10. CLAIMS PROCESSING

This section outlines details of the claims payment process and related matters.

10.1 TIME LIMITS

Claims must be submitted within 90 days from the date services are completed. However, in the case of long-term care such as extended hospitalization, claims must be submitted at least every 90 days **and** within 30 days of discharge.

Late claims should be sent as a separate batch apart from regular claims. A letter referring to the batch number, giving a full explanation for the delay, should be sent to the Claims Processing Manager.

PLEASE DO NOT WAIT UNTIL THE DEADLINE. Claims may be sent to MCP in small or large batches, but we encourage physicians to send batches to us at least twice a week. This allows MCP to process claims in a timely manner. Sometimes, physicians save their batches and do not transmit the majority of their claims to MCP until the deadline for submissions (the cut-off date). If there is a problem with a batch, this may result in physicians not receiving payment when it is expected.

10.2 CUT OFF AND PAY DATES

MCP has established twenty-six, two-week periods within the calendar year for the processing and payment of claims. Cut-off periods always end on a week day. Because a cut-off period cannot fall on a Statutory Holiday, a cut-off date that would, for example, fall on Monday May 22, 2006 (Victoria Day) would be moved ahead to the next day, Tuesday, May 23, 2006. Claims received after 3 p.m. on a cut-off date will be processed for payment in the next period. Claims processed in a two-week cycle are paid 21 days after the period cut-off. For example, if a cut-off date is Tuesday, February 28, 2006, the corresponding payment date would be Tuesday, March 21, 2006. A list of cut-off dates for the processing periods and the corresponding payment dates is published in a Newsletter shortly before the beginning of each calendar year. Access to MCP Newsletters is available on the internet at www.health.gov.nl.ca/mcp under the "Provider Information" link.

10.3 CLAIMS PROCESSING

The processing and payment of claims at MCP can be described in a series of steps or stages. The following is a brief overview:

10.3.1 Receipt

Every claim must have its own unique claim number. Within each claim (number), up to 99 items of service can be billed (99 lines). The computer automatically generates a claim and item number whenever a new claim item is keyed into the computer.

A collection of claims from one physician, submitted at the same time, is called a "batch". Batches are commonly referred to as "files" in computer terminology and each file has its own file name. For example, the file number shown on this screen is 91111150.011.

Once a batch has been submitted, the computer generates a new claim number when data entry for the next batch has begun.

Files should contain the claims of one physician only. Several files, containing the claims of a number of physicians may be grouped into one transmission.

When claim files are electronically sent to MCP, they are immediately acknowledged by a return message from the MCP computer. **Physicians should ensure that an acknowledgement is received from the MCP computer when files are transmitted. If files are transmitted and an acknowledgement is not received, the transmission was, in all likelihood, not completed.** If this occurs, the transmission should be attempted again. If the second attempt fails, MCP should be contacted as soon as possible.

10.3.2 Validation

All claims are subjected to an extensive computerized validation process to detect any errors or omissions. Claims that do not pass the verification process are either rejected for review by MCP staff or returned to the physician. Other claims are returned to physicians with instructions for correction and return.

10.3.3 Assessment

Claims which meet the validation criteria are subjected to a comprehensive computerized assessment process. In this process, the service is compared to other claims in each

patient's history. Claims which do not meet the assessment criteria are either changed or cancelled automatically or are rejected for manual review by MCP staff . At this point, some manually assessed claims are reprocessed. Other claims are held while the physician is asked to provide clarification and/or additional information. Some claims are returned as not payable because of General Preamble provisions.

During this stage, claims meeting the assessment criteria are added to each patient's claims history for use in the assessment of future claims.

10.3.4 Payments

In the payment step, the claims processed during the payment period are tabulated to produce bank deposits and remittance statements for each physician. Also, during this stage several management and control reports are produced for internal control at MCP.

Remittance statements are available through the electronic claims system. They can be retrieved electronically at any time once posted or upon the next claim file submission.

10.4 CLAIM REQUESTS AND NOTICES

10.4.1 Claim Categories

Claims received at MCP are entered into a computerized processing system where they are subjected to extensive validation and assessment criteria. Those claims which do not meet one or more of the validation rules are rejected for review by MCP staff. During the normal review, many of the claim items are corrected or judgement is exercised and the items are processed for payment.

Certain claims, because of errors or omissions, or due to the nature of the service claimed, require further information from the physician. These may be categorized as follows:

- Claims which have essential data missing, are incomplete or contain errors. These are usually detected at the validation stage.
- Claims which do not pass our computerized assessment rules—where the Claims Assessor feels additional supporting information or clarification is required.
- Claims which were processed and accepted for payment recently which now are questioned because additional claims have been presented for that patient.

