

## Life Cycle of a Claim

### A. Claim Line Received

1. Claim line is received electronically via an 837P electronic claim file or manually input into Diamond.

### B. Is the client enrolled in Diamond?

1. If the claim comes in electronically, Diamond looks for a match on UCI, first name, last name, date of birth and gender between the information on the claim file and the information in the member.
  - a. Diamond makes 4 attempts to match data on the incoming claim with that of the members on file. First it looks for a perfect match, when this fails it tries 3 different types of imperfect matches.
    - Perfect Match
      - Exact match on UCI, last name, date of birth and gender
      - Exact match on UCI, first name, last name and date of birth – not enough information to make a match on gender (gender is missing from either the claim file or the member file)
    - Imperfect Match
      - Exact match on UCI, first name, last name and gender – dates of birth do not match
      - Exact match on UCI, first name, last name and date of birth – gender does not match
      - Exact match on UCI and a partial match on first name, a match on date of birth and a match on gender.
    - For Pseudo clients – if gender = U on the member record, the date of birth and name must match exactly.
  - b. If Diamond fails to make a perfect or imperfect match the claim is rejected and you will get a critical error on your **PREDI-C** (critical error) report. If it is a valid UCI you will get an OPE010 Patient Person Number cannot be determined.
    - Imperfect matches will show up on the non-critical error report – **PREDI-N**.
2. If the claim is manually input, Diamond validates the UCI.

### C. Is the client eligible on the date of service?

1. If the UCI was validated or a perfect/imperfect match was found, Diamond looks to see if there is an eligibility span in Diamond for the client that covers the date of service on the claim line.

- a. If there is no eligibility span in the member file for the client that covers the date of service on the claim and the claim came in electronically, the claim is rejected as a critical error.
  - If the claim was manually entered the claim will be denied during the pricing of the claim with a denied reason of **MBRIN** (member ineligible), a Company Code of OHIO and the G/L Ref code will be DEF. (default).
    - These claims will need to be manually corrected so they will finalize in Diamond. Correct them by entering the correct Company Code and the board's default G/L Ref code.
- b. If there is an eligibility span in the member file for the client that covers the date of service Diamond then proceeds to see if there is a **Provider** contract (**PROVC**) that matches the client's line of business.

**D. Is there a Provider contract that matches the client's line of business?**

1. If there is no provider contract that matches the client's line of business for the date of service on the claim, the claim is denied due to **provider ineligible** or **PRVIN** and will have a Company Code of OHIO and a the G/L Ref code will be DEF (default).
  - a. Follow the same procedure as above to correct these claims so they will finalize in Diamond

**E. Is there is a contract that matches the client's panel?**

Diamond looks to see if there is a contract matching the client's **panel**.

- a. If there is a contract matching the client's panel, the information on the **Standard Contract** is used to price the claim.
- b. If there is not a contract matching the client's panel, the information on the **Default Contract** is used to price the claim.

**F. Claim is priced.**

Diamond looks at the appropriate contract based on panel and line of business to find the appropriate price schedule and rate (**PROCP**) in order to price the claim. Which contract and which rate (**PROCP**) is used to price a claim depends on the client's line of business, the client's panel and whether the service is Medicaid reimbursable or Non-Medicaid reimbursable.

The appropriate price schedule and **PROCP** record Diamond uses is determined by the value in the **PROVA** field.

1. A contract is found matching the client's panel so the **Standard** contract is used by Diamond. There will be a Medicaid and Non-Medicaid Standard contract and Diamond will use the one that matches the client's line of business.
  - a. **Medicaid and Non-Medicaid Standard Contract**
    - For **MCD** reimbursable services (whether or not the client's line of business is MCD or NON):

- If the provider address flag is 000 Diamond uses the Primary Price schedule and Price Region from the **PROVC** record to locate the appropriate PROCP record
  - If the Provider Address flag is 001 Diamond uses the Primary Price schedule and Price Region from the **AODINDIV PROVD** record to locate the appropriate PROCP record
  - If the Provider Address flag is 002 Diamond uses the Primary Price schedule and Price Region from the **MHGROUP PROVD** record to locate the appropriate PROCP record
  - For **Non-MCD** reimbursable services (whether or not the client's line of business is MCD or NON):
    - If the provider address flag is 000 Diamond uses the Alternate Price schedule and Price Region from the **PROVC** record to locate the appropriate PROCP record
    - If the Provider Address flag is 001 Diamond uses the Alternate Price schedule and Price Region from the **AODINDIV PROVD** record to locate the appropriate PROCP record
    - If the Provider Address flag is 002 – No Alternate Price Schedule attached to the **MHGROUP PROVD** record
  - If a rate (**PROCP**) is found for the date of service the claim is priced – **Allowed Amount** is populated on the claim and a **MEDEF** is assigned.
  - If a rate (**PROCP**) is not found for the date of service the claim is denied; there is no allowed amount.
2. A contract is **not** found matching the client's panel so the **Default** contract is used by Diamond. There will be a Medicaid and Non-Medicaid Default contract and Diamond will use the one that matches the client's line of business.

