

## 6 Receiving Reimbursement

This chapter describes the Remittance Advice (RA) report and the reimbursement schedule for Medicaid fee-for-service claims. A RA is an explanation of payment and claims processed in either a proprietary format or the HIPAA 835 transaction. Information in this section is in accordance with Alabama Medicaid Agency policy and procedure as well as Section 1104, Administrative Simplification, of the Affordable Care Act (Operating Rules) which includes Electronic Fund Transfer (EFT) and Electronic Remittance Advice (ERA).

### Effective July 2015:

All billing providers must be enrolled to receive an 835/ERA (electronic remittance advice). If already enrolled to receive 835s you do not need to re-enroll. For providers newly enrolling in Medicaid and/or enrolling a new site with Medicaid, the 835/ERA enrollment is part of the standard enrollment application.

Alabama Medicaid will begin releasing ERA/835's within three (3) business days (plus or minus) of the EFT being released. This is a change to current day processes where the 835/ERA is made available to providers even when funds related to the 835/ERA have not yet been released.

Note: There is currently no change to the availability of the proprietary RA which will continue to be available on the web portal following each check write cycle. Providers will also receive a 277U (Unsolicited) transaction along with their proprietary RA. The Unsolicited Claim Status transaction, returned once a claims payment cycle has completed, reports all claims adjudicated to a suspended status.

### NOTE:

Reimbursement information specific to managed care is described in Chapter 39, Patient 1<sup>st</sup>, of this manual.

### 6.1 Remittance Advice (RA) Report

It is the responsibility of each provider to follow up on claims submitted to HPE. The Remittance Advice (RA) is a vital tool for this process. The RA indicates claims that have been adjudicated (paid or denied) and lists claims that are currently in process (suspended claims). Providers are urged to examine each RA carefully and to maintain the document for future reference. Claims listed as claims in process are being processed and will appear on one of the next two RAs as paid, denied, or still in process.

Effective March 1, 2010, Medicaid no longer prints and distributes paper RAs to providers. A provider can receive an electronic copy of the RA or download a copy from the WEB. The electronic copy is the 835 Health Care Claim Payment/Advice. The electronic media has been expanded to include more information. Providers wishing to receive the 835 must be assigned a

‘submitter ID’ and an indicator must be set in the system to generate the electronic report. *The Electronic Remittance Advice Agreement Form is available on the Alabama Medicaid website.* All payee providers (individuals not within a group, groups and facilities) must also be enrolled in EFT.

The EOB (Explanation of Benefit) code that displays next to a paid or denied claim explains the adjudication of the claim. A provider who wishes to question a paid or denied claim should do so by calling the HPE Provider Assistance Center at 1(800) 688-7989. To request an adjustment of a previously paid claim, refer to Section 5.10, Adjustments, for more information.

Any claim that does not appear on an RA within forty-five working days from the time of submission should be resubmitted immediately. Before resubmitting, please verify that the claim has not been returned to you for correction or additional information.

Providers are required to maintain a copy of each claim submitted. The claim copies should be used for comparison if there are questions concerning the disposition of claims as shown on the RA.

### **6.1.1 Provider Remittance Advice (RA)**

Twice a month, providers are issued a single remittance check or Electronic Funds Transfer (EFT) transaction for all claims that have been processed for payment for that checkwrite’s pay period.

The RA displays the paid or denied status of adjudicated (settled) claims, as well as lists claims currently in process, claims credited to the Medicaid Agency, and any refunds that are processed. The sections of the RA are described in the following paragraphs.

Each page displays the payee provider’s submitter ID, name, address, National Provider Identifier (NPI) and the service location name, if different from the payee name, printed as it currently appears on HPE’ provider file. The RA number and checkwrite date display on each page of the RA as well.

The columns that display at the top of every page correspond to the header information in the sections that list paid and denied claims. Detail information for each claim has heading descriptions on each claim.

