DMAP Worker Guide XIII

Processing Claims

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Processing claims

Overview

DMAP's claims processing system is highly automated. It handles approximately 1 million claims per month. This total number of claims includes capitation payments, point-of-sale, EDI, paper claims and nursing home claims (turn-around document or TAD). If all information is correct, providers who input claims electronically by 2:00 p.m. on Friday could receive a check for payment the following week.

Branch staff members are vital to the smooth working of this system.

DMAP depends on field workers to enter timely and accurate eligibility information on clients. Two of the most common errors are that a client changes their name and it is not updated right away or a newborn is not added for medical coverage as soon as possible. If there is an error on a claim, such as a misplaced code or blank field, the claim could suspend or deny. Then the claim will be reviewed by a staff person, causing a delay in payment of several weeks.

Questions about billings:

- Managed care plan clients should contact their plan if they have questions about billings.
- Fee-for-service (open card) clients or clients with a Primary Care Manager (PCM) should contact DMAP Client Services Unit (CSU) at 1-800-273-0557 if they have questions about billings. It is necessary for CSU to have a copy of the bill in order to answer questions and identify possible solutions. Workers may fax, or have the client fax, a copy of the bill to CSU Billing at 503-945-6898.

How a Medicaid claim is processed

When a provider submits a fee-for-service claim to DMAP, it is processed primarily by a computer—the Medicaid Management Information System (MMIS). Unlike most private insurance companies, the DMAP claims processing system is highly automated. Claims are entered into the system prior to verification or visual checks for clerical errors. Because of this automation and the high claim volume, a misplaced code or a blank field can cause the claim to suspend or deny.

Here's how it works:

1. Paper claims submitted by mail go first to the Office of Forms and Document Management (OFDM) Imaging Unit. Here the claim is scanned, given an internal control number (ICN), and batched. Depending on volume, the mail intake and the ICN assignment process may take from one to five working days.
2. Claims are then delivered to the Data Entry Unit, where operators manually enter the information appearing on the claims into the MMIS processing system. ONLY required fields of information are keyed into MMIS. Data entry operators can process

a single claim in 45 seconds. Because of quality assurance and time requirements, data entry operators cannot alter the information on the claim forms, or take the time to read and annotate notes or written explanations attached to claims.

3 Providers who bill electronically bypass these first two steps and their data is entered directly into the system. It is not uncommon for providers to bill using electronic data interchange (EDI) by 2:00 p.m. on Friday and have a check the next week.

4. From this point on, the claim is not seen by any DMAP staff member unless it suspends for specific medical or administrative review. The only way staff can immediately access submitted claim information is to check certain MMIS screens.
5. When a claim suspends, in essence, MMIS is saying that it cannot make a decision — a claims analyst will have to review the data. It is also possible that internal files need to be updated before the claim can be paid; for example, patient eligibility is the most common reason for internal file discrepancy. Since eligibility is determined and updated at the local DHS branch level, DMAP depends on caseworkers to supply accurate and timely eligibility information to MMIS. If the claim has suspended for this reason, two weeks are allowed to pass. Then, if DMAP files still show "no eligibility for patient," the system will automatically deny the claim. Providers receive a denial notice on their remittance advice with an explanation of benefits (EOB) message, such as "Patient ineligible on date of service."
6. There are more than 900 potential questions MMIS may ask about a claim before it can make a payment decision. The computer will try to match data from the claim entered into the system with information about this recipient entered previously.
7. Most paper claims are processed within 30 days. Providers receive a remittance advice (RA)explaining payments and denials. The fewer questions the computer asks, the more quickly the claim can be processed.
8. Most claims are denied because of incomplete or incorrect patient or provider data. Please be sure your case information is complete and accurate. Only those procedures which require "cost documentation" or "by report" will suspend for medical review. The Medical Unit analyzes those claims.

The chart on the next page shows how a claim is processed.

Paper Claim

Electronic Claim

The first two steps of a paper claim may take 1-5 working days.

CMS 1500 or UB 92 received in mailroom

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Form is Microfilmed and an Internal Control Number (ICN) is assigned

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Data Entry Operators feed information from the claim into MMIS

Electronic claims skip the first two steps that a paper claim goes through.

Transmit claims electronically

[Rest of steps are the same for a paper or electronic claim.]

Computer compares info from claim with MMIS reference files

→ Claim suspends; not enough information. Is manually reviewed

Claim **does not** meet Payment Criteria

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Computer Denies Claim

Claim meets Payment Criteria

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Computer Makes Payment based on fee schedules

Remittance Advice Form sent to provider explaining action

Paper claims take about 30 days to process.

Electronic Claims submitted by 2:00 p.m. on Friday may be paid by the following week.