2025 Medicaid Statewide Provider Training

Claims and Billing

Utah Department of Health & Human Services

Agenda

- Housekeeping items
- OIG
- Health equity
- EDI
- Claims
- TPL/COB
- Remittance Advice (RA)
- Medical documentation
- Hearings and appeals
- Timely filing
- SPOTs
- Provider resources

Housekeeping items

Office of Inspector General

Utah Medicaid will turn providers over to the Office of Inspector General (OIG) for not abiding by the terms set forth in the Provider Agreement, including, but not limited to: members being sent to collections or balance billed for services.

The False Claims Act

Federal: § § 3729-3733] prohibits individuals or entities from submitting inaccurate claims to a government payer (i.e., Medicare, Medicaid). Entities can violate this law by knowingly presenting a false or fraudulent claim to one of these programs or causing a false claim to be presented.

Utah State: A person may not enter into an agreement, combination, or conspiracy to defraud the state by obtaining or aiding another to obtain the payment or allowance of a false, fictitious, or fraudulent claim for a medical benefit. 26B-3-1106 False claims for medical benefits prohibited.

Examples of potential false claims include, but are not limited to: (a) billing of items or services that were never rendered by the health care provider; (b) billing for services that are medically unnecessary; (c) upcoding (practice of billing for Medicare/Medicaid using a billing code providing a higher payment rate than the billing code intended to be used for the service or item furnished to the patient); (d) billing separately for services that should be bundled; (e) billing separately for outpatient services that were provided within 72 hours (before or after) an inpatient stay; (f) billing for a discharge in lieu of a transfer.

Health equity

Health equity at DHHS

DHHS vision:

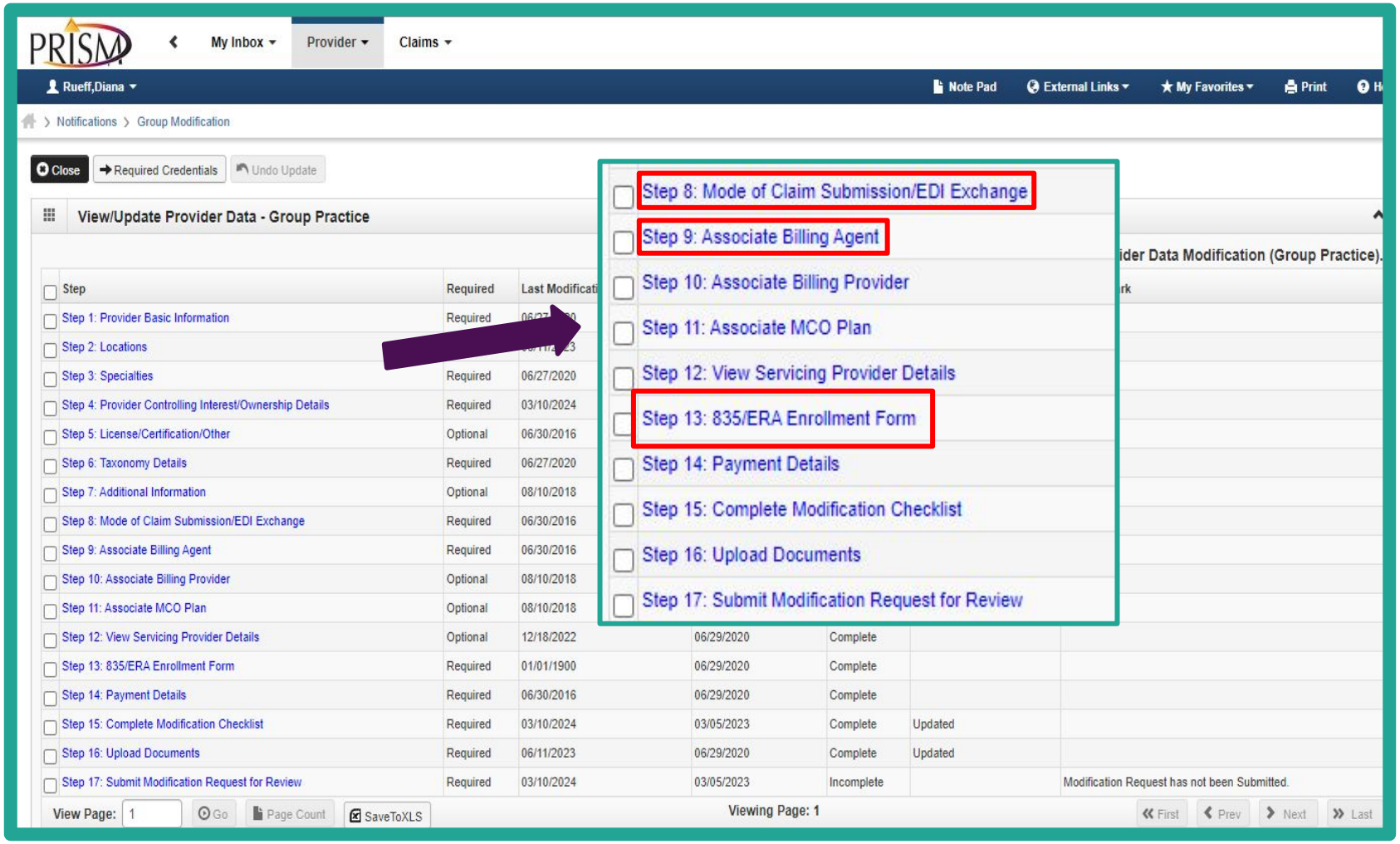
Advocate for, support, and serve all individuals and communities in Utah. We will ensure **all Utahns have fair and equitable opportunities to live safe and healthy lives.** We will achieve this through effective policy and a seamless system of services and programs.

