

Chapter Nine

Claims Processing

Chapter Overview

Introduction

Hospital claims for Medicaid reimbursement are processed by EDS. This chapter has two major subjects. The first describes claims processing procedures and explains the details of the Medicaid Remittance and Status Report (RA) to help the provider track activity on claims that have been submitted. The second addresses what the provider must do when claims require adjustments, refunds, recoupments, and payouts.

In This Chapter

This chapter contains:

Topic	See Page
The North Carolina Medicaid Remittance and Status Report	9-2
Parts of the RA	9-2
Explanation of Claim Number	9-4
The RA Cover Sheet	9-6
RA Cover Sheet Example	9-7
The Main (Paid Claims) Section of the RA	9-8
Example of A Paid Claim on Hospital RA	9-10
Example of A Crossover Claim on Hospital RA	9-12
The Adjusted Claims Section of the RA	9-13
Example of Adjusted Claim on Hospital RA	9-15
The Denied Claims Section of the RA	9-16
Denied Claims RA Example	9-18
The Claims in Process Section of the RA	9-19
Claims in Process RA Example	9-20
Financial Items Section of the RA	9-21
Financial Items RA Example	9-23
Claims Payment Summary Page of the RA	9-24
Common Denials and Their Resolution	9-25
Denials That Do Not Require Adjustments	9-27
The Adjustment Request Form	9-30
Medicaid Adjustment Form–Attachment A	9-33
The Medicaid Resolution Inquiry Form	9-34
Medicaid Resolution Inquiry Form–Attachment B	9-35
Refunds (When to Refund)	9-36
Refund Calculation	9-37
Refund Submission	9-37
Refund Application/Reflection	9-39
Erroneous Refunds	9-39
Recoupments	9-40
Payouts	9-41

The North Carolina Medicaid Remittance and Status Report

Introduction The Remittance and Status report, or Remittance Advice (RA), is a computer-generated document sent to providers showing the status of all claims submitted to EDS and a detailed breakdown of payments.

How RAs Are Mailed The RA is produced at the same time checks are issued. If the RA is ten pages or less for any checkwrite, it will be mailed with the check. If more than ten pages, the RA will be mailed under separate cover.

Record Keeping Retain all RAs in chronological order to assist in keeping all claims and payment records current. If after checking the RA, a provider does not find information on questions about claims payment, contact the Provider Relations Unit at EDS for assistance.

1099 Form The last RA received each year serves as the annual 1099 Form.

Parts of the RA

Introduction Information on the RA is identified by subject headings. Each major subject heading is further divided into subsections depending upon provider and/or claim type:

- Paid Claims
- Adjusted Claims
- Denied Claims
- Returned Claims
- Claims in Process
- Financial Items
- Claims Summary
- Claims Payment Summary

Paid Claims This section shows all claims that have had payment activity since the previous checkwrite.

- hospital RAs may be subdivided into:
 - a) inpatient claims
 - b) outpatient claims
 - c) inpatient crossovers, and
 - d) outpatient crossover claims
- each subsection is sequenced alphabetically by the recipient's last name
- each subsection has summary totals
- a grand total summary of all paid claims subsections appears at the end of the paid claims section.

Continued on next page

Parts of the RA, Continued

Adjusted Claims

This section shows the status of claims when requests for action have been made to correct overpayments, underpayments, or payment to the wrong providers.

Some of the most common causes of adjustments are clerical errors, incorrect claims information, and incorrect procedure coding.

There are no subsections under this heading.

A list of denial codes for which adjustments are not required is included under "Denials That Do Not Require Adjustments."

Denied Claims

This section identifies those claims denied for payment.

1. Common reasons for claims denial are:
 - eligibility status
 - billing for noncovered services
 - expired filing time limits
2. Claims in this section are divided into subsections to indicate the type of bill processed.
3. Recipient names are sequenced alphabetically in each subsection.
4. Zero will appear in all columns to the right of "Non-Allowed."
5. An explanation code specifying the reason for denial will appear in the far right column.

Denied claims are final, and no additional action will be taken on the claims unless the provider resubmits.

Returned Claims

This section lists claims that cannot be processed by EDS for reasons such as missing medical records or omitted signatures. An unprocessed claim appears only once on the RA unless the provider resubmits it with the correct information; it will then appear as pending, paid, or denied.

