Troubleshooting Claims in SmartCareMCO

This document is intended to outline Billing Best Practices as well as review the most common Unprocessed Reasons and Denial Reasons in SmartCareMCO, outlining the likely causes for these errors and providing solutions. Please keep in mind that areas described within this document may only be accessible to those assigned the Provider Claims Processor role.

1. Billing Best Practices

To ensure proper cash flow within your agency, follow these Billing Best Practices:

1. **Bill early in the week.** This allows for time to troubleshoot if necessary. Sometimes it takes multiple days to address an unprocessed or denied claim. Billing as early in the week as possible allows for ample time to work through any issues.

2. **Immediately work through unprocessed claims.** As soon as you upload an 837 billing file or Batch Claim Upload Spreadsheet, you will be able to instantly see if any claims were not processed. It's important to follow up on these claims and get them rebilled as soon as possible.

3. **Log back in the day after billing to check for denied claims and immediately work through those denials.** Claims adjudicate nightly. You can log into SmartCareMCO the day after billing to ensure that all claims are approved. If any claims are denied, you should address those promptly.

2. Common Unprocessed Reasons (837 Import)

Refer to the **SmartCareMCO Provider User Manual, Section IX. 837 Import** to review the process of importing and viewing an 837 file in SmartCareMCO. Here are the most common Unprocessed Reasons we see in SmartCareMCO:

1. Client is not authorized for this provider.

   - This error indicates that the client-to-provider linkage required to process claims in SmartCareMCO does not exist. This either means that the client is not enrolled with your agency or that the client was improperly enrolled with the incorrect agency by enrollment staff.

   - To resolve this, simply submit a new enrollment for the client. You will need to wait for the enrollment to be signed to rebill.

2. Client not found.

- This error indicates that the client entered within the file does not match any client record in SmartCareMCO. This error may also indicate that the UCI entered within the file is incorrect.

- To resolve this, either submit a new enrollment for the client (if the client is not enrolled in the system), or correct the UCI number within the file and rebill (if the UCI number was incorrect within the 837 file). Refer to the 837 Import Claim Line Details screen of the claim in question to determine the UCI number (Subscriber Number) entered within the file. Keep in mind, if re-enrolling the client, you will need to wait for the enrollment to be signed to rebill.

  Note: Sometimes this error can be coupled with the error "Insurer not found." Usually, when listed together, resolving the "Client not found" error will resolve both errors.

3. Insurer not found.

- This error indicates that the client is not properly linked with a board payer on the given claim's date of service. This typically means that the client's enrollment lists an effective date later than the claim's date of service or that the client was improperly enrolled with the incorrect board by enrollment staff.

- To resolve this, either submit a new enrollment with the correct, earlier effective date (the effective date should be the earliest date which the client began receiving services) or contact PartnerSolutions via the Helpdesk Ticket System to investigate further.

4. Claim place of service not found.

- This error indicates that the place of service (POS) code entered within the 837 file is not recognized by SmartCareMCO. This means that either no POS code was entered for the given claim or that the POS code '02' (Telehealth) was entered. Currently, SmartCareMCO does not recognize the '02' Telehealth POS code.

- To resolve this, simply rebill listing an appropriate POS code. In the place of the '02' Telehealth POS code, use the '11' Office POS code instead.

3. Common Unprocessed Reasons (Batch Claim Upload)

Refer to the **SmartCareMCO Provider User Manual, Section XI. Batch Claim Uploads** to review the process of importing and viewing a Batch Claim Upload Spreadsheet in SmartCareMCO. Here is the most common Unprocessed Reason we see in SmartCareMCO:

1. "XXXXX" Missing.

   - This error indicates that SmartCareMCO did not recognize a value for a specific field within the Batch Claim Upload Spreadsheet (i.e., InsurerId, SiteId, ClientId, FromDate, ToDate, BillingCode, Units, Charge, PlaceOfService, Diagnosis1). This usually means that the value was simply not entered within the spreadsheet.

   - To resolve this, simply correct the Batch Claim Upload Spreadsheet and resubmit the file. You may be contacted by PartnerSolutions regarding deleting your originally submitted errored file on your behalf.