Read more about OHE and our work at our website: https://healthequity.utah.gov/
For general questions, email: healthequity@utah.gov
Video https://healthequity.utah.gov/training-resources/

Electronic Data Interchange (EDI)

EDI enrollment steps

- **Step 8:** Select what transactions to exchange with Utah Medicaid.
- **Step 9:** Associate **Trading Partner Number** (**TPN**) from Billing agent/Clearinghouse.
    - **TPN** versus **Payer ID**:
        - **Payer ID:** Is 5 to 7 characters that are added to the provider's practice management software to route the claims to Utah Medicaid.
        - **TPN:** Is formatted as follows: HTxxxxxx-xxx. The provider must know the TPN at the time of enrollment if submitting claims electronically.
    - More information for the provider's Billing Agent/Clearinghouse can be found in the companion guides located on the Utah Medicaid website here: https://medicaid.utah.gov/claims/
- **Step 13:** Select how you would like to receive a remittance/EOB from Utah Medicaid.


PRISM
My Inbox
Provider
Claims
Rueff,Diana
Note Pad
External Links
My Favorites
Print
Notifications
Group Modification
Close
Required Credentials
Undo Update
View/Update Provider Data - Group Practice
Step 8: Mode of Claim Submission/EDI Exchange
Step 9: Associate Billing Agent
Step 10: Associate Billing Provider
Step 11: Associate MCO Plan
Step 12: View Servicing Provider Details
Step 13: 835/ERA Enrollment Form
Step 14: Payment Details
Step 15: Complete Modification Checklist
Step 16: Upload Documents
Step 17: Submit Modification Request for Review
Step
Required
Last Modificati
Step 1: Provider Basic Information
Step 2: Locations
Step 3: Specialties
Step 4: Provider Controlling Interest/Ownership Details
Step 5: License/Certification/Other
Step 6: Taxonomy Details
Step 7: Additional Information
Step 8: Mode of Claim Submission/EDI Exchange
Step 9: Associate Billing Agent
Step 10: Associate Billing Provider
Step 11: Associate MCO Plan
Step 12: View Servicing Provider Details
Step 13: 835/ERA Enrollment Form
Step 14: Payment Details
Step 15: Complete Modification Checklist
Step 16: Upload Documents
Step 17: Submit Modification Request for Review
Required
Optional
03/10/2024
06/27/2020
06/30/2016
08/10/2018
12/18/2022
01/01/1900
03/05/2023
06/11/2023
Complete
Incomplete
Updated
Modification Request has not been Submitted.
View Page: 1
Go
Page Count
SaveToXLS
Viewing Page: 1
First
Prev
Next
Last

