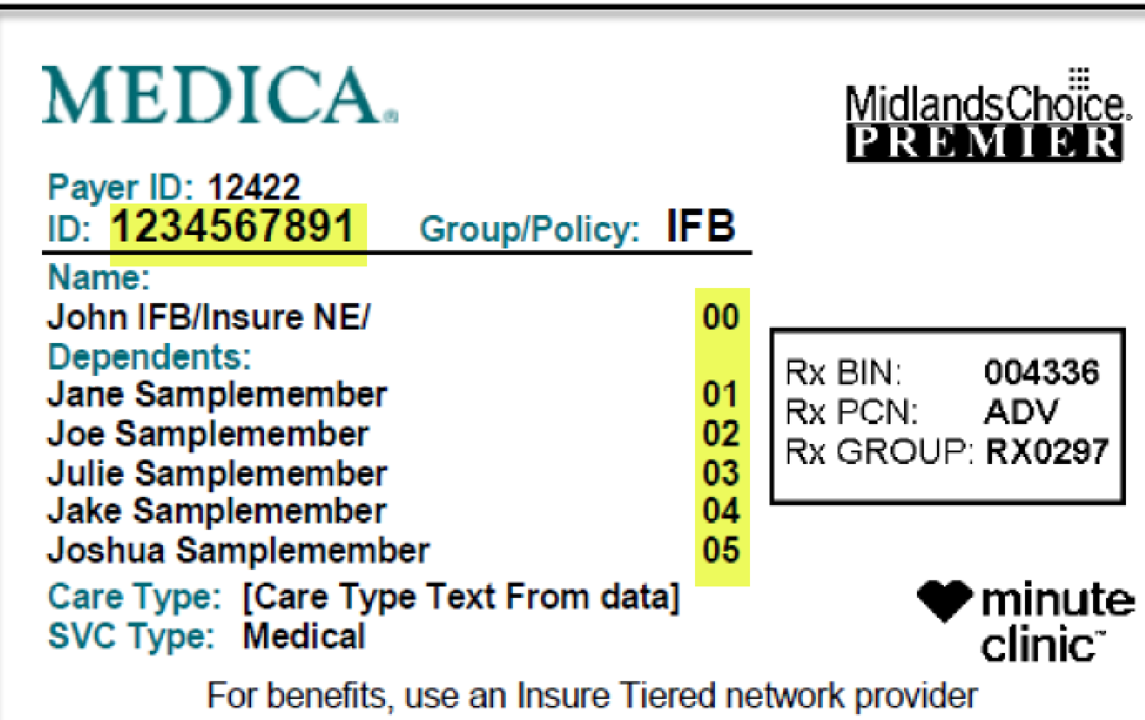


Claim Submission

The Claim Submission and Product Guidelines page will outline the following for each Payer ID:

- Address for Claims and Claim Appeals
- Attachment/Appeal Fax #
- Claim Numbers
- Electronic Commerce information
- Electronic Funds Transfer (EFT) payments
- Prior Authorization Submission
- Inpatient Notification Submission
- Referral Submission
- Clinical Guidelines
- Provider Service Center Contact Information
- Pharmacy
- Chiropractic Care
- Behavioral Health
- Links to Product Fact Sheets

Member ID Card



Members - medica.com/IndividualLogin Benefits Effective: 01/01/19

Claims:	Medica P.O. Box 981647 El Paso, TX 79998-1647
Medica Customer Service:	800-918-6164
TTY:	711
Pharmacists:	800-364-6331
Providers:	800-458-5512 or medica.com
Health Advocate NurseLine:	866-668-6548

Data Entry Requirements

Data Entry Requirements

Claims Data- Professional and Facility

- **Missing or invalid information** – Medica enters fields as they are submitted. If data elements are missing or invalid, the provider will receive a “send-back letter.”

- **COB/recovery** – When claim has missing or invalid data elements, claims should not be sent back to the provider if the other insurance has paid on the claim.

- **Member numbers (newborn claims) –** If a claim is submitted for a newborn — not yet enrolled — a letter will be sent to both the member and provider. The claim will not be returned.