10.4.2 Requests for Information—Turn Around Documents (TAD's)

Notices are produced for those claim items for which additional information is requested.

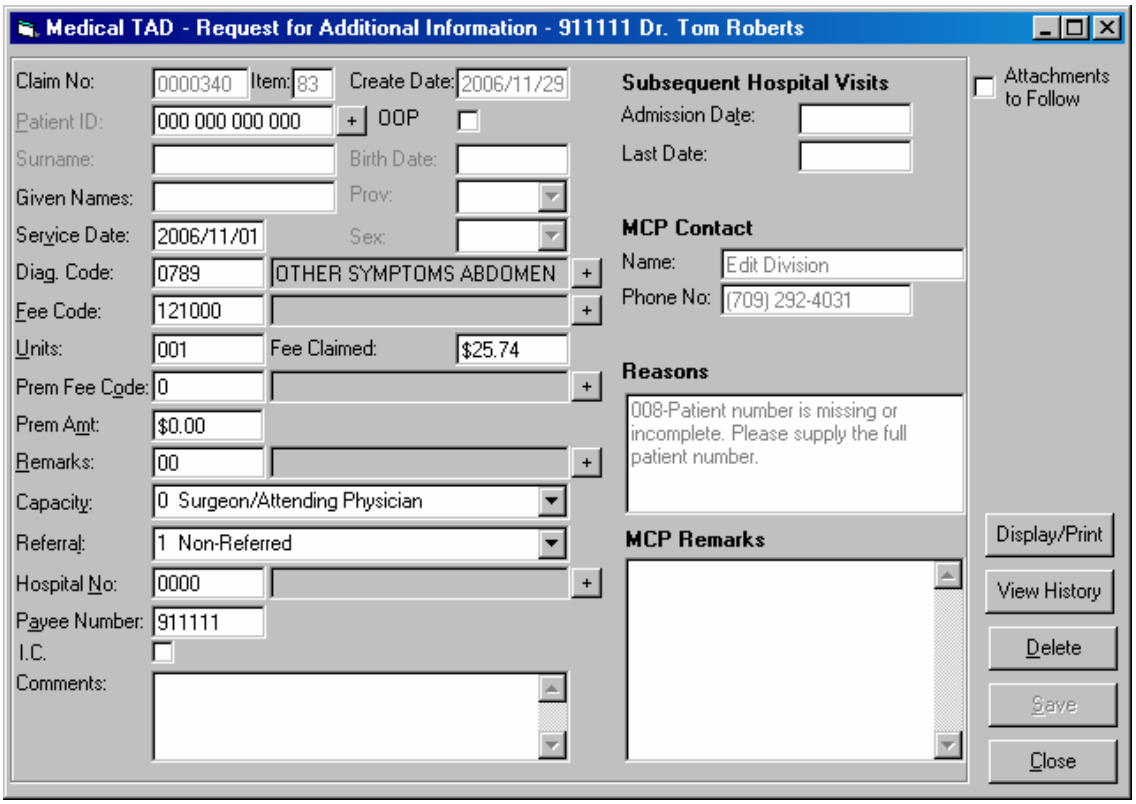
These TADS, which MCP sends electronically or in paper form, contain the following:

- The physician's name and number.
- The date issued.
- The reason for the information request. This will consist of a Reason Code and a brief explanation of what is incorrect or why the information is requested.
- The claim item is printed as it appeared on the claim.
- Space is available for physician's comments in which additional information may be entered to support the claim or provide clarification.
- The name and/or division of the MCP staff member who sent the document. Any queries should be directed to his/her attention.

The necessary corrections, clarification, etc. should be entered as appropriate and returned to MCP as soon as possible.

A second, final request will be sent if a response is not received within 60 days. If there is no response to the second request after a further 30 days, the claim items will be cancelled or recovered. **It is in a physician's best interest** to respond promptly to requests for information. When claim items are cancelled or recovered as a result of "no response" to the request, the physician will be notified by letter.

In this example, the claim was submitted to MCP with the Patient ID number missing. The doctor's office must enter the number in the usual location and resend.