Claims

Options to submit claims

Batch submissions

- Are electronically submitted by the provider's office with HIPAA compliance X12 capability
- Batch submission is **not** available **for Direct Data Entry**

Clearinghouse

- Submit claims through your preferred clearinghouse.

Direct Data Entry (DDE)

- Submit claims through PRISM via Direct Data Entry (DDE)

eLearnings: https://medicaid.utah.gov/prism-provider-training/

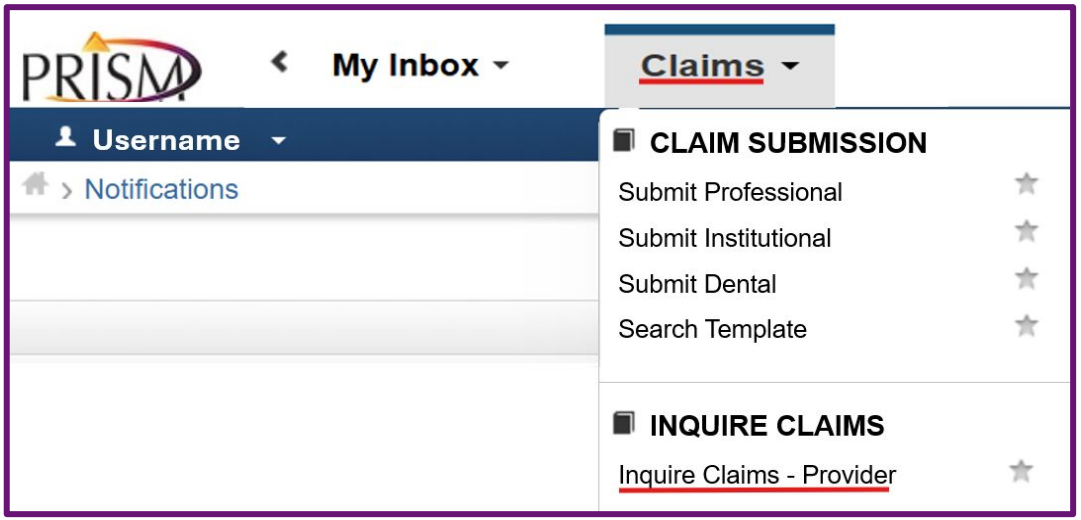
Claims and inquiry

Claims inquiry

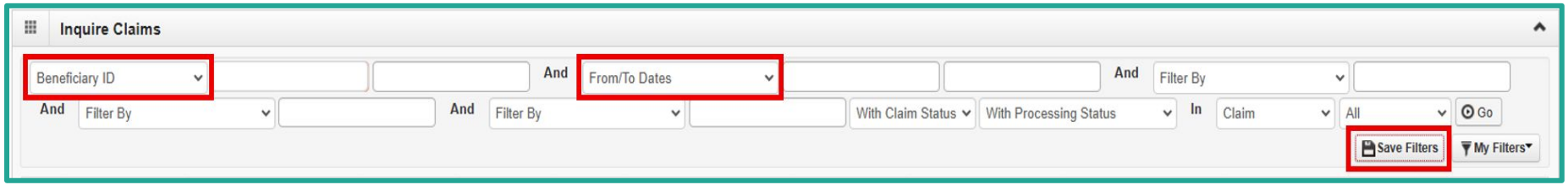
Enrolled providers can view their claims in PRISM (https://prism.health.utah.gov/)