Data Entry Requirements

Claims Data- Professional and Facility

- **Referring physician** – A referring physician NPI is required in accordance with CMS guidelines
- **Negative charges** – If a claim is submitted with a negative charge, it will be returned to the provider
- **Modifiers** – Use as appropriate
- **Assignment of Benefits** – Claims submitted by network providers will be paid to the provider
- **Missing codes –** A Dept. of Labor send-back letter will be sent to the provider (DOL letters are not applicable to IFB)

EDI Claim Submission

EDI Claim Submission

Acknowledgements and Rejected Claims

- Electronic claim submitters receive acknowledgements and notifications:
  - Providers must correct and resubmit claims that are rejected by the EDI submission process
  - IMPORTANT - Review all acknowledgements
  - Acknowledgements are returned to the submitter using the same channels as electronic claims (within 24 hours to 3 business days)
  - Your Practice Management vendor or clearinghouse can help you understand the acknowledgements

EDI Claim Support Questions

- Medica Support:
  - Call: Medica Provider Service Center (PSC) at 1-800-458-5512
  - Email: medica.electroniccommerce@medica.com

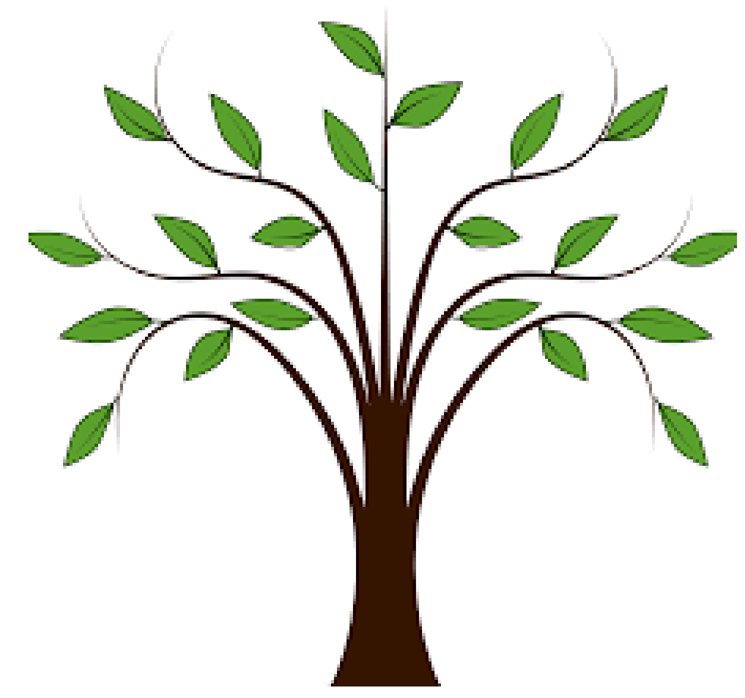
- Additional Support:
  - Call: United Healthcare EDI support: 1-800-842-1109 (Payer ID: 94265)
  - Email: supportedi@uhc.com (Payer ID: 94265)
  - Call: Availity Client Services: 1-800-282-4548 (Payer ID: 12422, MEDM1, 71890)
  - Availity EDI Portal (Payer ID: 12422, MEDM1, 71890)

EDI Claim Submission

Resources on medica.com

- Everything you need to know about successful electronic billing: medica.com-> For Providers-> Administrative Resources-> Claim Tools-> Electronic Commerce

Saves Paper
Simple Process
Seamless Payments



Rejected Claims

Rejected Claims

Common reasons for claim rejections:

- Member ID not on carrier files
- No coverage for the type of charges submitted
- Insured name/address does not match carrier files for SSN/Insured ID
- Coverage has been cancelled for the insured
- Handwritten claims- the data on the claim must be typewritten or computer printed on an official CMS-1500 or UB-04 form