Claims In Process

This section lists those claims which have been received and entered by EDS but are pending payment because further review of the claims is needed. Claims appearing in this section should not be rebilled.

Financial Items

This section contains a listing of payments refunded by providers, amounts being recouped since the previous checkwrite, and other recoupment activities being applied which will reflect negatively on the provider's total earnings for the year. The explanation code beside each item indicates what action was taken.

Continued on next page

Parts of the RA, Continued

Claims Summary	The claims summary is divided into inpatient and outpatient subsections and includes summary totals of revenue codes listed on the claims.
-----------------------	--

Claims Payment Summary	This section summarizes all payments and credits made to the provider by the Medicaid program for the specific pay period, entitled "Current Processed," and for the year, entitled "Year To Date Total."
-------------------------------	---

Explanation of Claim Number

Introduction	Each claim processed by EDS is assigned a unique 13-digit claim number that appears on the Remittance Advice (RA). The claim number identifies how the claim was submitted, when EDS received the claim, and how it was processed. The fields on the claim number provide useful information to both providers and EDS on how claims are received and processed.
---------------------	--

Fields of the Claim Number	<p>Each claim number consists of five fields:</p> <p>Region—indicates how the claim was submitted into the EDS system (see explanation of different regions)</p> <p>Year—indicates the year the claim was received (97=1997)</p> <p>Julian Date—indicates date the claim was received in the EDS Mailroom. The Julian calendar is used to identify the numerical day of the year (001=Jan 1 and 365=Dec 31).</p> <p>Batch—each claim received is batched in groups of 100. Paper claims are microfilmed and given a unique 3-digit number for identification.</p> <p>Claims in Batch—indicates the number of the claim within the batch of 100 (000=1st claim and 990=last claim).</p>
-----------------------------------	---

Continued on next page

Explanation of Claim Number, Continued

Explanation of Region

The table shown below explains how the region field (the first two numbers) of the claim number is assigned:

Region	Explanation
10	<u>Paper Submission</u> —A paper claim received in the EDS mailroom and keyed by EDS or contractor.
15	<u>Electronic Submission (Tape)</u> —An electronic claim submitted on magnetic tape.
25	<u>Electronic Submission (PC)</u> —An electronic claim submitted through a PC by modem or a mail-in diskette.
40	<u>Medicare Crossover</u> —Medicare crossover received by EDS from Medicare on magnetic tape. If the claim is not automatically crossed over from Medicare and the provider submits the claim copy and EOMB, the claim number will begin with a 10, indicating a paper claim.
90 or 95	<u>Adjustment Request</u> —Adjustment requested by provider, EDS, or DMA. A previous payment was made on this claim.
96	System-generated adjustments for DRG replacement claims.

Examples

The table below explains several examples of claim numbers:

Claim Number

Region	Year	Julian Date	Batch	# Claim	Explanation
10	98	001	300	000	Claim #10 98 001 300 000 indicates a paper claim received by the EDS mailroom on January 1, 1998. It is the first claim in batch 300.
15	97	155	400	320	Claim #15 97 155 400 320 indicates a claim received by EDS via magnetic tape on June 4, 1997. It is the 32nd claim in batch 400.
25	97	182	400	010	Claim # 25 97 182 400 010 indicates an electronic claim received by EDS on July 1, 1995. It is the first claim in batch 400.
40	97	200	300	500	Claim # 40 97 200 300 500 indicates a Medicare crossover claim received by EDS via magnetic tape on July 1, 1997. It is the 50th claim in batch 300.
90 or 95	97	352	500	990	Claim # 95 94 366 980 990 indicates an adjusted claim received by EDS on December 18, 1997. It is the 99th claim in batch 500.

The RA Cover Sheet

Introduction

The cover sheet is the first page of the RA. It contains basic information about the provider and claims for each RA statement.

Cover Sheet Example

The chart below describes each of the fields identified on the RA Cover Sheet example on the following page:

Field #	Field Name	Description
1	Provider Name and Address	Self-explanatory.
2	Provider Number	The 7-digit number assigned to the provider for participation in the program. Alpha suffixes, if applicable, will be shown.
3	Report Sequence Number	Assigned sequentially for the provider's convenience to identify the RA. The first RA received each year will be numbered 1, the second 2, etc.
4	Date	The date the RA was produced. It will match the date on any accompanying checks.
5	Page	The number, starting at 1, assigned sequentially to each page of the current RA.
6	Cover Page Messages	At times special informational messages will be printed on the cover page of the RA.