a. **Medicaid Default Contract**

- For **MCD** reimbursable services:
  - If the provider address flag is 000 Diamond uses the Primary Price schedule and Price Region from the **PROVC** record to locate the appropriate PROCP record
  - If the Provider Address flag is 001 Diamond uses the Primary Price schedule and Price Region from the **AODINDIV PROVD** record to locate the appropriate PROCP record
  - If the Provider Address flag is 002 Diamond uses the Primary Price schedule and Price Region from the **MHGROUP PROVD** record to locate the appropriate PROCP record

- If a rate (PROCP) is found for the date of service the claim is priced – **Allowed Amount** is populated on the claim and a **MEDEF** is assigned.
- If a rate (PROCP) is not found for the date of service the claim is denied; there is no allowed amount.
- For **Non-Medicaid** reimbursable services:
  - There are no alternate price schedules attached to the Default Medicaid Contracts. All Non-Medicaid reimbursable services are denied.
    - If a board wants to pay the Non-Medicaid reimbursable service they will need to manually price and adjudicate the claim.

**b. Non-Medicaid Default Contract**

- For **MCD** reimbursable services:
  - If the provider address flag is 000 Diamond uses the Primary Price schedule and Price Region from the **PROVC** record to locate the appropriate PROCP record
  - If the Provider Address flag 001 Diamond uses the Primary Price schedule and Price Region from the **AODINDIV PROVD** record to locate the appropriate PROCP record
  - If the Provider Address flag 002 Diamond uses the Primary Price schedule and Price Region from the **MHGROUP PROVD** record to locate the appropriate PROCP record
- For **Non-MCD** reimbursable services:
  - If the provider address flag is 000 Diamond uses the Alternate Price schedule and Price Region from the **PROVC** record to locate the appropriate PROCP record
  - If the Provider Address flag 001 Diamond uses the Alternate Price schedule and Price Region from the **AODINDIV PROVD** record to locate the appropriate PROCP record
  - If the Provider Address flag 002 – No Alternate Price Schedule attached to the **MHGROUP PROVD** record
- If a rate (PROCP) is found for the date of service the claim is priced – **Allowed Amount** is populated on the claim and a **MEDEF** is assigned.
  - All claims are put on hold with an OOCTY (out-of-county) hold reason.
  - Boards have the option of either denying the claim or making the claim payable.

- If a rate (PROCP) is not found for the date of service the claim is denied; there is no allowed amount.

### G. Claims are adjudicated.

Once a claim is priced the claim is adjudicated. Diamond looks at the member's eligibility to see what plan the client was enrolled in on the date of service. The **Benefit Rules (BRULEs)** that are associated with the client's plan via the **Benefit Package (BENEF)** are applied and a net amount is determined.

1. Diamond checks to see what plan is on the member's eligibility span that covers the date of service. The plan is tied to a Benefit Package (**BENEF**).
2. Diamond reviews the Benefit Rules (**BRULEs**) associated with the benefit package to determine which should be applied to the claim.
  - a. Diamond will apply a rule if the medical definition (**MEDEF**) assigned to the claim detail line is a medical definitions entered on one of the benefit rules.
3. Appropriate benefit rules are applied and a net amount is assigned to the claim.
  - a. Application of the benefit rules may change the claim status.
    - Ex. Service may be excluded and the claim status is changed from "P" (payable) to "D" (denied)
      - Not covered amount would be calculated and a not covered reason code assigned.
    - There are 6 types of benefit rules: Coinsurance, Limits, Deductibles, Out-of-Pocket Maximum, Message and Pend and Exclusions.

**NOTE: Duplicate checking and the application of BRULEs happens during the Post process and is not reflected on the Edit Reports.**

### H. Claims are finalized for payment.

Once the claims have been priced and adjudicated they will remain in an unfinalized status – **PROC STAT = "U"** – for one to two weeks depending on your board's "**lag**" time. This gives boards a chance to work any "**held**" claims, claims that need reviewed due to the "**Caution**" reports, etc.

1. The process of finalizing claims for payment is the Accounts Payable Process. Even though the Accounts Payable Process is made up of three steps (**APUPD**, **CKPRT** and **CKPST**) the entire process is commonly referred to as **APUPD**. The process begins every Monday morning but may not complete until Wednesday morning.
  - a. **APUPD** (accounts payable update) is the first step and finalizes the claim. The **PROC STAT** is changed from a "**U**" (unfinalized) to an "**F**" (finalized) and a **Post Date** will be assigned to the claim.
    - The selection criteria used for APUPD is Company, Received Date (from the ACPAY record) and a **thru date** which is based on the boards' lag time (one week or two weeks).
    - Finalized claims **cannot** be modified.

