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6 Receiving Reimbursement

This chapter describes the Remittance Advice (RA) report and the reimbursement schedule for Medicaid fee-for-service claims.

NOTE:

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

6.1 Remittance Advice (RA) Report

It is the responsibility of each provider to follow up on claims submitted to HP. 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.*

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 HP 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 HP' 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 HP 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 refiles 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 HP 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.

Field	***Description***
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.
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.

Field	***Description***
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.
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.

Field	*Description*
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 HP 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.

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