- **Profile** (need one of the following)
  - Claims inquiry - Provider, Claims Processor, Provider or Claims Submitter, Provider
- **Steps for inquiry:**
  - Log into PRISM > Locate the **Claims** tab along the top of the PRISM screen > Use the dropdown menu to scroll down and select **Inquire Claims Provider** > On the Inquire Claims page there are several 'Filter By' drop-down menus and corresponding search fields > **Select filter option** > Enter corresponding information > Click **Go**
- **Filters:**
  - **Saving filters:** On the Inquire Claims page there are several 'Filter By' drop-down menus and corresponding search fields > Use the drop down menu to scroll down and select the valued option > Leave the criteria boxes empty > Once all the desired 'Filter By' options have been selected click on the **Save Filters** button > Name the newly created filter, the description is optional > Click **Save**
  - **Finding the saved filters:** On the Inquire Claims page locate the **My Filters** button > Using the drop-down menu scroll down and select a filter based on the name > Selecting a saved filter will pre-populate 'Filter By' options that are used frequently
  - **Wild card:** PRISM has a 'wild card' option for unknown fields or may vary, like the rendering NPI
    - The 'wild card' is the % sign but it does not work for date span, beneficiary ID, and so forth

Claims tab



‘Filter By’ options and ‘Save Filters’



Corrected/ voided claims

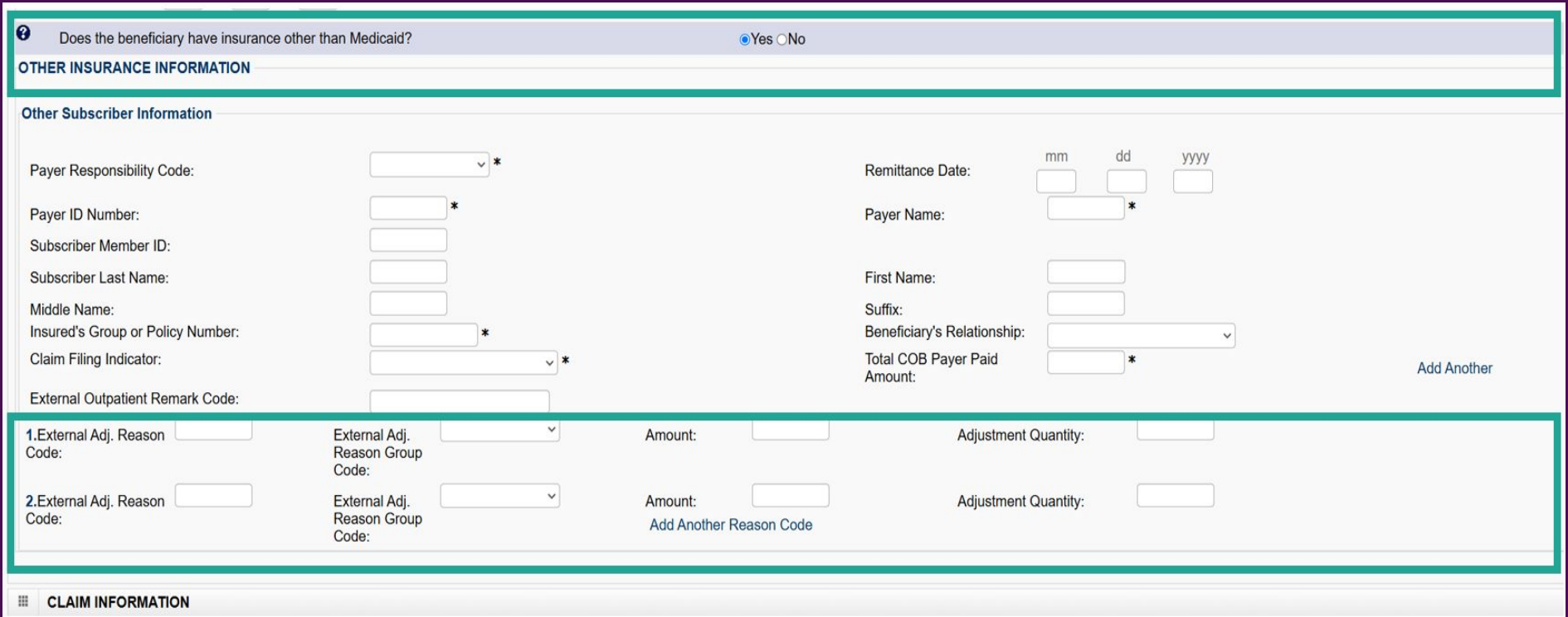
- To void or correct a claim it must have a claim status of paid and a pay cycle date
- Claims can be corrected/voided through either the clearinghouse, web batch or DDE