- The **Post Date** is the date APUPD is run.

**NOTE: Everyone needs to be out of claims from 6:00 a.m. to 8:00 a.m. on Monday.**

- b. **CKPRT** (check print) is the second step in the accounts payable process. This step creates a work file for the next step, **CKPST** (check post).
  - The date this process is run is the date used during **CKPST** to assign a check date to the claim.

**NOTE: Users do not need to be out of claims when this process is run.**

- c. **CKPST** (check post) is the third and final step in the accounts payable process. This step changes the **PROC STAT** from an “**F**” (finalized) to a “**P**” (paid) and assigns a check date (**CHCKDATE**) based on the date **CKPRT** was run.
  - If all the claims for an individual provider and company do not have a net dollar amount greater than zero the claims will remain in an “**F**” status until they total more than zero.
    - Once these claims have a net value greater than zero the **PROC STAT** will be changed from an “**F**” to a “**P**” and a check date assigned. The check date may be days or weeks after the **Post Date**.
    - These claims have already appeared on a payment file and have already been extracted.

**NOTE: CKPST is now run on Monday nights.**

2. All claims that have a **PROC STAT** of “**F**” or “**P**” will be on the payment files created the following Monday.

#### **I. Payment files are created and FTP'd to the Boards' RA directory.**

1. Payment files are created by the State (ODADAS) every Monday and the files are FTP'd to the boards' RA directory. A notice is sent to the boards to let them know the files are available.
  - a. There are five different payment files created:
    - ERA – electronic remittance advice files
    - RA – remittance advice files (printable format)
    - RJ – reject file that contains rejected/reversed claims
    - 835 – Health Care Claim Payment Advice
    - 835 Summary Report – summary of all 835 files created for a board

#### **J. Payment to Providers**

1. Boards must disburse an ASC X12N 835 Health Care Claim/Payment transaction to their providers for Medicaid and non-Medicaid services within 30 calendar days of

the distribution of the State-produced ASC X12N 835 Health Care Claim/Payment Advice which includes the claim even if all claims in the file are denied.

- a. If a Board has contractually agreed to pay a provider for non-Medicaid services on a fee-for-service (FFS) basis and/or the Board is using federal funds to pay for the non-Medicaid services, a check must also be disbursed in this timeframe.
  - b. Boards must remit 100% payment from non-Federal funds to the provider for Medicaid services within 30 calendar days of the claim being included on a State-produced ASC X12N 835 Health Care Claim/Payment Advice. Remitting payment means actually disbursing the check and the 835 file within the 30-day timeframe. The 835 file may precede the check or accompany the check, but cannot be disbursed after the check. This federal requirement applies to both in-county and out-of-county provider payments.
2. Administrators may not modify the ASC X12N 835 Health Care Claim/Payment Advice file as provided by MACSIS prior to disbursing it to the provider.
  3. Boards are not required to provide both a paper remittance advice and an electronic remittance advice file. Only the 835 is required per HIPAA regulations.
    - a. If contracting or a non-contracting provider requests an electronic 835 file, the Board or MACSIS Administrator must comply with that request regardless of file size per HIPAA regulations.

#### **K. Medicaid Claims Extracted to ODJFS.**

1. Valid Medicaid claims (claims with a **PROC STAT** of “F” or “P” and a Medicaid **MEDEF**) are extracted and sent to ODJFS for payment of FFP to the board.

ODADAS extracts on a weekly basis while ODMH extracts bi-weekly (usually on Thursday).

  - a. The **OHEXT** extract file is created every other Thursday for MH and every Friday for AOD and submitted to ODJFS on the following Monday.
    - Claims that cannot be extracted to ODJFS are reported on the **OHEXT Error Report** which is emailed to the boards.
      - The most common reason a claim cannot be extracted is that there is no Medicaid number in the USERDEF field of the applicable eligibility span.
      - Once these claims are corrected, they will be extracted the next time OHEXT is run.
  - b. ODJFS adjudicates the file (usually on Wednesday) and sends the payment file back to ODADAS/ODMH the following Monday.
  - c. The **OBREV** file (claims reversed by ODJFS) is created and then processed into Diamond.
    - These reversals will go through the Accounts Payable Process (see above) and will appear on a future payment file as rejects/reversals.

## **L. Reimbursement to Boards for FFP**

The payment files received by ODJFS are used to create the **ARA** (agency reimbursement amount) and **Vouchers** that reimburse the boards for the FFP already paid to providers.

1. The ARA files and vouchers are created bi-weekly.
  - a. The ARA files are ftp'd to the boards' extract subdirectory. An email is sent notifying boards that the ARA files are available.
  - b. The Voucher file is sent to the ODMH or ODADAS Medicaid Office for review/approval.
    - Funds are electronically transferred (EFT) to the boards.