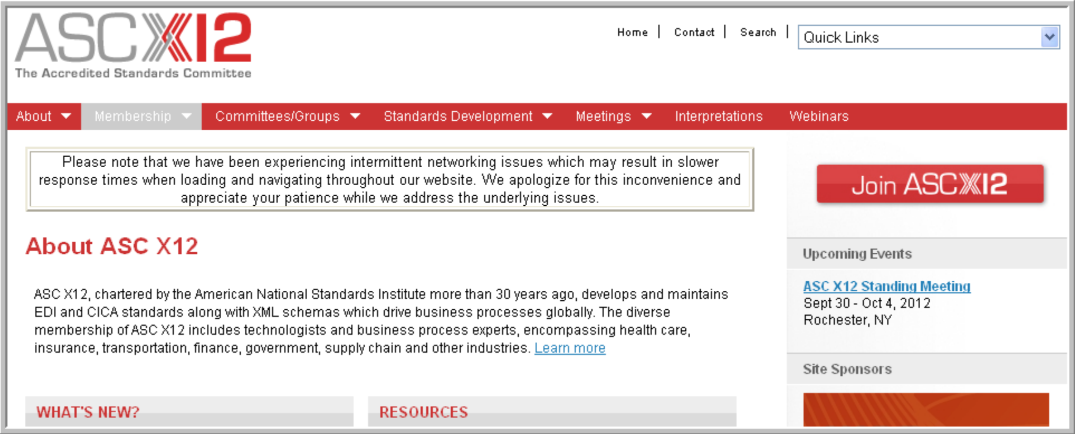
Rejected Claims

Rejections and Medica

- Medica does *not* input or track claims that have been returned to a provider due to improper claim information
- Medica maintains no information about rejected claims in its system
- Rejected claims will need to be corrected and resubmitted in most cases

Missing required information

- See the following Minnesota Uniform Companion Guides:
  - ASC X12 Version 5010 and NCPDP Version D.0



- For paper claim submission, use the appropriate guide (CMS-1500 or UB-04) to determine which fields require data. All required fields must be populated with valid information

Corrected or Replacement Claims

Corrected or Replacement Claims

Tips for sending in a Corrected/Replacement claim:

- When submitting a corrected or replacement claim, providers should follow Administrative Uniformity Committee (AUC) guidelines
- When submitting a corrected claim electronically, a claim frequency value of 7 represents a replacement claim
- A replacement claim should not be submitted until the prior submitted claim has reached final adjudication status
- When sending a replacement claim, the entire claim must be replaced

Corrected or Replacement Claims

Possible reasons for a Corrected Claim:

- Procedure code missing
- Modifier line being added
- Diagnosis code change or addition
- Procedure code change
- Revenue code change
- Change to injury date
- Change to related cause codes
- Change to place of service

Claim Edits

Claim Edits

Three types of basic claim edits:

- **Hard coded logic** – also referred to as “auto deny edits”
- **Auto-adjudication** – claims that a processor does not need to touch
- **Manual claims edits** – Manual claims edits are driven by policies/procedures and require processor intervention

Claim Edits

Auto-Adjudication

- Auto-Adjudication is the term used to indicate that a claim was paid or pended without the need for manual review by a processor
- Examples of Reimbursement Policies with specific auto-adjudication criteria:
  - Anesthesia
  - Assistant Surgeon Services
  - Bilateral Procedures
  - Global Days
  - Laboratory Services
  - Professional and Technical Components
  - Rebundling

Manual Claim Edits

- Set up in a logical sequence for processors to clear in the “pended” order

- Many different combinations can be placed within one manual claims edit including:
  - CPT Codes
  - Revenue Codes
  - Age ranges
  - Gender
  - Benefit level
  - Product category

Sequence of Claim Edits

- Data Validation
  - CPT/ICD-10 mismatch
  - CPT/POS (Place of Service) mismatch
  - CPT/provider specialty mismatch

- Benefit Review
  - Referral Processes: Administrative Resources-> Claim Tools
  - Prior Authorizations: https://www.medica.com/providers/policies-and-guidelines/um-policies-and-prior-authorization
  - Customized Self-Insured Employer Group Contracts

Advanced Claim Edits (ACE)

- These edits supply providers with information regarding claims that are certain to deny based on submitted codes
- Deny at the clearinghouse level on a 277CA report, before they are accepted by Medica
- A complete list of active edits can be located at: medica.com-> Administrative Resources-> Claim Tools-> Advance Claim Edits (ACE)

Claim Edits

Medica employs ACE edits in an effort to:

- Improve efficiency in claims processing
- Reduce claim denials
- Avoid delays in claim review
- Reduce rework
- Reduce provider denials
- Reduce provider expense to manage denials

What action do I take with an ACE edit?

