Nursing Facility Services Transitioning to STAR+PLUS:
Common Reasons for Denials and Rejections of Managed Care Claims

March 18, 2015

S.B. 7, 83rd Legislature, Regular Session, 2013, directs HHSC to deliver nursing facility services through the STAR+PLUS managed care model. Effective March 1, 2015, STAR+PLUS managed care organizations (MCOs) provide services to most Medicaid clients residing in nursing facilities.

When submitting nursing facility claims for STAR+PLUS managed care residents through the TMHP TexMedConnect portal or MCO portals, claim rejections or denials may be related to some common data entry errors during claims submission. Below are common reasons for rejections or denials reported by the MCOs' claims adjudication systems. Please note that whether a claim with incorrect data is rejected or denied is dependent upon the MCO's specific system. Additional explanation is provided in this news notice regarding these categories of rejections and denials.

Common Rejections:
1. **Diagnosis Codes:** entering invalid codes; must be to the highest number of digits possible (4th or 5th digit)
2. **External Cause of Injury Diagnosis codes:** entry of a ICD-9 code that is not an E code
3. **TaxID:** entry of a DADS contract number in the TaxID field or missing TaxID
4. **Attending Provider NPI:** entry of invalid format and fails the check digit for HIPAA
5. **Claims with Other Insurance:** Other Insurance Group Name must not be used if the Group Number is submitted

Common Denials:
1. **Diagnosis Codes:** entering invalid codes; must be to the highest number of digits possible (4th or 5th digit)
2. **TaxID:** entry of a DADS contract number in the TaxID field or missing TaxID
3. **Duplicate Claims:** entry of two or more claims for the same dates of service, individual and Provider
4. **Duplicate Claim line items:** entry of two or more line items for the same service and same dates of service
5. **Provider is on Hold:** claims submitted may be denied by the MCO

Option of Direct Billing to MCO Portals
Although rejections may still occur, providers utilizing the MCO portals for submission will receive immediate and more robust feedback on missing or incorrect information and can make adjustments immediately rather than waiting for the MCO to respond to TMHP indicating that a claim has been rejected or accepted. For more efficient payment, nursing facilities may submit claims directly to the MCO portals. **Only the MCO portals can be used to check the adjudication status of a claim for a managed care member.**

Please note that when billing through the TMHP TexMedConnect portal, claims are forwarded to the appropriate MCO within an hour of submission; however, it may take more than a business day for the portal to indicate that the MCO accepted or rejected the claim.   The claim on the TMHP TexMedConnect portal will show a status of forwarded until a response is received from the MCO system.

To access STAR+PLUS MCO Portals:
- Amerigroup: https://providers.amerigroup.com/pages/tx-2012.aspx
- Cigna-HealthSpring: https://starplus.hsconnectonline.com/login.aspx
- Molina: http://www.molinahealthcare.com/providers/tx/medicaid/Pages/home.aspx
- Superior: https://provider.superiorhealthplan.com/sso/login
- United Healthcare: https://www.unitedhealthcareonline.com

Below is additional claim submission guidance related to the common reasons for rejection and denial. Some of this same information was previously shared in a news notice and is intended to serve as a reminder within the context of these common reasons.

A. Claims with Other Insurance

Managed Care claims with Other Insurance information may be rejected if both the 'Group Name' field (seen as 'Employer Name' on TexMedConnect) **AND** Group Number are completed on the claim.   The HIPAA Regulations and Implementation guide indicates that if the group number is not available then the group name should be submitted on the claim but not both. On TexMedConnect, although only one of the fields is needed, both can be entered as indicated in the screen example below. Please ensure that your managed care claim does not contain both values. For those managed care claims that have been rejected or denied by the MCO for processing, correct the claim with this information and resubmit for processing.

As a reminder, policy and procedures information related to claims submitted for Managed Care residents with Other Insurance is detailed in the DADS Information Letter 15-10:
http://www.dads.state.tx.us/providers/communications/2015/letters/IL2015-10.pdf

For managed care claims, providers will continue to:
- determine the liability of third party insurance companies;
- report on the claim the other insurance paid amount collected; and
- maintain third party insurance documentation on file.

To report other insurance **paid amount** on the claim through TexMedConnect, the provider must:
- click the 'Add New Policy' button on the Other Insurance/Finish tab
- fill in the required fields
- complete the attestation which continues to be required for both TexMedConnect and Electronic Data Interchange (EDI) submissions of claims at TMHP.