Continued on next page

RA Cover Sheet Example

MEDICAL ASSISTANCE REMITTANCE AND STATUS REPORT

1
WEBB COUNTY HOSPITAL
111 HEALTHY LANE
EMERGENCY, NC 27514

2
 PROVIDER NUMBER 3400000

3
 REPORT SEQ NUMBER 6

4
 DATE 02/15/98

5
 PAGE 1

NAME RECIPIENT ID	SERVICE DATES	DAYS OR UNITS	PROCEDURE/ACCOMMODATION/DRUG CODE AND DESCRIPTION	TOTAL BILLED	NON ALLOWED	TOTAL ALLOWED	PAYABLE CUTBACK	PAYABLE CHARGE	OTHER DEDUCTED CHARGES	PAID AMOUNT	EXPLANATION CODES
			6 Medicaid Fair—May 19, 1998								
			WEBB COUNTY HOSPITAL 111 HEALTHY AVE EMERGENCY, NC 27514								

The Main (Paid Claims) Section of the RA

Introduction

The main section of the RA shows all the claims that paid during the period covered by the statement.

Example

The chart below describes each of the fields shown in the main section of the RA (an example follows):

Field #	Field Name	Description
1	Recipient ID	The recipient's 10-character identification number. This is 9 digits with an alpha suffix.
2	Patient Name	The last and first name of the recipient.
3	County Number	The county of residence of the recipient.
4	Claim Number	The unique 13-digit number assigned to each claim form by EDS for internal control purposes. REFERENCE THIS INTERNAL CLAIM NUMBER (ICN) WHEN CORRESPONDING WITH EDS ABOUT A CLAIM.
5	Medical Record Number	The medical record number as listed on the claim for identification of the recipient. The RA will show up to 9 digits and/or letters in this field. If a medical record number is not entered on the claim, the RA will show 0.
6	Service Dates	Format MMDDYY (Month, Day, Year) in "From" and "To" dates of service. "From" indicates the beginning date of service for this detail. "To" indicates the ending date of service for this detail.
	RCC	The ratio of cost to charge, indicating the percentage of total allowed charge to be paid (when applicable).
8	Days or Units	The number of times a particular type of service is provided within the given service dates. Depending on the provider type, either the number of days or units of service is given. (i.e., for institutions, number of days for professional services, units of service.)
9	Procedure/Revenue Code	Numerical procedure/revenue code. Code corresponding to the service performed and a brief description of the service.
10	Total Billed	The amount the provider bills on each claim detail line.
11	Total Nonallowed	Difference between Total Billed column and Total Allowed column.
12	Total Allowed	The total amount Medicaid allows for a particular charge. Each service detail will be deemed a "covered charge" or a "noncovered charge." TOTAL ALLOWED will be zero for a noncovered charge. (Total Allowed = Total Billed – Nonallowed).

Continued on next page

The Main (Paid Claims) Section of the RA, Continued

The Main Claims Section (Continued)		
Field #	Field Name	Description
13	Payable Cutback	The difference between what Medicaid allows and what Medicaid will pay for a particular charge based on the RCC or reimbursement amount.
14	Payable Charge Amount	The amount that Medicaid will pay the provider before other deductions (copayment, patient liability, third party liability). This maximum amount is calculated from the Total Allowed Column times the REIM x RCC, or 100% of the state-wide schedule, or 100% of billed amount, whichever is less.
15	Other Deducted Charges	Other sources of medical service funds must be deducted from the payable charge or cost before the Medicaid program pays its charge. These deductions, which must be applied, are other monies, such as TPL, patient liability and co-payment. (For hospital claims, patient liability is deducted from the total billed and is shown in the nonallowed column).
16	Paid Amount	The amount payable to the provider (Paid Amount = Payable Charge - Other deducted Charges).
17	Explanation Codes	Numeric representation of messages which explain the method of payment or reason for denial. Full descriptions for each explanation code (EOB) are in the final section of the RA.
18	Spend down (Deductible)	Total amount of spend down (deductible) for the claim. This amount is listed beneath the claim information for each recipient, if applicable. Spend down is applied to Billed Amount for each detail line until the total amount of spend down is met.
19 20 21	Patient Liability Copayment TPL	These amounts are listed directly beneath the claim information of each recipient, if applicable. Patient Liability, Copayment and Third Party Recovery will be deducted from the Payable Charge and designated as Other Deducted Charges. (See Other Deducted Charges).

