

## How Recipient Data, Plan of Care, and Claims work together in the new MMIS system for Long Term Care NF claims

(Please note that this write up does not address co-insurance NF claims)

Following is a very simplified explanation of how the subsystems in the MMIS operate with re: to NF claims and claim processing. In briefly analyzing a claims sample from February, we are seeing errors posting in all of the areas below, which are resulting in suspension or denial of many NF claims.

### Recipient Eligibility

In order for a recipient to be eligible to receive NF services, that recipient must be both Medicaid eligible and NF service eligible. This eligibility information is transmitted to the MMIS through two interfaces – one for Medicaid eligibility and one for NF Service eligibility. The system assigns benefit plans that reflect each type of eligibility. Both of these benefit plans must be in place in order for the claim to pay.

The Medicaid eligibility system passes both Medicaid eligibility information and patient liability information to the MMIS system.

The NF Service eligibility system passes NF eligibility and level of care information to the MMIS system.

### Plan of Care

The plan of care is used to authorize a particular provider to provide NF services to a particular client. The POC requires the user to enter the benefit plan under which the service is being authorized. For NF services, the worker must select the NFC benefit plan. If that benefit plan has been rejected in the interface, closed in error, etc... it will not be available for the worker to select. Thus, the POC cannot be created.

Please note that the claims processing logic does not use the POC data in processing. The claims engine merely looks to see that a POC record is in place for the dates of service being billed. If there is no POC for the dates, the claim suspends.

### Claims Processing

When a NF claim comes into the MMIS, a series of edits are performed.

- One set of edits looks at the data on the claim itself and identifies any inconsistencies. Common examples include: the number of days does not equal the dates of service, the dollar figures do not add up, etc...
- A second set of edits asks whether the recipient is eligible to receive the service. The system looks at all of the recipient's benefit plans, in a particular order, to determine if any benefit plan covers the service being billed. If the system finds a plan that does cover the service, it looks to see that the rules defined in that plan have been met. The NFC benefit plan has rules that require a Plan of Care record. This is where the system

checks to see if a plan of care for the recipient and provider on the claim exists for the dates of service. If no POC is present, the claim suspends or denies.

- A third set of edits deal with the pricing of the claim. The system takes the level of care information stored in the recipient record and finds the associated rate for that level of care. If the level of care information is missing or corrupted in the recipient record, the system cannot price the claim and it denies the claim.

### Financial Processing

Once the claim has been adjudicated it will pass through the weekly financial cycles. Several things happen in the financial cycle.

- Accounts Receivable and other forms of withholding are considered here, which might result in a reduction in the final payment to the provider. This is where the transitional payments are recouped.
- Payments are generated - checks/EFT
- Remittance advices are generated.
- The financial processing also validates the funding codes on the claim, which are used in accounting and budgeting in DHS. If the funding codes are incorrect, the claim will not be passed through the financial cycle and is written out as an error.