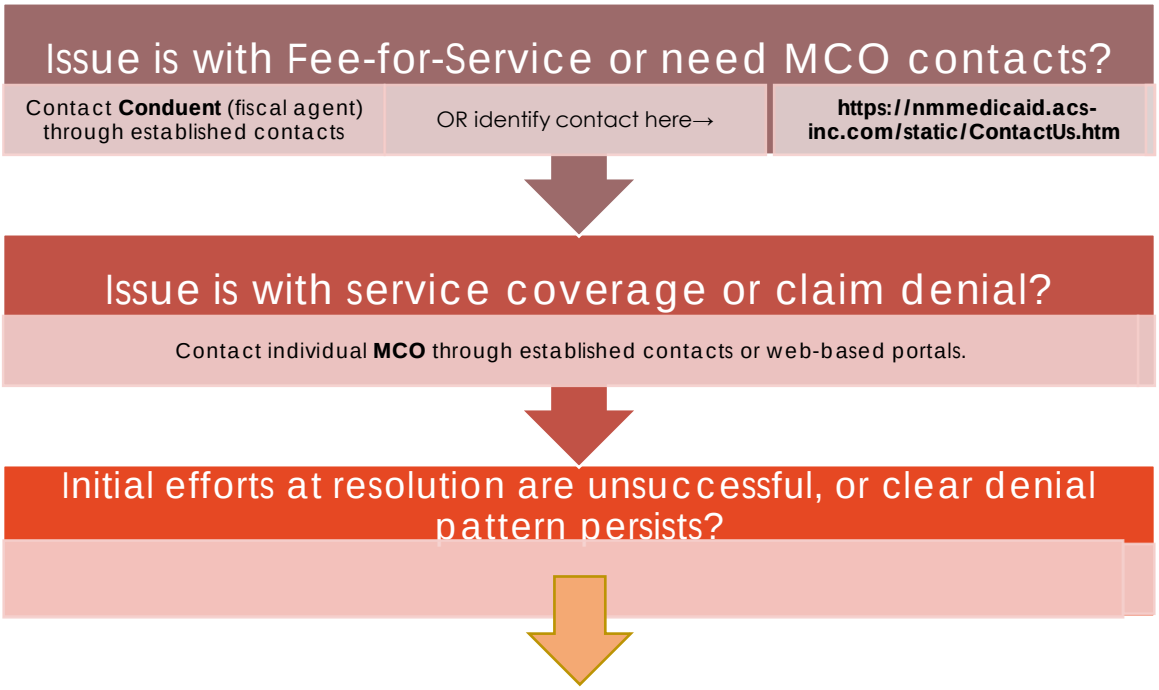
Troubleshooting Claims Submission & Payment

- In order to rapidly identify any problems and/or patterns of claims denial, it is recommended that hospitals establish a plan to examine data at regular intervals on claims submitted and payment received.
- The flowchart below identifies steps in following up on any identified concerns:



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Suggested Template for LARC Claims Data Monitoring

- The template below represents a summary of relevant data points.
- Also consider designing data pulls to include categories such as, ***denials by payer***, ***denial trends***, or to fit with other institutional plans for claims-data analysis.

Total Procedures IP Medicaid Primary or Secondary					
Count of Procedures	**Column Labels**				
Payer	**J7300 (Paragard)**	**J7298 (Mirena)**	**J7297 (Liletta)**	**J7307 (Nexplanon)**	**Grand Total**
(All Centennial Care MCOs allow separate billing for IPP LARC.)					
Grand Total					

Total Denials					
Count of Denial Amount					
Row Labels	**J7300**	**J7298**	**J7297**	**J7307**	**Grand Total**
Attach/Doc. required to adjudicate claim					
Claim lacks info needed for adjudication					
Duplicate claim/service					
Non-covered charge(s)					
The provider is not eligible to perform service					
The time limit for filing has expired					
This procedure is not paid separately.*					
Grand Total					
Denied as % of Performed					

Total Paid					
	J7300	**J7298**	**J7297**	**J7307**	**Grand Total**
Count of Payment					
Paid as % of Performed					

Total Pending

	J7300	**J7298**	**J7297**	**J7307**	**Grand Total**
Count of Pending					

(Template by UNMH Financial Services, 2016)

This reason for denial should NOT occur per Medicaid policy, and should be investigated.