Third Party Liability (TPL)

Coordination of Benefits (COB)

TPL is REQUIRED at both Header and Service Line level

TPL at Header level



How to access TPL at Line Level

Previously Entered Line Item Information

Click a Line No. below to vier/update that Line Item Information

Click on Insurance Info to enter each Line's Insurance Information

Total Fee: $130.00

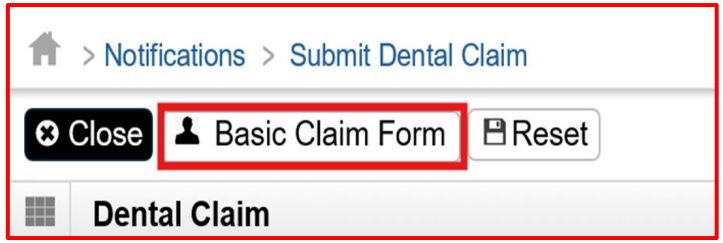
Line No	Service Date	Area of Oral Cavity	Tooth Number/ Letter	Surface 1 2 3 4 5	Procedure Code	Diagnosis Pointer 1 2 3 4	Quantity	Fees	Prior Auth Number		
1	1/1/2024		8		D6066			130.00	Insurance Info	Copy	Delete

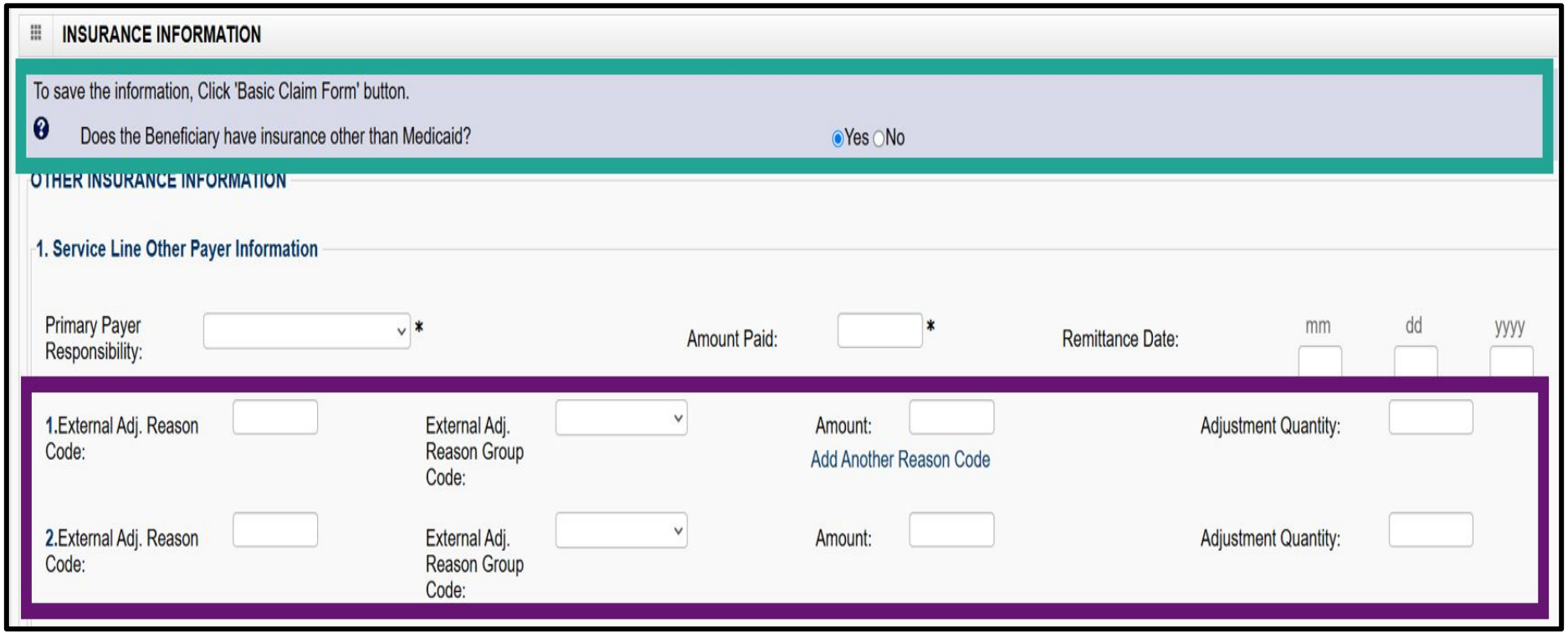
Scroll all the way to the bottom of the claim form > Click on Insurance Info > a new window opens > Click on Yes