If the provider **chooses to report** other insurance **denials** on the Medicaid claim, additional information may be required by the MCO for the claim to be adjudicated causing the claim to be in a pended status. Only the MCO portals can be used to check the adjudication status of a claim for a managed care member.

B. Duplicate Claims and Duplicate Claim Line Items

If more than one claim is submitted for the same Managed Care resident with the same dates of service and same provider, the MCO will deny the proceeding claim as a duplicate claim. MCOs will deny claims as a duplicate claim line item when more than one claim line item is submitted on a claim for the same service and dates of service.

Claims submitted through the TMHP TexMedConnect portal and directly submitted to the MCO systems for the same Managed Care resident, same services, same dates of service and same provider also will be denied as duplicate claims. TexMedConnect and the MCO system cannot be used for claim submission of the same claim.

The duplicate claims submission creates a workload for all involved in claim submission and processing. Your attention to monitoring this activity to alleviate this workload would allow for greater focus on claims payment and is greatly appreciated.

C. Nursing Facility Providers on Payment Hold

When a Nursing Facility is placed on a payment hold by the State, including during the change of ownership process, MCOs are notified of the hold for claims adjudication purposes. If claims are submitted by the Provider during the hold, MCOs will deny or pend the claims dependent upon their specific system.

To prevent additional denials, please do not submit claims when you are on payment hold.

D. Diagnosis Codes

Diagnosis Code Format: The National Correct Coding Initiative and HHSC require MCOs to deny any claims with diagnosis codes that do not include the 4th or 5th digit. In order to prevent future denials, it is necessary for nursing facilities to submit valid ICD9 codes. This may require an update to your Group Templates on TMHP TexMedConnect if you are not directly billing to the MCO.

Please consult with your Nursing Staff to determine the appropriate diagnosis code for each resident. If you did receive a denial, you can resubmit the claim with a corrected diagnosis code.

The table below demonstrates accurate diagnosis reporting examples:

▶ 250 Diabetes mellitus
   ▶ 250.0 Diabetes mellitus without mention of complication
      ▶ 250.00 Diabetes mellitus without mention of complication, type II or unspecified type, not stated as uncontrolled convert 250.00 to ICD-10-CM
      ▶ 250.01 Diabetes mellitus without mention of complication, type I [juvenile type], not stated as uncontrolled convert 250.01 to ICD-10-CM
      ▶ 250.02 Diabetes mellitus without mention of complication, type II or unspecified type, uncontrolled convert 250.02 to ICD-10-CM
      ▶ 250.03 Diabetes mellitus without mention of complication, type I [juvenile type], uncontrolled convert 250.03 to ICD-10-CM

External Cause of Injury Diagnosis Codes: Diagnosis codes entered on the TexMedConnect Claim Submission screen are positional in the list and regarded as follows:
- Item 1: Principal Diagnosis is required on all 837 Institutional Claims
- Item 2: Admitting Diagnosis is conditionally required based on the Claim Frequency
- Item 3: External Cause of Injury Diagnosis is optional.

If the External Cause of Injury Diagnosis is entered on TexMedConnect or directly in the MCO system it must be a valid ICD-9 'E code' or it may result in a rejection by the MCO system.

E. Tax Identification Number (TIN)

A valid TIN is required for all Managed Care claims submitted either on TexMedConnect or directly to the MCO systems.

To enter a TIN when submitting claims through the TexMedConnect portal:
- navigate to the Provider tab
- select 'Employer' in the ID Qual field
- enter the TIN in the 'Other ID' field
- this information will be provided to the associated member's MCO in the appropriate field for TIN

F. Attending Provider NPI

When submitting Institutional claims for Managed Care (STAR+PLUS) residents Providers must include a valid **National Provider Identifier (NPI)**, which is a unique identifier for healthcare providers made up of 10-digits with no alphabetic or special characters, in the required Attending Provider NPI field.

To enter a valid Attending Provider NPI when submitting claims through the TexMedConnect portal:
- navigate to the Provider tab
- enter the Attending Provider NPI
- this information will be provided to the member's MCO in the appropriate field for Attending Provider ID

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For questions related to this information, please contact HHSC at:
Managed_Care_Initiatives@hhsc.state.tx.us

For questions related to the TMHP TexMedConnect portal, please contact TMHP at:
1-800-626-4117, Option 1