Bulletin ID: No. 14 - Provider Payment Issues

As stated at the September 26, 2006 provider retreat, the Department of Mental Health ("DMH") is committed to resolving the existing provider payment issues. At the retreat, DMH reviewed a number of policies that were put in place to streamline the current process and we committed to evaluate its progress. While DMH has seen some progress on the number of claims adjudicated and warranted for provider payments it is still not at an acceptable level. In reviewing the current situation, DMH has identified and addressed the following issues.

1. Modifications to the Authorization Validation Edit

DMH made a system modification that no longer compares the accumulated authorizations request to a provider's task order. This means providers can submit an authorization request without regard to the task order limit, which has been identified by providers as a major barrier to submitting claims for payment. The accumulated claims amount will continue to be compared to the task order amount and all claims submitted that exceed the task order limit will be denied. This modification still requires the authorization plan and will continue to generate an authorization number that must be placed on the claim.

DMH has tested this process out with a large provider and saw immediate positive results meaning that a significant number of authorization plans that were previously denied upon entry for exceeding the agreement limit are now being approved. In addition to this modification, on October 12th, the IT department reset existing authorizations denied for Exceeding Agreement Limits to a status of Not Processed. These will be reprocessed within 48 hours by AutoAuth and thereafter if approved can be claimed against. To assist you with knowing which records were reset we are placing a listing of your denied authorizations in your download folder entitled Authorization denial reports which will be available by October 17th.

Please be aware that:

An authorization number does not guarantee claims payment against said authorization. Claims payment is based on, among other things, there being sufficient funds remaining in the task order.
Authorizations are still required but will not be validated against the authorization limits.
Claims will continue to be validated against the agreement limit based on task orders and any claims over the agreement limit will be denied.
DMH will continue to generate authorization position reports for your use.
Providers must continue to seek prior authorization and /or clinical approval for those services that require prior authorization and /or clinical approval.

2. Claims Payment Adjustment

A number of providers have complained that certain claims were submitted and appeared to have fallen into a "black hole." Our research revealed that payments for services delivered by sub- or specialty providers were being made to the Core Services Agencies where the consumers are enrolled, rather than to the sub- or specialty provider. Upon discovery of this issue, the

Department has corrected and has taken action (October 10th through October 13th) to restore funds that were not paid to a vendor and will be rescinding payments that were incorrectly paid.

3. Denied Claims Reports

While reviewing a denied claims report, the Department of Mental Health staff discovered that the report contained incorrect data. The report incorrectly classified claims that were reworked and adjudicated by DMH as denied claims; in essence, the report overstated denied claims. Based on further investigation this problem appeared to be isolated to the system logic used to generate this denied claims report. InfoMC is aware of this problem and they are currently working to correct the problem. We will keep you informed of the progress that is made toward correcting this problem.

We will continue to monitor closely the payment system and ensure that legitimate claims are processed and paid in a timely manner.