# TRANSCRIPT: Preventing Claims Denials: What You Can Do

Claims payment denials are often unexpected and bring about necessary, additional paperwork to receive payment. Fortunately, there are a number of things providers can do to reduce the chances that a claim will deny.

First, it's essential that prior authorizations are received when necessary. Lack of a prior authorization is the number one reason claims deny for payment. To initiate this, visit the For Providers' page of our website, under Manuals, Forms, and Support. Right here in the top right corner is the form. You'll find that it's easily fillable, online, so that you can save it to your desktop and electronically send it in.

To see the list of covered services, along with the very important list of services requiring prior authorization, visit pages 22 and page 27 of the Title 19 provider manual.

The next thing you can do is make sure the right form is used, and that it's filled out completely. This is another frequent reason that claims deny for payment – they may be filled out using the wrong form, or the form may be submitted before it's complete. The CMS 1500 claim form, or UB-04 form for hospitals, must be completely and correctly filled out. You can find valuable tips and information on completing these forms by simply running a Google search on the term, "CMS 1500," or, "Completing a UB-04 Form." When sending this in, make sure you're marking the appropriate plan the child is enrolled in – either Title 19 (MMA/Medicaid) or Title 21 (CHIP).

If you are submitting your claims electronically, you'll want to check the message center in the electronic clearinghouse for any notes about pending or denied claims. If you have submitted a claim but have not received payment, check the clearinghouse first, before calling MED3OOO or Ped-I-Care. The reason is, if it doesn't make it through the clearinghouse, it doesn't make it to them or us. MED3OOO is the CMS Plan/Ped-I-Care third-party administrator for claims payment, and the messages in the box are meant to inform you of known problems that need to be addressed. Ped-I-Care is unable to see or review your claim submission at the clearinghouse, so it is very important that you check the message center. As of the date of this recording, April 2017, our clearinghouses are Availity and Emdeon. You can always keep up with any changes for this by reviewing the provider pages of our website.

Another way to improve your chances of a "clean" claim is to make sure, when filling out the electronic form, that you use the correct National Provider identification number, or NPI. Each provider has their own. It's also important to use the correct Tax ID number. For those providers who are with a group practice or healthcare facility, it's essential that each provider with the group or facility is listed as part of the group and registered with Ped-I-Care. Our team of Provider Relations Liaisons, or PRLs, can help with this process. If you're not sure how to reach the PRL in your area, please call our main line at (352) 627-9100 or Toll-Free at (866) 376-2456 for assistance.

When new providers try to submit a claim, if they are not yet an official part of the network, their claim may deny. The group practice will need to contact Ped-I-Care's network management division, via their Provider Relations Liaison, to have them identified as part of the group so this doesn't happen. Be sure to submit your claims as soon as possible after services are rendered. This will give you time to make corrections if there are errors that lead to a claims denial. A "clean" claim – one that is accurate and

complete – must be submitted within 365 days from the date of service. Any claims received after this date, including corrected claims, may deny for timeliness and not be paid.

With all claims denials, you have the right to an appeal. Information on this and other topics related to claims may be found in our provider manual starting on page 55. Remember, a claims denial is different from a denial of authorization. Claims denials happen after a service has been provided and submitted to the insurance plan for payment.

In summary, make sure all services needing prior authorization have received it; be sure that the provider is listed as part of a group if appropriate; and submit the claim form to eliminate known issues related to claims denials.