4. Common Denial Reasons

Refer to the **SmartCareMCO Provider User Manual, Section XIV. Viewing Claims** for more information on searching for and viewing claims in SmartCareMCO. Here are the most common Denial Reasons we see in SmartCareMCO:

1. Add-On Code: corresponding base claim line has not been approved

   - This error indicates that the service is an add-on service and that its base claim line was not approved.

   - To resolve this, identify the base claim and discover why it was denied. Make the necessary correction to both claims and allow overnight re-adjudication. You can easily identify an add-on code's base claim by navigating to the Claim Line Detail screen and clicking on the Claim ID hyperlink (Not to be confused with the Claim *Line* ID). Refer to any additional claims sharing the Claim ID to locate the base claim and determine its denial reason.

2. Add-On Code: no corresponding base claim line found

   - This error indicates that the service is an add-on service but was not billed with a base claim. Add-on codes are only recognized when billed in conjunction with a base claim line.

- To resolve this, the claim will need to be rebilled alongside its corresponding base claim. You can easily identify an add-on code's base claim by navigating to the Claim Line Detail screen and clicking on the Claim ID hyperlink (Not to be confused with the Claim *Line* ID). If the add-on code was not billed alongside a base claim, no corresponding claim will be listed.

3. Claim line submitted with partial units

- This error indicates that the claim was not billed listing a whole unit amount. SmartCareMCO does not recognize partial units.

- To resolve this, rebill the claim listing the appropriate whole unit amount or correct the unit amount directly in SmartCareMCO. Refer to the *PS Billing Code and Billing Code Rules Report* available directly in SmartCareMCO by navigating to the My Reports QuickLink within the My Office menu. This report will list multiple details surrounding specific billing codes, namely a billing code's unit type.

4. Claim was received after the period mentioned in contract

- This error indicates that a claim was billed after the designated contract period has been terminated.

- Typically, the claim will no longer be payable in this case. In rare cases, you may file an appeal with your associated board to request payment for the claim. It is recommended to contact PartnerSolutions via the Helpdesk Ticket System to request an appeal with your board.

- Contract termination dates are typically outlined within the contract provided by your associated board. PartnerSolutions also has a notification process in place which will notify agencies via email ahead of time leading up to the termination of a contract period.

5. Invalid Diagnosis Code for Billing Code

- This error indicates that the diagnosis code entered within the claim is not allowable for the listed billing code.

- To resolve this, rebill the claim listing the appropriate diagnosis code or correct the diagnosis code directly in SmartCareMCO. Refer to the *PS Allowable Diagnosis Codes Report* available directly in SmartCareMCO by navigating to the My Reports QuickLink within the My Office menu. This report allows you to look up all allowable diagnosis codes for a specific billing code.

6. Invalid Service for Same Member on Same Date (NCCI MUE Edits)

- This error is the first of three with similar phraseology. “NCCI MUE Edits” are National Correct Coding Initiative Medically Unlikely Edits. These are rules put in place by the Centers for Medicare and Medicaid Services (CMS) to define the maximum units of a single service that a provider would report under most circumstances for an individual client on a single date of service. This error cannot be overridden. Claims denying for this reason usually indicate that the unit amount listed in the claim exceeds the daily unit cap for that service delivered to a single client on a single date of service.

- To resolve this issue, rebill the claim listing an appropriate unit amount or correct the unit amount directly in SmartCareMCO. Refer to the *PS NCCI MUE Lookup Report* available directly in SmartCareMCO by navigating to the My Reports QuickLink within the My Office menu. This report allows you to look up any limits associated with a specific billing code.

  Note: Though the error code seems to indicate that multiple provider agencies may have billed for the client for the same service on the same date of service, this is typically not the case. However, if you are unable to identify an obvious cause, it is recommended to contact PartnerSolutions via a Helpdesk Ticket to request further investigation. Additionally, if receiving this error in coordination with the error reason, “Same claim line exists,” this simply indicates that the claim is a duplicate.