Claim data pages sort together by claim type, then in Adjusted, Paid, Denied and In Process within claim type. The exception is Inpatient Encounter claims. These claims sort within the inpatient claim type following each inpatient claim status section.

#### **First Page**

A “Banner Message” from HPE appears on this page. The “Banner Message” delivers information to the provider community and includes updates to current policies and procedures.

#### **Paid Claims**

The RA lists a payment for each claim in alphabetical order by recipient last name.

Claims are grouped by claim type, with a total for each. A grand total of paid claims and paid amounts displays at the end of this section.

Paid claims may include an EOB code to provide more information about the payment amount. For example, a provider may bill an amount higher than Medicaid allows for a procedure. The EOB code next to this paid claim explains why the provider received a lower payment than he submitted.

Paid claims have been finalized. No additional action will be taken on them unless the provider or Medicaid requests an adjustment and makes appropriate corrections.

### **Denied Claims**

The RA lists each denied claim in alphabetical order by recipient last name. An EOB appears beside each claim. Please reference the listing at the end of each RA that defines the codes used on that RA.

Claims are grouped by claim type, with a total for each. A grand total of denied claims and billed amounts displays at the end of this section.

Denied claims are finalized. No additional action will be taken on them unless the provider makes appropriate corrections and re-files the claim. This section also includes denied adjustments.

### **Claims In Process**

The Claims In Process section of the RA lists claims currently in process for the provider, in alphabetical order by recipient last name. Claims that appear in this section are paid, denied or suspended as appropriate on a future RA. Providers should not submit inquiries or resubmit suspended claims as long as they appear on the RA as suspended. If a claim appears in this section for more than two remits, please contact the HPE Provider Assistance Center to verify the status of this claim.

### **RA Claim Page Field Descriptions**

Most of the field descriptions for each of the claim type Adjusted, Paid, Denied, and In Process are the same. Each claim type/Status may have fewer of the fields and a few have fields specific to the claim type. For example, Dental contains tooth references, Drug contains NDC codes.

The following table lists the fields in all the claims sections. The table includes all fields that display on all claim types. The Adjustments pages contain a few more fields that are described in the next section.

Note: The fields listed in the following tables are based on information available at the time of publication. The information is subject to change based on further review.

<i>Field</i>	<i>Description</i>
Name	Displays the recipient's last name, and first name. Claims are displayed in alphabetical order by last name.
Pat Acct No.	Displays the Patient Account Number assigned to the recipient by the provider.

<b>Field</b>	<b>Description</b>
ICN	Displays the internal control number of the claim. Use this number when inquiring about the claim.
MRN	Displays the Medical Record Number assigned to the recipient by the provider.
Rendering Provider	Displays the National Provider Identifier (NPI) of the rendering provider.
Attending ID	Displays the National Provider Identifier (NPI) of the attending physician, if applicable.
Recipient ID	Displays the 12 digit recipient Medicaid ID number as submitted by the provider.
Admit Date	Displays the admitting date submitted on the claim, if applicable.
Dispense Date	Displays the dispense date submitted on the claim, if applicable.
Days	Displays the number of days submitted on the claim, if applicable.
Dates Of Service First Date Of Service - Last Date Of Service,	Displays the dates of service submitted on the claims in MMDDYY format. This displays for each line item billed, if applicable.
Dist Plan (District Plan)	Displays the District Plan Code for the inpatient claim, if applicable
Surf (Tooth Surface)	Displays the tooth surface on the detail line, if applicable.
POS Or PL SERV (Place Of Service)	Displays the place of service as submitted on the claim, if applicable.
TN (Tooth Number)	Displays the tooth number on the detail line, if applicable.
Procedure/Revenue/ NDC Code	Displays these codes as they were submitted on the claim. This displays for each line item billed, if applicable.
Modifiers	Displays the procedure code modifiers as they were submitted on the claim.
Desc	Displays the first six characters of the NDC code description
Billed Amount	Displays the amount billed on the claim. This displays for each line item billed, if applicable.
Non Allowed	Displays the amount of the billed amount that Medicaid will not cover. This displays for each line item billed, if applicable.
Allowed Amount	Displays the amount of the billed amount that Medicaid will cover. This displays for each line item billed, if applicable.
Patient Liability	This displays the patient liability applied to the claim payment, if applicable.