Example of A Paid Claim On Hospital RA

Items on RA

The inpatient claim RAs (including crossovers) are formatted to reflect DRG reimbursement. The following items appear on the RA:

- DRG code
 - DRG amount
 - DRG weight
 - Average Length of Stay
 - First Diagnosis and Procedure used in grouper placement
 - Outlier code (Cost or Day)
 - Outlier payment
-

Example of Paid Claim on Hospital RA

The following RA shows an example of an Admit through Discharge claim. The paid amount column represents the DRG amount of \$2196.09 plus disproportionate share dollars totaling \$54.90. If this claim had been eligible for any outlier payments, they would have been added to the paid amount.

Continued on next page

Example of A Paid Claim on Hospital RA

**NORTH CAROLINA MEDICAID
REMITTANCE AND STATUS REPORT**

Webb County Hospital
111 Healthy Avenue
Emergency, NC 27514

PROVIDER NUMBER 3400000

REPORT SEQ NUMBER 2

DATE 03/04/98

PAGE 2

NAME RECIPIENT ID	SERVICE DATES	DAYS OR UNITS	PROCEDURE/ACCOMMODATION/DRUG CODE AND DESCRIPTION	TOTAL BILLED	NON ALLOWED	TOTAL ALLOWED	PAYABLE CUTBACK	PAYABLE CHARGE	OTHER DEDUCTED CHARGES	PAID AMOUNT	EXPLANATION CODES
			PAID CLAIMS INPATIENT HOSPITAL								
MITCHELL BEVERLY 901221437S	A CO=87 022198 022498	RCC= 3	CLAIM NUMBER=1097020305880 MED REC=1040104 A 203 INTENSIVE CARE PEDIATRIC	1140.00	1110.99	2250.99	0.00	ATTN PROV 2250.99	=8972357 0.00	1.0000 2250.99	98
	022198 022498		B 460 PULMONARY FUNCTION-GEN CLASS	120.75	120.75	0.00	0.00	0.00	0.00	0.00	9271
	022198 022498		B 250 PHARMACY-GEN CLASS	446.50	446.50	0.00	0.00	0.00	0.00	0.00	9271
	022198 022498		B 258 PHARMACY-IV SOLUTIONS	141.78	141.78	0.00	0.00	0.00	0.00	0.00	9271
	022198 022498		B 270 MED/SURG SUPPLIES & DEVICES-GEN	739.25	739.25	0.00	0.00	0.00	0.00	0.00	9271
	022198 022498		B 301 LAB-CHEMISTRY	65.00	65.00	0.00	0.00	0.00	0.00	0.00	9271
	022198 022498		B 305 LAB-HEMATOLOGY	75.00	75.00	0.00	0.00	0.00	0.00	0.00	9271
DRG CODE	417	ALOS 2.9	WEIGHT 8170	DRG AMOUNT 2196.09							
DIAGNOSIS	0380	PROC	OUTLIER	OUTLIER AMT 0.00							
DEDUCTIBLE	0.00	PAT LIAB .00	CO PAY= 0.00	TPL= 0.00	2728.28	477.29	2250.99	0.00	2250.99	0.00	2250.99
1	CLAIMS	5	INPATIENT HOSPITAL *****								
*****	TOTAL PAID CLAIMS	1 CLAIMS									

EOB Listing - 098=Fee adjusted to maximum payable
9271=Payment included in DRG reimbursement on first accommodation detail

Example Of A Crossover Claim On Hospital RA

This example is one of a crossover claim received via tape from Medicare. Medicare will cross over to Medicaid the DRG, DRG amount paid by Medicare, and any applicable coinsurance payments. Medicaid will use the Medicaid weight associated with the DRG given by Medicare, the deductible amount of \$716.00 in this example, and the facility's DRG rate on file in the crossover calculations for the example.