7. Invalid Service for Same Member on Same Date (NCCI PTP Edits)

- This error is the second of three with similar phraseology. “NCCI PTP Edits” are National Correct Coding Initiative Provider-to-Provider Edits. These are rules put in place by the Centers for Medicare and Medicaid Services (CMS) to define billing codes that should not be reported together for an individual client on a single date of service for a variety of reasons. Some billing codes may be reported together only in defined circumstances, and the error can be overridden by listing an appropriate override modifier within the claim (XE – “Separate Encounter,” XS – “Separate Structure,” XP – “Separate Practitioner,” or XU – “Unusual Non-Overlapping Service”). Claims denying for this reason usually indicate that the claim lists a billing code which cannot be reported for the same client on the same date as another claim’s billing code which has already been approved or paid.

- To resolve this, determine if the edit can be overridden. If it can be overridden, rebill the claim listing the appropriate override modifier or add the override modifier directly in SmartCareMCO. Unfortunately, if the edit cannot be overridden, it will not be payable in the system. Refer to the *PS NCCI PTP Lookup Report* available directly in SmartCareMCO

by navigating to the My Reports QuickLink within the My Office menu. This report allows you to look up whether a specific billing code has any other billing codes which cannot be reported on the same date. Additionally, the *Ohio Department of Medicaid Behavioral Health Manual* as well as the *SmartCareMCO National Correct Coding Initiative (NCCI) and Ohio Department of Medicaid (ODM) Edits Report* available at https://partnersolutions.starkmhar.org/data-analytics/ list all available override modifiers and when to use them.

Note: Though the error code seems to indicate that multiple provider agencies may have billed for the client for the same service on the same date of service, this is typically not the case. However, if you are unable to identify an obvious cause, it is recommended to contact PartnerSolutions via a Helpdesk Ticket to request further investigation. Additionally, if receiving this error in coordination with the error reason, "Same claim line exists," this simply indicates that the claim is a duplicate.

8. Invalid Service for Same Member on Same Date (ODM PTP Edits)

- This error is the third of three with similar phraseology. "ODM PTP Edits" are Ohio Department of Medicaid Provider-to-Provider Edits. Similar to NCCI PTP Edits, these are rules to define billing codes that should not be reported together for an individual client on a single date of service. These, however, are put in place directly by the Ohio Department of Medicaid. This error cannot be overridden. Claims denying for this reason usually indicate that the claim lists a billing code which cannot be reported for the same client on the same date as another claim's billing code which has already been approved or paid.

- Unfortunately, as these cannot be overridden, claims denying for this reason cannot typically be corrected, unless it is simply a case where the incorrect billing code was listed on the claim. If this is the case, the claim should be rebilled listed the correct billing code or the billing code should be corrected directly in SmartCareMCO. Refer to the *PS ODM PTP Edits Lookup Report* available by navigating to the My Reports QuickLink within the My Office menu. This report allows you to look up whether a specific billing code has any other billing codes which cannot be reported on the same date.

  Note: Though the error code seems to indicate that multiple provider agencies may have billed for the client for the same service on the same date of service, this is typically not the case. However, if you are unable to identify an obvious cause, it is recommended to contact PartnerSolutions via a Helpdesk Ticket to request further investigation. Additionally, if receiving this error in coordination with the error reason, "Same claim line exists," this simply indicates that the claim is a duplicate.

9. LPN/RN as rendering provider requires ordering provider

- This error can be confusing, as this rule no longer applies for services rendered by an RN. This error indicates that a claim was billed listing a rendering provider credentialed as an LPN but that a required ordering provider was not listed alongside the rendering provider. All Medicaid-recognized services rendered by an LPN must include a valid ordering medical provider within the claim.

- To resolve this, the claim should either be rebilled adding the missing ordering provider, or the ordering provider should be added directly in SmartCareMCO. Refer to the *PS Rendering Provider Lookup Report* available directly in SmartCareMCO by navigating to the My Reports QuickLink within the My Office menu to look up specific rendering provider credentials.

10. Member is not eligible for any Plan

- This error indicates that the client does not have accurate board coverage on the claim's date of service. This usually means that the client's coverage plan was inappropriately terminated.