- Correct the claim and resubmit
- Withdraw/cancel the claim
- Resubmit the claim with no changes

Pre-Pay Edits: Overview

- Pre-pay edits are performed in an effort to identify overpayments based on coding rules and conventions defined by CMS and the American Medical Associations CPT manual along with guidelines developed by national societies, analysis of standard medical and surgical practices and a review of current coding practices

- These types of edits are required by the Centers for Medicare and Medicaid Services (CMS) as well as the Minnesota Department of Human Services (DHS)

Pre-Pay Edits: Basics

- After the claim goes through the standard Medica claim edits, it then goes through the pre-pay edits
- The claim lines are reviewed for appropriate billing. A determination of payment is made and adjudication is completed
- If the claim or a claim line is denied, the provider will see the denial reason on the Explanation of Benefits they receive from Medica

Pre-Pay Edits: Disputes

- If the provider does not agree with the denial, they would submit a Claim Adjustment or Appeal Request Form along with supporting medical documentation for the denied charges

- If the appeal denies and the provider has *new* information they would like to have reviewed, they may submit a second appeal using the claim appeal form listed above, attaching the additional documentation

Pre-Pay Edits: Additional Information

- As patterns with denials are identified, there is a process in place to ensure that the proper provider education occurs
- Correct coding procedures will be validated and providers may be removed from the edits as appropriate
- Additional waste and error controls (pre-pay edits) will continue to be developed and deployed as needed

Post-Pay Edits: Overview

- Post-pay edits review already paid claims for overpayments based on the same rules and conventions as our pre-pay edits
- Erroneous billing detection procedures are required by CMS as well as the Minnesota Department of Human Services (DHS) for contracted Health Plans

Post-Pay Edits: Additional Information

- Already paid claims go through post-paid edits. If the claim is flagged it is then reviewed by someone with coding certification. A determination is made as to whether an adjustment should be made to the claim

- As patterns with denials are identified, there is a process in place to ensure that the proper education occurs

- Correct coding procedures will be validated and providers may be removed from the edits as appropriate

Timely Filing- Claim Submission

Timely Filing- Claim Submission

Overview

- Definition: Timely filing is a term used to reference the amount of time providers or members have to submit claims or adjustment requests to Medica for consideration

- All original claims submission from in network (INN) providers must be received at the designated claims address no more than 180 days after the date of service or date of discharge for inpatient claims for all Medica products (except Medica Select Solution® & Medica Prime Solution®)

Timely Filing- Claim Submission

Additional Guidelines:

- For Medica Select Solution and Medica Prime Solution when Medicare is the payer, the timely filing limit is 180 days after the payment date on the explanation of Medicare benefits (EOMB) statement
- When Medica is the payer, the timely filing limit is 180 days after the date of service or date of discharge for inpatient claims for INN providers
- The Timely Filing and Late Claims Policy is located on medica.com under Providers → Administrative Resources→ Claim Tools

Coordination of Benefits (COB)

Coordination of Benefits (COB)

COB Guidelines

- Coordination of Benefits (COB) applies for all commercial and Medicaid products, but does not apply to Medica Prime Solution and Medica Select Solution products

- When Medica is the secondary plan, Medica will reimburse for the balance of expenses up to the primary plan's fee maximum or the primary plan's contracted rate for the service. The same policy applies when Medica is the tertiary plan. This does not apply to government products

Coordination of Benefits (COB)

COB Guidelines, Continued

- If the primary plan excludes the service or line item as member liability, then Medica pays that claim or line item per the member's contract. (As if Medica was the primary payer in the absence of the other coverage)

- Must include primary payer information in the following acceptable formats:
  - EOB
  - Electronic 837 payment information

COB with Medicare

- Applies to Medica Prime Solution and Medica Select Solution
- If Medicare is the primary carrier, Medica will coordinate up to 100% of the Medicare allowable and pay the member's Medicare deductible and coinsurance
- Acceptable formats for payer information:
  - Explanation of Medicare Benefits (EOMB)
  - Medicare Summary Notice
  - Crossover Claim
  - Electronic 837 payment information

Policies that Affect Claim Processing

Policies That Affect Claim Processing

UM Policies and Prior Authorization

- medica.com-> For Providers-> Policies and Guidelines-> UM Policies and Prior Authorization
- Utilization Management policies contain clinical criteria used by Medica staff for prior authorization, appropriateness of care determination and coverage
- Includes a list of codes that require Prior Authorization:

Service Category	Policy Name	Current Procedural Terminology (CPT) Codes	Commercial products	Individual & Family Business (IFB) products	Medica Advantage Solution® PPO *as of 1/1/19*	Medica DUAL Solution® (MSHO); plus Medica AccessAbility Solution Enhanced (SNBC SNP) *as of 1/1/19*	Medica Choice Care (MSC+), Medica AccessAbility Solution* (SNBC)	Mayo Medical Plan (MMP) *as of 1/1/19*	Medica Health Plan Solutions (MHPS) *as of 1/1/19*
Air Ambulance Non-Emergent	Air Ambulance Non-Emergent	A0140, A0430, A0431, A0435, A0436, S9960, S9961	Yes	Yes	Yes	No	Yes	No	Yes
Bariatric Surgery	Bariatric Surgery	43644, 43645, 43770, 43771, 43772, 43773, 43774, 43775, 43842, 43843, 43845, 43846,	Yes	Yes	Yes	No	Yes	Yes	Yes

Policies That Affect Claim Processing

Coverage Policies

- Coverage Policies are documents that were developed to communicate decisions about coverage and benefits for various medical services

- Both the Coverage Policy and Utilization Management Policy sections should be checked to determine coverage for a particular service

Reimbursement Policies

- Medica Reimbursement Policies provide payment methodology guidelines for medical, surgical and associated services submitted