NORTH CAROLINA MEDICAID REMITTANCE AND STATUS REPORT

Webb County Hospital
111 Healthy Avenue
Emergency, NC 27514

PROVIDER NUMBER 3400000 REPORT SEQ NUMBER 2

DATE 03/17/98

PAGE 2

NAME RECIPIENT ID	SERVICE DATES	DAYS OR UNITS	PROCEDURE/ACCOMMODATION/DRUG CODE AND DESCRIPTION	TOTAL BILLED	NON ALLOWED	TOTAL ALLOWED	PAYABLE CUTBACK	PAYABLE CHARGE	OTHER DEDUCTED CHARGES	PAID AMT	EXPL. CODE
			PAID CLAIMS INPATIENT CROSSOVER								
HOLDMAN OLIVIA M 8-27 032148417R	CO=92 012098	RCC= 012498	CLAIM NUMBER=4097042984009 MED REC=806219408- WEIGHT 2.7901 DRG AMOUNT 0.00 OUTLIER OUTLIER AMT DEDUCTIBLE= 0.00 PAT LIAB= 0.00 CO PAY= 0.00 TPL= 0.00 1 CLAIMS 23 INPATIENT CROSSOVER ***** ***** TOTAL PAID CLAIMS 1 CLAIMS	716.00	0.00	716.00	0.00	ATTN PROV= 0.00		716.00	8930

EOB listing - 8930=Medicare coinsurance/deductible paid

The Adjusted Claims Section of the RA

Introduction	<p>The adjusted claims section of the RA shows the status of claims that are pending to correct:</p> <ol style="list-style-type: none">1. an overpayment2. an underpayment3. payment to the wrong provider
Credit Adjustment	<p>When adjustments are processed and recouped, a new claim number is assigned as the adjustment ICN. The original ICN and original RA date are referenced on the current RA. This information appears on the same line as the recipient's name. This activity results in a credit adjustment (credit to be provided). The financial item on the RA lists the credit amount with EOB 112 indicating that the amount being recouped will be applied to the provider's 1099.</p>
Debit Adjustments	<p>Debit adjustments appear on the RA with the a new claim number (this is the adjustment ICN). The original ICN is referenced on the RA as well as the original RA date. This information appears on the same line as the recipient's name. Debit adjustments indicate net amounts being paid. For example, if the original payment for a detail was \$25.00 and the provider increased his payable amount to \$35.00, the amount paid on the RA would be \$10.00, the difference in the original claims payment and the adjusted claim.</p>
Denied Adjustments	<p>Denied adjustments appear on the RA with the adjustment ICN as the claim number. It also references the medical record number. This is the cross-reference information to the original claim. Denied adjustments also reference the original dates of service, RC, billed amount, etc. When questioning these denials, always refer back to the original ICN.</p>
Manual Recoupments	<p>Manual recoupments appear on the RA with the information entered into the system manually. This can consist of any span of dates, billed amounts, etc. Manual recoupments are usually done when the provider is asked to submit a refund that was never received. EDS will then initiate the recoupment manually.</p>

Continued on next page

The Adjusted Claims Section of the RA, Continued

Fields

The following chart describes the fields on an adjusted claim:

Field #	Field Name	Description
1	Patient Name	The recipient's last name, first and middle initial.
2	Service Dates	Format MMDDYY (Month, Day, Year) in "From" and "To" dates of service
3	Adjustment Claim Number	The unique 13-digit number assigned for adjustment claim form.
4	Debt or Credit Indicator	<p>A "Debit to" means that additional monies have been paid to the provider. Beside the "Debit to" portion of the adjustment, a breakdown of a positive corrected payment will be reflected as was explained in "Paid Claims." It will be identified by "****Adjustment****Debit to," followed by:</p> <ul style="list-style-type: none"> • the original claim number • the date the original claim was paid • the positive amount being paid <p>A "Credit to" shows monies that are to be recouped from the provider for incorrect payments. The "Credit to" portion of an adjustment is reflected in negative amounts. Beside "****Adjustment****Credit to" are the following identifications:</p> <ul style="list-style-type: none"> • the original claim number being adjusted • the original paid date • the amount to be recouped

Example

The following is an example of a replacement claim. The adjustments section shows the recouping of a previous payment(s). The claim number preceded by the phrase "adj debit to" is the claim being recouped. The claim number following the phrase "DRG Replacement Claim" shows the claim number under which the newly paid claim can be found. This claim is located under the paid claims section of the RA.