<i>Field</i>	<i>Description</i>
TPL Amount	Displays the amount paid by a third party insurance. This displays for each line item billed, if applicable.
Paid Amount	Displays the amount Medicaid paid the provider for the claim. This displays for each line item billed, if applicable.
HEADER And DETAIL EOBS	Displays an Explanation Of Benefit code about claim adjudication. This displays for each header and line item billed, if applicable.
Copay Amount	This displays the copay applied to the claim payment, if applicable.
QTY Or UNITS	Displays the quantity or units submitted.
Rx No.	Displays the prescription number.
Total Billed	Displays the total billed for all the claim.
Total Non-Allowed	Displays the total payment that Medicaid will not cover for all the claims.
Total Allowed	Displays the total allowed amount for all the claims.
Total Patient Liability	Displays the total patient liability for all the claims.
Total Copay Amount	Displays the total copay for all the claims.
Total TPL Amount	Displays the total TPL for all the claims.
Total Paid Amount	Displays the total amount of Medicaid payment for the claims.

### Adjusted Claims

This section of the RA lists adjustments made to correct payment errors in alphabetical order by recipient last name. Each adjustment has a single 'mother' line with the Internal Control Number (ICN) of the claim that is adjusted, followed by the 'daughter' claim with the adjustment ICN.

- **Additional Payment:** If the adjustment generates an additional payment, the additional amount is displayed below that adjustment.
- **Net Overpayment (AR):** If the adjustment generates an accounts receivable, the amount due is displayed below that adjustment.
- **Refund:** If a cash receipt is posted for a claim, the amount applied is displayed below that adjustment.

### Financial Transactions Page

There are three sections:

- **Payouts:** This lists non-claim expenditures made to the provider.
- **Refunds:** This lists cash receipts received from the provider.
- **Accounts Receivable:** This lists both non-claim and claim accounts receivables. A non-claim AR may be set up to be reduced for a specific dollar amount or percentage per financial cycle. This section

displays the original amount, the amount applied and the remaining balance for each AR.

### **Summary Page**

This page of the RA is divided into two sections. Claim activity reports first, followed by payment reporting.

Payment reporting is displayed as follows:

- The 'top' of the payment section contains payment information and the check/EFT amount appears as NET PAYMENT. If a credit balance is due to Medicaid, this number will appear as \$0.00. The amount owed to Medicaid is contained on the CREDIT BALANCE DUE 'letter' at the end of the RA.
- If you are to receive a Capitation Payment, it will appear as a single line and the amount in this 'top' section.
- The 'bottom' of the payment section displays any other financial data that may affect your NET EARNINGS.
- If any of your payment is being sent to the IRS, the deduction amount is noted in the 'bottom' section, and detailed in a message at the very bottom of the page.

Each section displays current and year-to-date totals.

#### **NOTE:**

The last RA issued for the calendar year notifies providers of the amount submitted to the Internal Revenue Service for tax reporting.

### **Third Party Insurance Information**

If a claim has denied for third party insurance, the claim ICN will post on this page with the third party carrier and policy information.

### **EOB Codes**

Following the summary page is a listing of definitions for the EOB codes used on each statement. This section also contains Adjustment codes identifying adjustments.

### **Encounter Data**

These sections of the RA contain encounter claim data and follow each of the Inpatient pages as the main part of the RA. The encounter data is for informational purposes only and does not show any dollar amounts paid. However, the provider should resubmit any correctable denied encounter data claims for payment. The plan code identifies the payer of these claims followed by the district. Example: PXX would be a Maternity Care claim processed by the Maternity Contractor in district XX and HXX would be a PHP claim processed by district XX.

