

## Cardinal Care Provider Appeal, Claims and Billing Flow Chart



Providers who have received a claim (payment) denial from DMAS may wish to submit a new claim that includes corrections on the claim instead of filing an appeal. If you are unclear about why the claim was denied, DMAS encourages you to contact the **Provider Helpline at (800) 552-8627** before deciding whether to file an appeal. If an appeal is filed, it will **only** address the denial reason(s) set forth on the remittance advice. **Filling an appeal does not correct the denial reason(s) nor does an appeal involve reprocessing claims.** If you are seeking to correct your claim, do so and resubmit your claim with the claim corrections for payment rather than filing an appeal. Denial codes and resolutions can be found on the new Claims and Billing webpage at <a href="https://www.dmas.virginia.gov/for-providers/claims-and-billing/">https://www.dmas.virginia.gov/for-providers/claims-and-billing/</a>

Resubmitted claims will be processed as quickly as possible and paid 30 days or less. If another denial occurs, that remittance advice will have the new claim denials (edits) that will need to be resolved with a refiled claim. If needed, each claim will have new appeal rights with DMAS.

As a reminder, always check a member's eligibility before any Cardinal Care Medicaid services begin. DMAS provides Providers two self-service systems to check Member eligibility, claims status, check amounts, service authorizations and service limits. The Medicall System instructions can be found at <a href="https://www.dmas.virginia.gov/media/4oyhhcwc/how-to-use-medicall.pdf">https://www.dmas.virginia.gov/media/4oyhhcwc/how-to-use-medicall.pdf</a> The Medicaid Enterprise System (MES) information can be found at <a href="https://vamedicaid.dmas.virginia.gov/provider">https://vamedicaid.dmas.virginia.gov/provider</a>

If you have CCMC claims and billing questions, please see telephone number and links for each below.

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CCMC Plan	Provider Help Number	CCMC Plan Claims website
Aetna Better Health	(800) 279-1878 (TTY:711)	https://www.aetnabetterhealth.com/virginia/providers/index.html
Anthem Health Keepers	(800) 901-0020 (TTY:711)	https://providers.anthem.com/virginia-provider/home
Molina HealthCare	(800) 424-4518 (TTY:711	https://www.molinahealthcare.com/providers/va/medicaid/home.aspx
Sentara Health Plan	(800) 229-8822 (TTY:711)	https://www.sentarahealthplans.com/providers/billing-and-claims
United HealthCare	(844) 284-0146 (TTY: 711)	https://www.uhcprovider.com/

The flow chart below demonstrates the different steps of what happens to a claim that is submitted to DMAS. The claim can either pay, be denied and resubmitted by provider making the required corrections or Appealed. We also show suggestions on what to check when utilizing a billing company.

Provider submits a claim according to all instructions

Provider receives remit showing claim processed & will pay

Provider receives payment the following week after claim is adjudicated

Provider receives claim denial & elects to correct claim issue(s) & resubmit

Provider reviews DMAS
website for claims
resolution or calls
Provider Help line to ask
claims questions

Provider refiles corrected claim

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Provider receives remit showing claim either denied or processed. If denied correct the new denial reason(s) & resubmit

Resubmitted corrected claim the Provider receives payment 30 days or less for properly refiled submitted claim Provider receives claim denial with appeal rights & elects to file Appeal

DMAS Appeals Unit has 180 days to respond with a summary decision

Provider loses Appeal because claim wasn't filed correctly

If Provider still needs to rebill correctly to receive payment

Filing an Appeal does not fix a claim if not refiled correctly

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If Provider doesn't rebill correcting issues no payment made.

Provider sends service information to Billing Company (BC) to bill DMAS

BC completes claim and submits to DMAS

BC receives remit for claims including denied claims

Check if the BC Appeals Claim Denials instead of correcting denial reasons and resubmit for payment

Check to see BC receives notice Appeal was lost & reason is claim not submitted correctly

Check to see BC writes off claim instead of correcting and resubmitting claims

Please ensure your BC is communicating with you on claim denials & Appeal notices



5/21/24