Continued on next page

Example of Adjusted Claim on Hospital RA

NORTH CAROLINA MEDICAID REMITTANCE AND STATUS REPORT

Getwell County Hospital
222 Wellness Lane
Healthy, NC 28289

PROVIDER NUMBER 3400000

REPORT SEQ NUMBER 2

DATE 06/06/97

PAGE 2

NAME RECIPIENT ID	SERVICE DATES	DAYS OR UNITS	PROCEDURE/ACCOMMODATION/DRUG CODE AND DESCRIPTION	TOTAL BILLED	NON ALLOWED	TOTAL ALLOWED	PAYABLE CUTBACK	PAYABLE CHARGE	OTHER DEDUCTED CHARGES	PAID AMT	EXPLA NATION CODES
			Adjusted Claims INPATIENT Adjustments								
MITCHELL BEVERLY M 094349123L	CO=67 022197 022497	RCC=3 3 A	CLAIM NUMBER=97070961088 *ADJ**DEBIT TO 25970453000560 203 INTENSIVE CARE PEDIATRICS	2250.99	0.00	2250.99	ATTN PROV= 0.00	C80654 2250.99	0.00	2250.99-	9294
86	ADJUSTMENT OF CLAIM 022197 022497	B	2597045300560 460 PULMONARY FUNCTION-GEN CLASS	0.00	0.00	0.00	0.00	0.00	0.00	0.00	9294
86	ADJUSTMENT OF CLAIM 022197 022497	B	2597045300560 250 PHARMACY-GEN CLASS	0.00	0.00	0.00	0.00	0.00	0.00	0.00	9294
86	ADJUSTMENT OF CLAIM 022197 022497	B	2597045300560 258 PHARMACY-IV SOLUTIONS	0.00	0.00	0.00	0.00	0.00	0.00	0.00	9294
86	ADJUSTMENT OF CLAIM 022197 022497	B	2597045300560 270 MED/SURG SUPPLIES & DEVICES-STER	0.00	0.00	0.00	0.00	0.00	0.00	0.00	9294
86	ADJUSTMENT OF CLAIM 022197 022497	B	2597045300560 301 LAB-GEN CHEMISTRY	0.00	0.00	0.00	0.00	0.00	0.00	0.00	9294
86	ADJUSTMENT OF CLAIM 022197 022497	B	2597045300560 305 LAB-HEMATOLOGY	0.00	0.00	0.00	0.00	0.00	0.00	0.00	9294
86	ADJUSTMENT OF CLAIM		2597045300560				0.00				
DRG REPLACEMENT CLAIM			2597067307258								
DEDUCTIBLE 0.00			PAT LIAB= 0.00	CO PAY= 0.00	TPL= 0.00						
1	CLAIMS	23	INPATIENT ADJUSTMENT *****								
*****	TOTAL ADJUSTED CLAIMS		1 CLAIMS								

EOB Listing - 9294=DRG Recoupment

The Denied Claims Section of the RA

Denied Claims Section

The chart below describes each of the fields shown on the denied claims section example, which follows this description:

Field #	Field Name	Description
1	Recipient ID	The recipient's 10 character identification number. (This will be 9 digits with an alpha suffix).
2	Patient Name	The recipient's last name and first name.
3	County Number	The county of residence of the recipient.
4	Claim Number	The unique 13-digit number assigned to each claim form by EDS for internal control purposes. REFERENCE THIS INTERNAL CLAIM NUMBER (ICN) WHEN CORRESPONDING WITH EDS ABOUT A CLAIM.
5	Medical Record Number	The medical record number, as listed on the claim, for identification of the recipient. The RA will show up to 9 digits and/or letters in this field. If no medical record number is entered on the claim, then the RA will show 0.
6	Service Dates	Format MMDDYY (Month, Day, Year) in "From" and "To" dates of service. "From" indicates the beginning date of service for this detail. "To" indicates the ending date of service for this detail.
7	RCC	The ratio of cost to charge, which indicates the percentage of total allowed charge to be paid (where applicable).
8	Days or Units	The number of times a particular type of service is provided within the given service dates. Depending on the provider type, either the number of days or units of service is given. (For institutions, the number of days is listed. For professional services, units of service is listed.)
9	Procedure/Revenue Code	The numerical code corresponding to the service performed as well as a brief description of the service. Note: The character preceding the procedure code is the type of service code.
10	Total Billed	The amount the provider bills on each claim detail line.
11	Total Non-Allowed	Difference between Total Billed column and Total Allowed column.
12	Total Allowed	The total amount Medicaid allows for a particular charge. Each service detail will be deemed a "covered charge" or a "noncovered charge." TOTAL ALLOWED will be zero for a noncovered charge. (Total Allowed = Total Billed – Nonallowed).