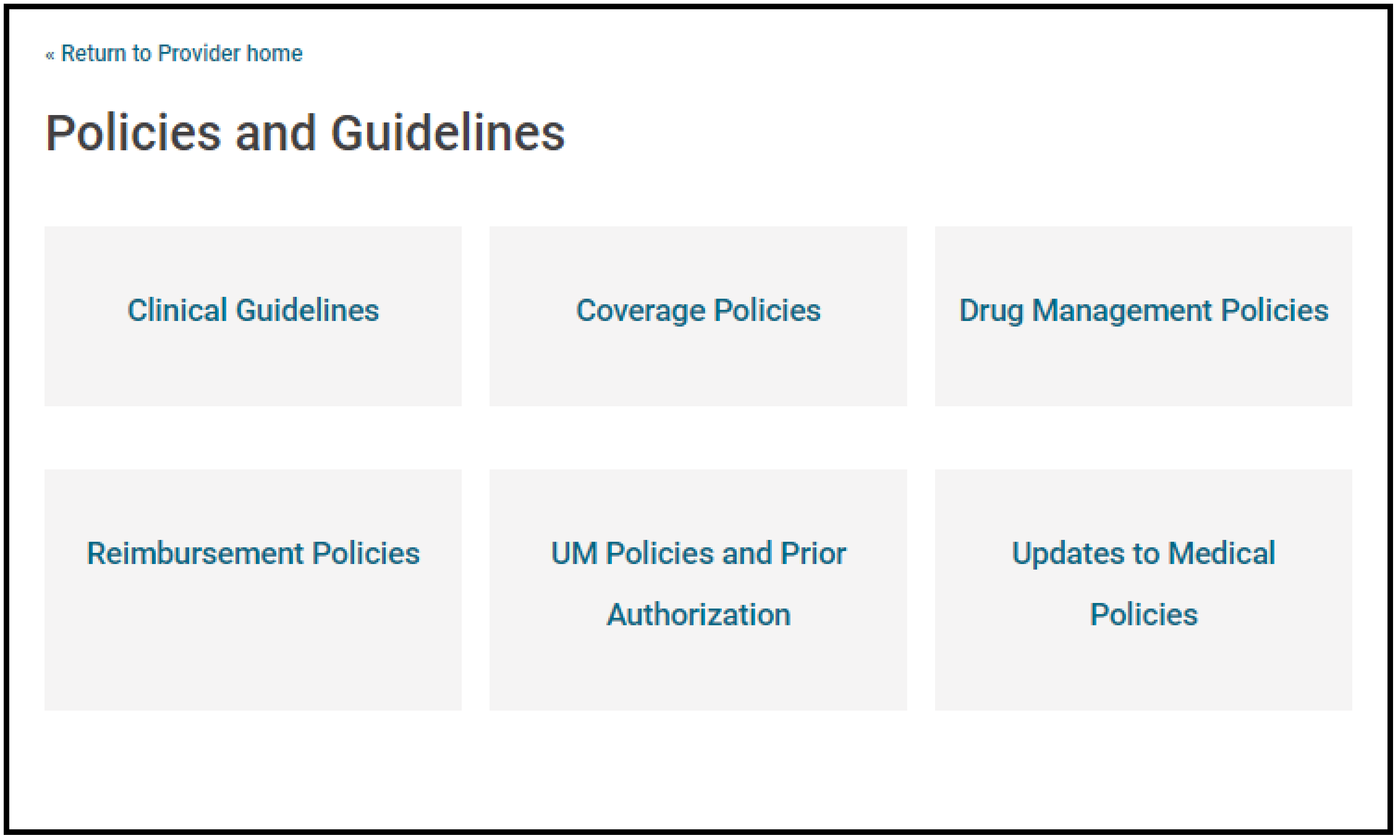
Reimbursement Policies

Medica reimbursement policies provide payment methodology guidelines for medical and surgical services submitted on professional claims (CMS-1500 or its electronic equivalent) and, when specified, for those submitted on facility claims (UB-04 or its electronic equivalent). These reimbursement policies are provided in conjunction with other Medica policies, including, but not limited to any applicable participating provider contract, provider administrative manual and credentialing plan. Inclusion of a code in a policy does not guarantee payment of the service. Additionally, these policies may not process identically on the different processing systems utilized by Medica. However, Medica makes every effort to minimize these variations.

Policies

- 3-Day Payment Window (Refer to National Government Services (NGS) website.)
- Add-On Code
- Adverse Health Care Events (Applicable to Facility/UB-04 Claims Only)
- After Hours and Weekend Care
- Anesthesia
- Assistant Surgeon
- Bilateral Procedures

Locating Policies and Guidelines: For Providers-> Policies and Guidelines



Claim Output

Claim Output

Provider Remittance Advice/ERA

- A PRA or ERA is also known as an explanation of benefits (EOB) when sent to members
- Issued for each unique provider number for which a claim was reimbursed
- The PRA/ERA is a member-by-member account of:
  - The amount billed
  - The amount disallowed (if any)
  - Copayments
  - Coinsurance or deductible amounts and reserves
  - Amount reimbursed
  - Reason codes

Claim Output

Provider Remittance Advice (PRA)

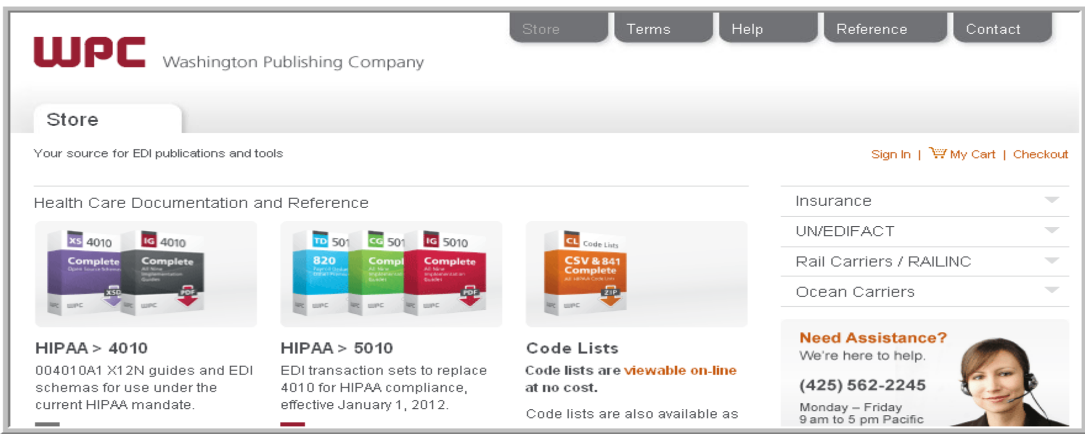
- There are sample PRA documents on Medica.com->For Providers-> Administrative Resources-> Claim Tools-> Payment Resources, accompanied by an explanation of each information field

Payment Resources (for EOB/PRA/835)