- **This will need to be done for each individual line**

TPL at Line Level

https://medicaid-documents.dhhs.utah.gov/Documents/pdfs/PRISM-Reference-Guide_Submitting-Payment-Information.pdf





Coordination of Benefits

Medicaid is always last to pay

- Provider MUST submit and secure payment from all other liable third parties before submitting a claim to Medicaid
    - Such as Medicare Part A and B
    - For more information, refer to the Medicaid General Information Section 1, Chapter 11.

- Claims denied as non-covered services by Medicare should be submitted as Fee for Service to Medicaid, not as a crossover claim

Remittance Advice (RA)

Paper RA/EOB

- To find a digital copy of the Paper RA:
  - Profile needed
    - Claims Processor - Provider
    - EDI Analyst
  - Steps to finding the RA/EOB
    - Log into PRISM > Go to the **My Inbox** tab at the top of the PRISM screen > Select Manage Archived Documents > Change the Document Type from **ALL** to **Claim Documents** > Click **Go**

NOTE: The scanned date on the RA page, correlates to the pay cycle date listed on the claim

835 will be sent to the clearinghouse listed in the providers file in PRISM

Medical documentation

Document submissions

- Documentation MUST be uploaded to the "**Document Management Portal**"
    - Consent forms
    - Wheelchair evaluations
    - Manual review
    - Emergency Only Program
    - Provider preventable conditions
    - Timely filing
- Documentation will only be accepted via fax in emergencies. If documents are sent via mail, they will be discarded and not reviewed.
- Medicaid staff can NOT move documentation from one TCN to another.

NOTE: Refer to the **Document Management Portal Quick Reference Guide** for further instructions on how to upload documents at:
https://medicaid.utah.gov/wp-content/uploads/2023/04/DMPquickReferenceGuideProviders.pdf

Documentation submission limits

- Submit **ONLY** the minimum necessary documentation to be reviewed for the requested claim/episode of care. This includes but not limited to:
  - Manual Review
  - Emergency Services Program for Non-Citizens
  - Sterilization Consent Forms
  - Timely Filing
  - Provider Preventable Conditions

NOTE: X-rays and primary EOBs are no longer accepted or necessary to submit.
Refer to **Submitting Payment Information for Medicare or Other Insurance** on the website:
https://medicaid-documents.dhhs.utah.gov/Documents/pdfs/PRISM-Reference-Guide_Submitting-Payment-Information.pdf

Manual review correspondence

- Providers can view letters of decision regarding members claims that have been reviewed by:
  - Manual Review
  - Emergency Only Program for Non-Citizens.

