SAMPLE COUNTY HEALTH DEPARTMENT

**Policy and Procedure**

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| Manual: **Administrative Policy Manual** | Applicable Signatures/Title |
| Title: **Review/Rebilling Denied Claims** | Program Coordinator/Specialist: |
| Chapter: | Supervisor: |
| **⁭** Program Policy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Program | Supervisor: |
| ⁭ Program Procedure: \_\_\_\_\_\_\_\_\_\_\_\_\_\_Program | Supervisor: |
| **X** Management/Department-wide Policy | Supervisor: |
| ⁭ Personnel/Fiscal Policy | Supervisor: |
| ⁭ Standing orders | Director of Nursing: |
| Distributed to: | Health Director: |
| Board of Health Chair: | Effective Date: 4-1-2017 |
| Medical Director: | Supersedes: |

**Purpose:** This policy is intended to establish guidelines for Medicaid billing and handling and/or rebilling of Medicaid denials.

**Policy:** It is the policy of Sample County Health Department to bill Medicaid no later than twelve (12) months from the original date of service. Sample County Health Department will review the Medicaid Remittance Advice for denials and non-payment of services submitted to Medicaid on a weekly basis. Denials will be corrected as appropriate and rebilled at least once a month.

**Definitions:**

Remittance Advice (RA): document received from Medicaid/NCTracks which details what services were billed, paid, or denied.

Explanation of Benefits (EOB): document received from third party insurance which details what services were billed, paid or denied.

**Applicable Law, Rules and References:**

N/A (unless you reference this in other policies)

**Responsible Person(s):**

This policy applies to all lead billing and Management Support staff.

**Equipment Required:**

\_\_\_\_\_\_\_\_\_\_\_ EMR

**Patient Preparation/Teaching/Documentation:**

N/A

**Procedures:**

A. Patients will electronically sign a consent allowing the Health Department to file insurance and a copy of the insurance card will be scanned at that time into the patient’s medical record

B. Claims are filed electronically using ­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_. Payments are posted  
electronically to patient accounts. If applicable, secondary insurance is filed.

C. Denials will be researched using the Remittance Advice (RA) for Medicaid and EOB’s for private insurance. Lead billing staff will work with providers to correct the claim and then submit for payment.

D. Any remittance or final denial will be posted to the patient’s account. Remaining balance for Medicaid clients will be adjusted off.

**Reference Plans and Policies: N/A**

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