- When encountering this error, it's best to reach out to PartnerSolutions via a Helpdesk Ticket, as the client's coverage will need re-added. Sometimes, a new enrollment may need to be submitted.

11. Multiple Providers exceed the Billing Code Standard Allowed Units

- This error indicates that, for an individual client on a specific date of service, the billing code daily unit limit has been exceeded. Usually, this means that the claim itself lists a unit amount exceeding the limit, but it can mean that a separate provider agency has billed the same service for the client on the listed date. It is important to note, though, that if receiving this denial reason alongside the denial reason, "Same claim line exists," this simply means that the claim is a duplicate.

- To resolve this, either rebill the claim listing the correct unit amount or correct the unit amount directly in SmartCareMCO. Or, if the unit amount seems correct, and you see no other claims for the client for the listed date of service, submit a ticket to PartnerSolutions via the Helpdesk Ticket System, as it will need to be determined if another provider has billed for the same service. Refer to the *PS Billing Codes and Billing Codes Rules Report* available directly in SmartCareMCO by navigating to the My Reports QuickLink within the My Office menu. This report allows you to look up any rules, including unit limits, assigned to a specific billing code.

12. No rate can be found for this claim line

- This is the most common denial reason in SmartCareMCO. This error indicates that the claim as entered does not match any contracted rates in the system. This can be caused by a number of different issues related to distinct elements within the claim. Each issue requires different resolution. The following issues may cause this denial reason:

a. Your agency is not contracted for the listed billing code.

- Refer to your agency's Contract Rate Sheet. This Excel spreadsheet is distributed to all provider agencies prior to the start of each new State Fiscal Year. If you do not have this document, contact SmartCareSupport@starkmhar.org for a copy. Search both Medicaid and Non-Medicaid Eligible tabs within the spreadsheet to determine if the billing code is listed.

- Alternatively, refer to the *PS Provider Contract Rate Lookup Report* available directly in SmartCareMCO by navigating to the My Reports QuickLink within the My Office menu. Enter the necessary values within each required field to search for the desired billing code to determine if your agency is contracted for the service.

- If it is determined that your agency is not currently contracted for the billing code, the claim will not be payable in the system. If you believe that your agency should be contracted for the billing code, it is recommended to contact PartnerSolutions via the Helpdesk Ticket System to discuss with your board. In rare occasions, the board may determine to add the service to your contracted rates.

b. The claim was billed under the incorrect NPI Service Type.

- Some billing codes must be billed specifically under your agency's Mental Health (MH) or Substance Use Disorder (SUD) NPI (if applicable). Refer to your agency's Contract Rate Sheet. This Excel spreadsheet is distributed to all provider agencies prior to the start of each new State Fiscal Year. If you do not have this document, contact SmartCareSupport@starkmhar.org for a copy. Search both Medicaid and Non-Medicaid Eligible tabs within the spreadsheet for the desired billing code. The first column titled "Service Type" will list either "MH" for Mental Health or "SA" for Substance Abuse.

- Alternatively, refer to the *PS Provider Contract Rate Lookup Report* available directly in SmartCareMCO by navigating to the My Reports QuickLink within the My Office menu. Enter the necessary values within each required field to search

for the desired billing code. The column titled “Site Type,” will list either “MH” for Mental Health or “SA” for Substance Abuse.

- To determine which NPI Service Type the claim itself was billed under, while within the Claim Line Detail screen, look for the item titled “Site” within the Claim Line Information section. Next to your agency’s ID, either “MH” or “SA” will be listed. Ensure that this value matches what is applicable within your Contract Rate Sheet or *PS Provider Contract Rate Lookup Report*.

- If it is determined that the claim was billed under the incorrect NPI Service Type, simply rebill the claim under the correct NPI Service Type (This error cannot be corrected directly in SmartCareMCO, and the claim must be rebilled).

c. The claim is missing required modifiers or lists invalid modifiers.

- Refer to the *PS Provider Contract Rate Lookup Report* available directly in SmartCareMCO by navigating to the My Reports QuickLink within the My Office menu. Enter the necessary values within each required field to search for the desired billing code. Within the columns titled “Modifier1,” “Modifier2,” “Modifer3,” and “Modifier4,” you will be able to see any modifiers required for this billing code, including program modifiers specifically designated by the board (if applicable).