- If you have one of the profiles listed below, a notification will be sent to you when there is a letter of decision available to view.
  - Claims Submitter – Provider
  - Claims Inquiry – Provider
  - Claims Processor – Provider
  - EXT Provider Account Administrator

Note: Steps to view the decision letters, **My Inbox** > Archived Documents > PEGA Correspondence Out > ‘Filter By’: use the drop down menu to select the desired option > Click **Go**

Record keeping

Providers are **required** to maintain accurate clinical records and are subject to audits in which findings could result in the recoupment of payment from the provider. It is the provider's responsibility to maintain accurate clinical records, including:

- Progress notes applicable to the date of service
- Each individual's plan of care, maintained and updated
- Document specific tasks performed on date of service
- Document services billed (number of units billed should support units documented)
- Record of physician's order
- Submit record keeping documentation, as requested by the department or under the direction of an audit
- Providers are required to bill accurately in accordance with supporting documentation

Refer to Section I: General Information, Chapter 4, on the Utah Medicaid website:
https://medicaid.utah.gov/Documents/pdfs/SECTION1.pdf

Hearings

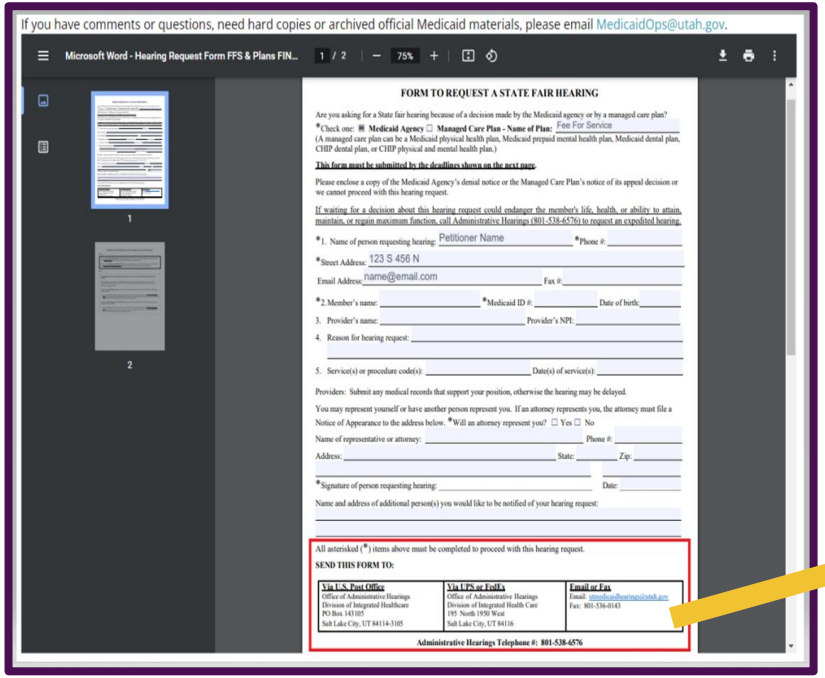
Hearings

States are required to have **a fair hearing system** that complies with the provisions of 42 CFR 431, Subpart E. The Department's administrative hearing procedures are described in Utah Administrative Code R410-14.

- **The purpose of the fair hearing will be to determine whether the action taken was in accordance with Medicaid policy.**
- A provider can request a hearing to challenge an action.
- An **action** is defined as:
  - A denial, termination, suspension, or reduction of medical assistance for a recipient
  - A reduction, denial or revocation of reimbursement for services for a provider
  - A denial or termination of eligibility for participation as a provider
  - A determination by skilled nursing facilities and nursing facilities to transfer or discharge residents
  - An adverse determination, meaning a determination made that the individual does not require the level of services provided by a nursing facility or that the individual does not require specialized services
  - An adverse benefit determination made by a Managed Care Entity

Request a fair hearing

Requests for a hearing, other than those challenging an adverse benefit determination made by an MCE, must be filed within **30 calendar days** of the date the Department sent the provider notice of its intended action.