## 6.2 Reimbursement Schedule

Claims that have been accepted for processing either through electronic submission or manually by HPE staff are processed on a daily basis. Payment for these claims is disbursed based on the twice a month checkwriting schedule as approved by the Alabama Medicaid Agency.

Information regarding checkwriting schedules is listed in the bimonthly publication of the Alabama Medicaid Provider Bulletin and can also be obtained on the Medicaid website at [www.medicaid.alabama.gov](http://www.medicaid.alabama.gov).

EFT is the required method to deposit funds for claims for payment. These funds can be credited to either checking or savings accounts, directly into a provider's bank account, provided the bank selected accepts Automated Clearing House (ACH) transactions. EFT also avoids the risks associated with mailing and handling paper checks, ensuring funds are directly deposited into a specific account.

The following items are specific to EFT:

- The release of direct deposits depends on the availability of funds. EFT funds are released as directed by the Alabama Medicaid Agency. The earliest funds are available is Saturday mornings following the checkwrite.
- Pre-notification to your bank takes place following the application processing. The pre-notification process takes place over a time frame of twenty-one (21) days. Direct deposits when owed to a provider will be made according to the release guidelines in the bullet above. The 835/RA (Remittance Advice) furnishes the details of individual payments made the provider's account during the weekly cycle.
- The availability of the proprietary RA reports is unaffected by EFT and are typically received by the end of the week following the checkwrite.

HPE must provide the following notification according to ACH guidelines:

"Most receiving depository financial institutions receive credit entries on the day before the effective date, and these funds are routinely made available to their depositors as of the opening of business on the effective date.

However, due to geographic factors, some receiving depository financial institutions do not receive their credit entries until the morning of the effective date and the internal records of these financial institutions will not be updated. As a result, tellers, bookkeepers, or automated teller machines (ATM) may not be aware of the deposit and the customer's withdrawal request may be refused. When this occurs, the customer or company should discuss the situation with the ACH coordinator of their institution who, in turn, should work out the best way to serve their customer's needs."

The effective date for EFT under the Alabama Medicaid Program is based on the release of funds as directed by the Alabama Medicaid Agency. The earlier effective date is Saturday following the checkwrite (if funds were made available from the Agency for the particular provider).

### 6.3 Rule 370 Resolving Late or Missing EFT or ERA/835

Providers *may* receive their 835/ERA immediately following the financial check write cycle if one of two conditions occur:

1. There is zero or negative payment on the 835/ERA (no EFT will be generated for this 835/ERA), or:
2. The provider receives paper checks rather than EFT during the pre-note EFT verification process.

If you determine an EFT or 835/ERA is late or missing there are some initial steps to take:

- **Contact your financial institution** - If you determine you have not received your EFT within three (3) business days of your 835/ERA, contact your financial institution. Once funds are released Alabama Medicaid has no way to track funds through your bank.
- **Contact your trading partner** - If you determine you have not received your 835/ERA within three (3) business days of your EFT, contact your trading partner. Alabama Medicaid produces 835/ERAs for your trading partner who will then distribute your information directly to you.

If you determine there is not an issue with your financial institution distributing funds, and/or there is not an issue with your trading partner distributing the 835/ERA to you, there are additional steps you can follow to resolve late or missing EFT and 835/ERA transactions:

1. Rule 370, Section 6.3 Resolving Late or Missing EFT and ERA Transaction Resolution procedures only apply when an EFT and/or 835/ERA enrollment has been set up.
  - If you have not set up 835/ERA, please follow the below steps:
    - If you **DO NOT** have a trading partner ID, visit the Alabama Medicaid Interactive Portal at:  
<https://www.medicaid.alabamaservices.org/ALPortal/Tab/41/content/InformationLinks/InformationLinks.html.spage>. Click on Information/Alabama Links and download the trading partner ID Request Form. Complete the appropriate sections and submit to the Electronic Media Claims (EMC) Help Desk as directed on the form.
    - If you **DO** have a trading partner ID visit the **Administrative Forms** section of the Alabama Medicaid website at  
[http://medicaid.alabama.gov/CONTENT/5.0\\_Resources/5.4\\_Forms\\_Library/5.4.6\\_Provider\\_Enrollment\\_Forms.aspx](http://medicaid.alabama.gov/CONTENT/5.0_Resources/5.4_Forms_Library/5.4.6_Provider_Enrollment_Forms.aspx). Download the [Electronic Remittance Agreement](#). Complete the appropriate sections and submit to the EMC Help Desk as directed on the form.
  - If you have not set up EFT to deposit funds for claims approved for payment please refer to the Alabama Medicaid Agency's website for EFT enrollment information at:  
[http://medicaid.alabama.gov/documents/5.0\\_Resources/5.4\\_Forms\\_Library/5.4.6\\_Provider\\_Enrollment/Fillable\\_Forms/5.4.6\\_Web\\_Portal\\_App\\_EFT\\_Form\\_7-14-15.pdf](http://medicaid.alabama.gov/documents/5.0_Resources/5.4_Forms_Library/5.4.6_Provider_Enrollment/Fillable_Forms/5.4.6_Web_Portal_App_EFT_Form_7-14-15.pdf).

Deleted:  
[http://medicaid.alabama.gov/...App\\_EFT\\_Form\\_1-5-12.pdf](http://medicaid.alabama.gov/...App_EFT_Form_1-5-12.pdf).

Added:  
[http://medicaid.alabama.gov/...EFT\\_Form\\_7-14-15.pdf](http://medicaid.alabama.gov/...EFT_Form_7-14-15.pdf).

- Effective December 2016, the submission process for the required EFT enrollment supporting documentation will be updated to allow providers to upload or fax supporting information via the Forms menu on the Alabama Medicaid Interactive Web Portal. The provider may upload enrollment supporting documents such as EFT supporting documentation in PDF format or create a fax barcode coversheet from the Web Portal.

Added: [Effective December 2016, the...Interactive Web Portal.](#)

**NOTE:**

Providers must maintain this barcode coversheet to submit additional documentation via fax at a later time and have that documentation combined with their original documents. Detailed instructions for digital submission of enrollment supporting documentation will be made available within the Forms Library on the Alabama Medicaid website and the Forms menu on the Alabama Medicaid Interactive Web Portal.

2. Ensure enough time has elapsed to receive the EFT or 835/ERA. Providers can expect their 835/ERA to become available within three business days (plus or minus) of the EFT being released.
3. Allow a minimum of two (2) check write cycles or 30 days to receive funds electronically if a bank account was recently updated or enabled.
4. Confirm that you have contacted your bank to receive the Re-Association information on your EFT.
5. Verify the correct Re-association Trace Number is being used to correlate the 835/ERA with the payment. The Re-association Trace Number can found on the 835/ERA (TRN02).
6. Verify the trading partner ID associated with the EFT and 835/ERA is correct as providers may have multiple trading partner IDs. Providers should also be aware if they change their trading partner ID, any 835/ERA files produced prior to such a change will go to the previous trading partner.
7. Providers may receive 835/ERA files for a single check write cycle over the course of multiple days, as 835/ERA files will become available as funds are released. Providers can use proprietary RA, 276/277 (claim status request and response), Automated Voice Response System (AVRS), or Provider Electronic Solutions (PES) for claim and check/payment information.

If the above information has not produced an answer to the late or missing EFT or 835/ERA, please contact the EMC Help Desk at (800-456-1242), Monday – Friday, 7:00 a.m. – 8:00 p.m. CST, or Saturday, 9:00 a.m. – 5:00 p.m. CST.

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