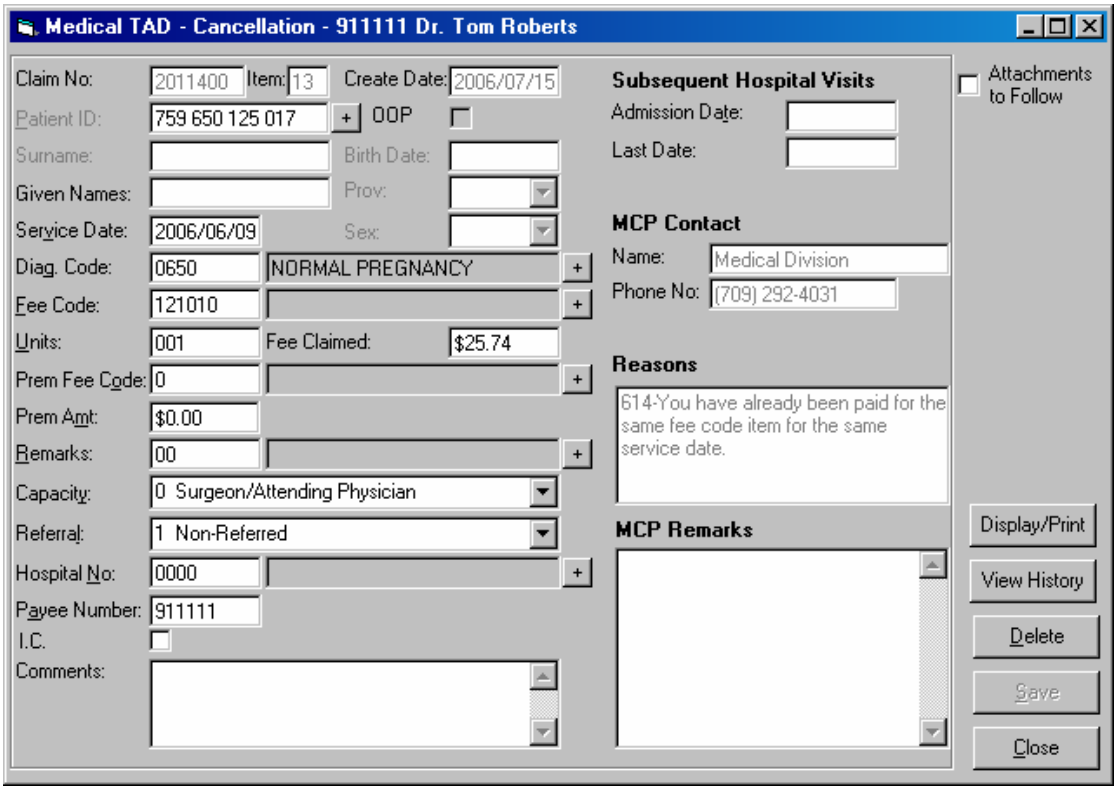


10.4.3 Notice of Cancellation

In certain cases, MCP may find it necessary to cancel a claim item. When this occurs, the physician will receive a Notice of Cancellation. If the situation is such that information can be provided to support the reinstatement of the claim, this should be done in the same manner as is outlined under the preceding section—Requests for Information.

When notices of cancellation are received, the physician's record of outstanding claim items should be updated accordingly. This will eliminate subsequent queries to MCP to determine why the claim has not been paid. This procedure applies both to records contained in a computerized claim system and paper claim records.

In this example, the doctor's office inadvertently billed MCP twice for the same service.



10.5 METHOD OF PAYMENT

Physicians are paid via electronic bank deposit. Under this method, the payment for the period is transferred electronically to a bank of the physician's choice. The funds are deposited on the published payment date.

10.6 UNPAID CLAIM INQUIRIES

Outlined below are procedures to follow in making enquiries on unpaid claims. These have been designed to expedite MCP's response to your enquiries:

- Before enquiring, check Remittance Statements to ensure the item(s) have not already been paid. (Refer to Section 10.8—Remittance Statement for explanation and example.)
- Check correspondence from MCP to ensure the item(s) have not been returned previously or are cases where MCP has requested additional information which has not been sent.
- Send enquiries to the attention of Claims Processing with the item(s) queried clearly indicated. Enquiries without proper information will be returned unchecked. (Electronically produced lists should be double spaced, claim item(s) in numeric order by claims and by item within claim number, and have patient name, PIN, date of service, fee code, and fee claimed.)
- Wait until four payment periods have elapsed since the claim submission date before making an enquiry. Enquiries must then be submitted within one month of the expiration of the waiting period.

10.7 CLAIM APPEAL PROCEDURES

Physicians have the right to request a review of claim assessment decisions directly to MCP. Most matters related to the settlement of claims can be resolved by contacting Claims Assessing. Failing resolution at this level, the claims will be referred to Management. Issues which are not resolved at this level will be taken to the Medical Advisory Committee. When requesting a claim assessment review, physicians should quote the claim number and line item number as indicated on the Remittance Statement.