Filling out the form:

- medicaid.utah.gov
- Fill out online
- Save to your computer
- Complete all of the fields marked with an asterisk symbol (*)
- Include all required documentation.

For hearing updates, you can contact the hearings office or send an email requesting an update.

All asterisked (*) items above must be completed to proceed with this hearing request.

SEND THIS FORM TO:

Via U.S. Post Office	Via UPS or FedEx	Email or Fax
Office of Administrative Hearings Division of Integrated Healthcare PO Box 143105 Salt Lake City, UT 84114-3105	Office of Administrative Hearings Division of Integrated Health Care 195 North 1950 West Salt Lake City, UT 84116	Email: utmedicaidhearings@utah.gov Fax: 801-536-0143

Administrative Hearings Telephone #: 801-538-6576

Timely filing

- The time limit to submit a Medicaid claim is **365 days** from the date of service, per federal regulations.
  - For institutional claims the 365 days begins on the end date of the claim.
  - Any adjustments/corrections must be received within the 365-day limit.

- Requesting a review for a claim that exceeds billing deadline.
  - Claims received by Medicaid after the billing deadline will be denied.
  - Providers may correct a claim outside of the timely filing deadline; however, no additional funds will be reimbursed.

Claims denied for timely filing

Requesting a review for payment

- The situations below may be considered for review, provided specific, appropriate documentation is submitted:
  - Provider is under investigation for fraud or abuse
  - Court order
  - Situations involving a provider who conforms with Medicaid requirements by billing a third-party payer first, resulting in non-payment after the 365-day billing deadline, have been allowed as an exception to the filing deadline in hearing decision numbers
    - 13-078-02 and 13-239-03. In accordance with 42 CFR §447.45(d)(4)(iv) and the above paragraph, if a provider files a claim beyond the 365-day limit in such a situation, it is a "same situation" as to prior agency hearing decisions and may be processed
  - Situations involving agency error in processing a timely clean claim resulting in the provider having to again file the claims beyond the one-year deadline have been allowed as an exception to the filing deadline in hearing decision numbers
    - 13-212-08 and 13-212-22. In accordance with 42 CFR §447.45(d)(4)(iv) and paragraph 2 above, if a provider files a claim in such a situation, it is a "same situation" as to prior agency hearing decisions and may be processed

Clean claim

Clean claim in reference to timely filing

- **Clean claim**
  - Federal regulations define a clean claim as a claim that Medicaid can process without obtaining additional information within 365 days from the date of service.
- **Not a clean claim**
  - A claim that is denied for omitted, incorrect date or missing attachments.
  - A claim filed more than 365 days after the date of service.

SPOTs:

- Change requests
- System defects
- Future enhancements

https://medicaid.utah.gov/prism-faq/

- PRISM release notes:
  - Completed SPOTS
- Future proposed PRISM release notes:
  - In progress SPOTS

Provider resources

- **Provider manuals**
  - https://medicaid.utah.gov/manuals/
- **Medicaid Information Bulletins (MIBs)**
  - https://medicaid.utah.gov/medicaid-information-bulletins/
- **Trainings**
  - Submitting Claims with and without Primary Insurance https://www.youtube.com/watch?v=n0ZJo0L0kP0
  - Adjust, Void, Reprocess Claims with and without Primary Insurance https://www.youtube.com/watch?v=N2-MwY8Al2Q

Contact us

Provider Enrollment:

Phone: 801-538-6155, choose option 3 then option 4
Email: providerenroll@utah.gov

Customer Service:

Phone: 801-538-6155 choose option 3 then option 2