- If it is determined that any required modifiers are missing, either rebill the claim listing the appropriate modifiers or add those required modifiers directly in SmartCareMCO.

d. The Place of Service (POS) Code entered within the claim is not allowable for the listed billing code.

- Refer to the *PS Provider Contract Rate Lookup Report* available directly in SmartCareMCO by navigating to the My Reports QuickLink within the My Office menu. Enter the necessary values within each required field to search for the desired billing code. Within the column titled “PlaceofService,” all allowable POS Codes allowable for the billing code will be listed.

- If it is determined that the POS Code listed within the claim is not allowable, either rebill the claim listing an appropriate POS Code or update the POS Code directly in SmartCareMCO.

e. No rendering provider is listed within the claim when one is required, or the rendering provider listed lacks the appropriate credentials to deliver the service.

- Refer to the *PS Provider Contract Rate Lookup Report* available directly in SmartCareMCO by navigating to the My Reports QuickLink within the My Office menu. Enter the necessary values within each required field to search for the desired billing code. Within the column titled "License Types," all rendering provider credentials allowable for the billing code will be listed.

- Additionally, refer to the *PS Rendering Provider Lookup Report* available directly in SmartCareMCO by navigating to the My Reports QuickLink within the My Office menu. Enter the necessary values to search for a specific rendering provider to determine their associated credentials as well as credentialling effective dates. A list of all rendering providers within SmartCareMCO is also available from the SmartCareMCO Resources website and updated weekly at https://partnersolutions.starkmhar.org/data-analytics/.

- To determine the rendering provider listed within a specific claim, while within the Claim Line Detail screen, look for the item titled "Rendering Provider" within the Service/Charge section.

- If it is simply determined that no rendering provider was listed or that the incorrect rendering provider was listed, either rebill the claim listing the appropriate rendering provider or add the rendering provider directly in SmartCareMCO.

- Alternatively, if you believe that the rendering provider listed holds the appropriate credentials but that those credentials are not listed or are listed inaccurately in SmartCareMCO, it is recommended to contact PartnerSolutions via a Helpdesk Ticket. Oftentimes, PartnerSolutions can confirm whether a rendering provider's credentials need updated in the system and will do so. The claim will still either need to be rebilled or reprocessed manually in the system.

13. Pended claim was reviewed then denied

- This error indicates that the claim was originally pended due to a rule initially set up by a local board but was then denied after the board reviewed the claim.

- Typically, this cannot be resolved. However, if you have a question concerning why a specific claim was pended by a board, you should contact the board directly. In rare occasions, the board may review the claim again and release it for payment.

14. Same claimline exists

- This error indicates that a claim for the same service has already been approved or paid for this client on the same date of service. The error reason will list the original Claim Line ID. Simply hover your mouse over the denial reason text to view the entire message.

- Typically, since the service has been paid, nothing needs to be done, and this denial can be ignored.

15. Third Party Plan is fully responsible

- This error indicates that the client has active Medicaid coverage on the claim's date of service, and that the service is Medicaid payable.

- Typically, this indicates that the claim should instead be billed to Medicaid for payment. Sometimes, although rare, SmartCareMCO may have the wrong Medicaid data. If this seems to be the case, open a PartnerSolutions Helpdesk Ticket to resolve the issue.

  Note: You can always check a client's Medicaid ID and coverage directly in SmartCareMCO. First, search for the desired client by using the Client Search function. Type the client's name in the format of 'last name, first name.' Once within the Client menu, access the Client Coverage Plans Quicklink. Here, you will be able to see the client's Medicaid ID (if applicable) under the section titled Client Plans. The Medicaid ID will be under the Insurer ID column next to Medicaid. Within Plan Time Spans, by default, only current plans will be shown, Uncheck the 'Show Current Plans Only' checkbox to view all coverage spans. For more information, refer to **Section XIII. Viewing Client Information, subsection b.) Client Coverage Plans.**