10.8 REMITTANCE STATEMENT—ELECTRONIC MEDIA

Remittance Statements are placed in a computer file which the physician may retrieve via telephone link with MCP's computer system. The statement on the MCP computer system may

be retrieved when claims are submitted or by a connection to MCP made solely to retrieve the Remittance file.

These electronic Remittance Statements consist of two separate computer files.

10.8.1 Text remittance statements include the full information as follows, a text file which the physician is able to display and/or print on a computer. It should be printed, acted upon as necessary, and retained as a permanent record of MCP claim and other activity. An example is shown at the end of this section.

- **Bulletins and Messages—**This section contains information that MCP wishes to distribute to physicians.

- **Legend of Standard Claim Reason Codes—**Claim items paid for an amount or with a fee code different than that claimed, have a Reason Code shown opposite that item on the Remittance Statement. These Reason Codes have been inserted automatically by our computerized assessment process or by an Assessor in Claims Processing. Commonly used explanations are called "Standard Codes". If the Reason Code does not provide a satisfactory explanation, or, if there is a problem with the results of the assessment, queries should be directed to the Assessing Division of the Claims Department.

- **Legend of Special Claim Reason Codes—**Claim items paid for an amount or with a code different than that claimed have a Reason Code shown opposite that item on the Remittance Statement. When the explanation provided is not commonly used, Reason Code **999** will appear on the statement opposite that item. You will find the explanation for this "Special Claims Reason Codes" listing under the claim number concerned.

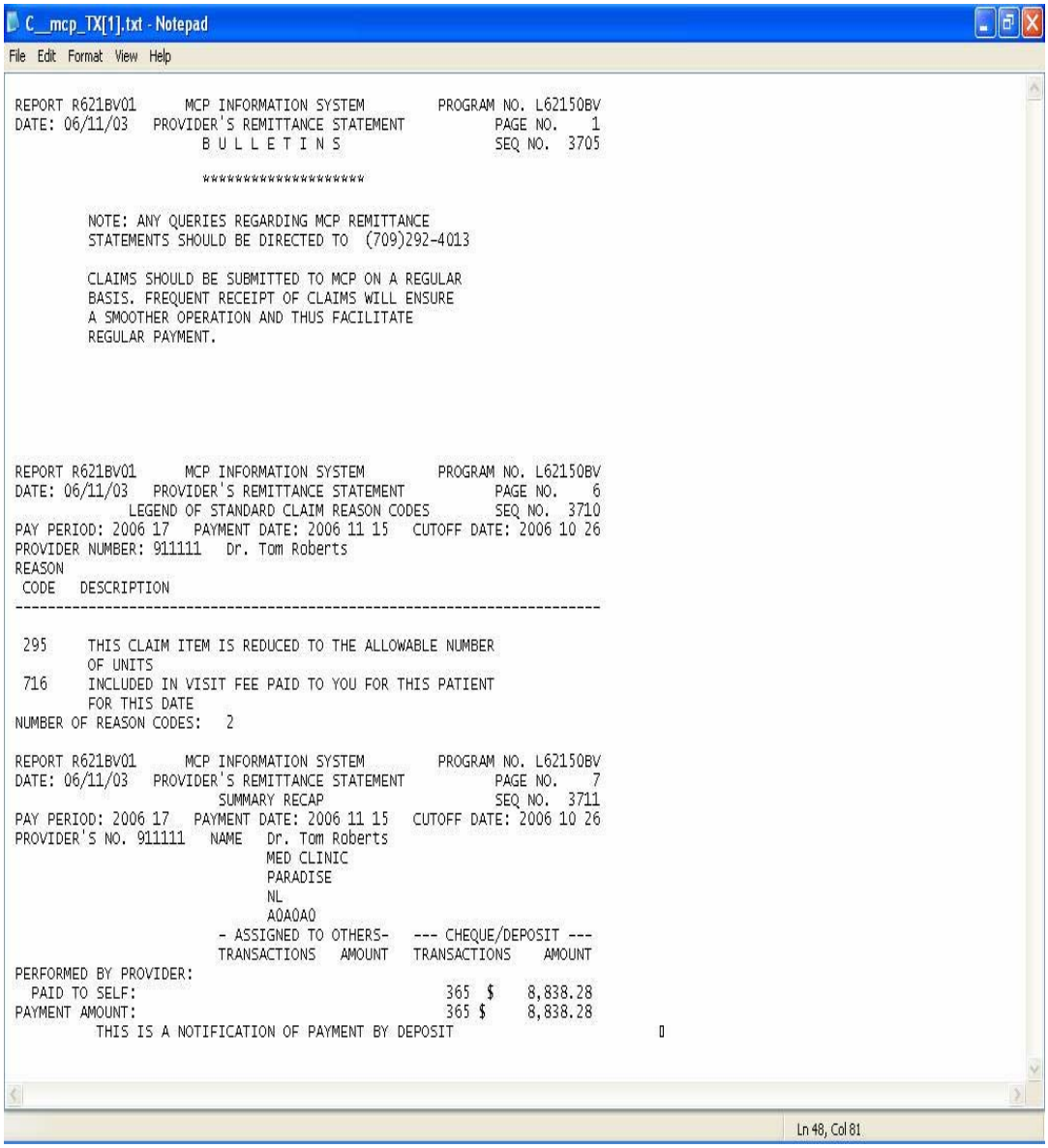
- **Summary Recap—**This is a summary of the amounts of claims paid. There are three categories of assigned payment arrangements:

  - claims for services performed by the physician and paid to the physician
  - claims for services performed by the physician and paid to another physician or institution
  - claims submitted by another physician and paid to you as the payee

  These payments to and from other physicians only appear when the assigned payment arrangements are in place with MCP.

- **Financial Adjustments Total—**This is a total of any financial adjustments and a final total of the payment for the period.

Example of Text Remittance Statement



C__mcp_TX[1].txt - Notepad

File Edit Format View Help

```
REPORT R621BV01      MCP INFORMATION SYSTEM         PROGRAM NO. L62150BV
DATE: 06/11/03   PROVIDER'S REMITTANCE STATEMENT           PAGE NO.    1
                       B U L L E T I N S                   SEQ NO.  3705

                       **********

         NOTE: ANY QUERIES REGARDING MCP REMITTANCE
         STATEMENTS SHOULD BE DIRECTED TO  (709)292-4013

         CLAIMS SHOULD BE SUBMITTED TO MCP ON A REGULAR
         BASIS. FREQUENT RECEIPT OF CLAIMS WILL ENSURE
         A SMOOTHER OPERATION AND THUS FACILITATE
         REGULAR PAYMENT.




REPORT R621BV01      MCP INFORMATION SYSTEM         PROGRAM NO. L62150BV
DATE: 06/11/03   PROVIDER'S REMITTANCE STATEMENT           PAGE NO.    6
              LEGEND OF STANDARD CLAIM REASON CODES        SEQ NO.  3710
PAY PERIOD: 2006 17   PAYMENT DATE: 2006 11 15   CUTOFF DATE: 2006 10 26
PROVIDER NUMBER: 911111   Dr. Tom Roberts
REASON
 CODE   DESCRIPTION
--------------------------------------------------------------------------

 295     THIS CLAIM ITEM IS REDUCED TO THE ALLOWABLE NUMBER
         OF UNITS
 716     INCLUDED IN VISIT FEE PAID TO YOU FOR THIS PATIENT
         FOR THIS DATE
NUMBER OF REASON CODES:   2

REPORT R621BV01      MCP INFORMATION SYSTEM         PROGRAM NO. L62150BV
DATE: 06/11/03   PROVIDER'S REMITTANCE STATEMENT           PAGE NO.    7
                       SUMMARY RECAP                       SEQ NO.  3711
PAY PERIOD: 2006 17   PAYMENT DATE: 2006 11 15   CUTOFF DATE: 2006 10 26
PROVIDER'S NO. 911111   NAME   Dr. Tom Roberts
                               MED CLINIC
                               PARADISE
                               NL
                               A0A0A0
                        - ASSIGNED TO OTHERS-   --- CHEQUE/DEPOSIT ---
                        TRANSACTIONS   AMOUNT   TRANSACTIONS    AMOUNT
PERFORMED BY PROVIDER:
  PAID TO SELF:                                    365  $    8,838.28
PAYMENT AMOUNT:                                    365 $     8,838.28
         THIS IS A NOTIFICATION OF PAYMENT BY DEPOSIT                    0
```

Ln 48, Col 81

10.8.2 The Remittance Detail Report consists of the detailed claims paid. This section, called a **Reconciliation Report**, contains information on claim items processed for payment within the processing cycle. There are normally one or more pages listing claim items submitted by a physician and paid to that same physician. It may also contain pages which list claims submitted by one physician and paid to another physician under assigned payment. Each group of claims in the three categories listed in the Summary Recap will be listed separately. The totals of each group are listed in the Summary Recap.

Example of a Remittance Statement (Reconciliation Report)