- Cosmos Platform PRA (PDF)
- Provider Remittance Advice (PRA) Guide for Medica2 Platform (PDF)
- United Platform EOB (PDF)

EPRA- Disallow/Denial Codes

- **Denial reason code:** 3-digit reason code explaining why the entire claim was denied
- **Disallow reason code:** 3-digit reason code that describes why all or a portion of the billed amount is not being reimbursed
- Implementation guides for each ANSI X12N transaction adopted as a HIPAA standard can be found at www.wpc-edi.com



Claim Adjustments

Adjustments

Overview

- Can be initiated internally within Medica or done at a provider's request
- Viewable on the PRA/ERA
- When a payment has already been made on a claim, but a change to it is necessary, the Claim Adjustment or Appeal Request Form should be completed:

CLAIM ADJUSTMENT OR APPEAL REQUEST FORM

NOTE: Appeals related to a claim denial for lack of prior authorization must be received within 60 days of the denial date. *All other adjustments and appeals must be received within 12 months of the original denial date.*

FOR MEMBERS WITH GROUP/POLICY:

with only numbers (payer ID 94265) send to:	beginning with B or IFB (payer ID 12422) send to:	beginning with A (payer ID 71890, 53589 or 88090) send to:
Medica PO Box 30990 Salt Lake City, UT 84130	Medica PO Box 21051 Eagan, MN 55121-0051	Medica PO Box 211435 Eagan, MN 55121-0051
Or fax this form to: 1-801-994-1076	Or fax this form to: 952-992-1427 Or submit this form electronically	Or fax this form to: 952-992-3024 Or submit this form electronically

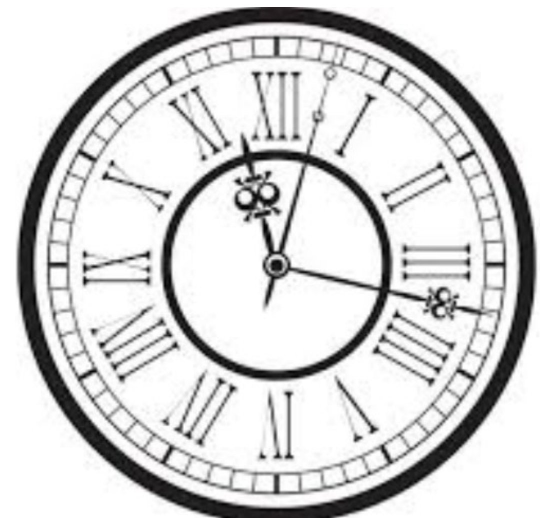
Adjustments

Timeframes

- There is a 12-month limit for adjustments:
  - If a claim is denied or rejected, the clean claim must be resubmitted & received within 12 months of the date of the denial or rejection
  - If the claim was paid and an adjustment to the payment is being requested, the request must be rec'd within 12 months of the check date on the PRA/ERA
  - If a request for more information is received, the corrected claim or additional information must be resubmitted and received within 60 days of the date on the letter from Medica

Additional Timeframes

- Adjustments due to: (1) Coordination of Benefits recovery; (2) payments subject to subrogation recovery; (3) duplicate claims payments; and (4) retroactive terminations due to a retroactive determination of a member's eligibility for a government program or subsidy, are not considered corrective adjustments and may be made at any time by Medica.



Adjustments

Adjustment Reason Code

- A 3-digit reason code describes why the claims needed to be corrected or adjusted
- Adjustment codes are found on the PRA/ERA and are used for error trending, and affords an opportunity for provider education/feedback

Adjustments

Recovery

- Medica will attempt to recover overpayments with our participating providers by withholding payments on a future PRA/ERA
- When overpayments are identified for providers where withholding was not possible, a letter is sent to the provider requesting a payment for the amount of the overpayment
- OptumInsight™ is the Medica credit balance vendor
- The vendor performs audits on site with approval from the provider

Need Further Assistance? Contact the Medica Provider Service Center

- Providers can reach the Provider Service Call Center by calling 1-800-458-5512

- Call Center hours (CST):
  - Monday- Friday 7:00am-5:00pm

    *Closed Mondays from 8:00am-9:00am

- PSC is the first point of contact for providers with website, eligibility, benefit, claim payment and claim process questions

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