COMMISSIONER
Chris Traylor

July 19, 2010

To: Nursing Facility (NF) Providers
Hospice Providers

Subject: Information Letter No.10-83
Managing the Most Common Rejected and Denied NF and Hospice Provider Claims

This letter provides guidelines and instructions to manage the most common errors that result in NF and Hospice claim rejections and denials. Providers are encouraged to review and share this information with their billing staff to reduce errors and maximize efficiency.

During the first three quarters of the state Fiscal Year (FY) 2010 (September 2009 through May 2010), the Claims Management System (CMS) processed 4,393,710 NF claims; this included 146,331 NF claims that were rejected and another 159,565 NF claims that were denied. During the same timeframe, CMS processed 299,735 Hospice claims; this included 9,438 Hospice claims that were rejected and another 8,196 Hospice claims that were denied.

**Rejected Claims**

A rejected claim fails initial system edits, and is returned to the provider for correction without being submitted for processing. The majority of NF and Hospice claims are rejected due to the following reasons:

1. Explanation of benefit (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 client's service authorization.

   To resolve this issue:
   - Verify that the National Provider Identifier (NPI), Provider Number, Medicaid Number, Clients Name and the Referral Number are correct.
   - Is there an established Resource Utilization Group (RUG) and service authorization for the entire timeframe billed?
   - Are the correct codes used? Use the most recent Long Term Care (LTC) Bill Code Crosswalk located at http://www.dads.state.tx.us/providers/hipaa/billcodes/.
   - For Hospice providers, do the contract numbers on the Medicaid Eligibility Service Authorization Verification (MESAV) match the contract number on the claim? The contract numbers that are on the MESAV must match the contract number on the claim.

2. EOB F0155 "Unable to determine appropriate fund code for service billed, verify Medicaid eligibility." This error occurs when a client loses eligibility or the wrong Medicaid coverage codes are on the MESAV.

   To resolve this issue:
   - Verify the client's Medicaid eligibility, coverage code, category code, and program type for the dates billed.
   - If the client has no eligibility for the service billed, contact the caseworker to establish eligibility for the client.
   - If the client has eligibility for the service billed, all information on the claim is correct and the error persists, contact TMHP at 1-800-626-4117, option 1 for assistance.

3. EOB F0147 "Client's Level of Service (LOS) type and level do not match service group and billing code requirements." Claims reject with EOB F0147 because the claim has an incorrect billing code for the client's level, or the client is missing a valid LOS record, or the provider on the LOS record is not the same as on the submitted claim. LOS is the level of effort necessary to provide service to a client, and is a factor in determining the payment rate for services to the client.

   To resolve this issue:
   - Verify on the MESAV that the client has a valid, active LOS for the dates of the claim. If no LOS exists, initiate a valid, active LOS and resubmit the claim once this is complete.
   - Check if the LOS dates are split up. 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 client 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 and processes but payment is denied. Denied claims appear on the Remittance & Status (R&S) Report in the Non-Pending section. The majority of NF and Hospice claims are 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.

   To resolve this issue:
   - Verify a paid claim exists in the R&S Report history for the same client, provider, billing code, and dates of service as the submitted claim.
   - Resubmit the claim with the correct, non-duplicate information.

2. EOB F0138 "A valid service authorization for this client for this service on these dates is not available." Claims deny with the EOB F0138 because the client 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 client has a valid, active service authorization on the MESAV:
    - If the client does not have a valid, active service authorization, has a Form 3618/3619 been submitted? If not, 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.
    - If all information on the claim is correct and the client has a valid, active service authorization for the service dates of the claim and for the service group and service code billed, and an error message is still received, contact TMHP at 1-800-626-4117, option 1 for assistance.

For assistance regarding claim rejections or denials, as well as other billing questions, please contact Texas Medicaid & Healthcare Partnership (TMHP) at 1-800-626-4117, option 1.

Sincerely,

*[signature on file]*

Gordon Taylor
DADS Chief Financial Officer

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