Continued on next page

The Denied Claims Section of the RA, Continued

Denied Claims Section (Continued)

Field #	Field Name	Description
13	Payable Cutback	The difference between what Medicaid allows and what Medicaid will pay for a particular charge based on the RCC or reimbursement amount.
14	Payable Charge Amount	The amount that Medicaid will pay the provider before other deductions (co-payment, patient liability, Third Party Liability). This maximum amount is calculated from the Total Allowed Column times the REIM X RCC or 100% of the statewide schedule or 100% of the billed amount, whichever is less.
15	Other Deducted Charges	Other sources of medical service funds must be deducted from the payable charge or the cost before Medicaid pays its charge. These deductions are other monies, such as TPL, patient liability and copayment. For hospital claims, patient liability is deducted from the total billed and is shown in the nonallowed column.
16	Paid Amount	The amount payable to the provider (Paid Amount = Payable Charge - Other Deducted Charges).
17	Explanation Codes	Numeric representation of messages which explain the method of payment or reason for denial. The descriptions for each explanation code (EOB) used are listed in the final section of the RA.
18 19 20	Patient Liability Co-Payment TPL	These amounts are listed directly beneath the claims information of each recipient, if applicable. Copayment and Third Party Recovery will be deducted from the Payable Charge and designated as Other Deducted Charges. (Refer to "Other Deducted Charges").
21	Recipient's Other Insurance Information	This field consists of the insurance company code, the policy number, the insurance coverage code, and the policy holder name. Note: To request a copy of the list of insurance company codes, contact DMA Third Party Recovery.

Continued on next page

Denied Claims RA Example

MEDICAL ASSISTANCE REMITTANCE AND STATUS REPORT

GETWELL HOSPITAL
222 WELLNESS LANE
HEALTHY, NC 28289

PROVIDER NUMBER 3400000

REPORT SEQ NUMBER 2

DATE 05/17/98

PAGE 2

NAME RECIPIENT ID	SERVICE DATES		DAYS OR UNITS	PROCEDURE/ACCOMMODATION/DRUG CODE AND DESCRIPTION	TOTAL BILLED	NON ALLOWED	TOTAL ALLOWED	PAYABLE CUTBACK	PAYABLE CHARGE	OTHER DEDUCTED CHARGES	PAID AMOUNT	EXPLAN- ATION CODES
	FROM MMDDYY	TO MMDDYY										
2	3	7	8	DENIED CLAIMS MEDICAL						22		
ANDERSON JAMES 220632262S 1	CO=41 RCC 042498 04249 8 6 21 Company=091	1	CLAIM NUMBER =2594115323160 MEDREC=49378 3 99211 OV ESTAB PT. MINIMAL W/WO PHY 9 PTLIB= 18 COPAY= 19 TPL= 20 327699294 Coverage Code= Policy Holder=	20.00 10 James	20.00 11 Anderson	00.00 12	00.00 13	00.00 14	SERVPHY= 00.00 15	8912345 00.00 16	094 17	
MILLER FAITH 665839962Q	Co=41 RCC 040294 04029 4	1	CLAIM NUMBER =2594133300064MEDREC=63469 3 71010 CHEST SINGLE VIEW	100.00	100.00	00.00	00.00	00.00	SERVPHY= 00.00	8981790 00.00	024	
2 CLAIMS		2		120.00	120.00	00.00	00.00	00.00	00.00	00.00		
			PAID CLAIMS SCREEN									
TODDLER TIMMY 123456789O	CO=41 RCC= 033198 033198	1	CLAIM NUMBER=4594132033007MEDREC=76625 3 W8010 EPSDT SCREEN	75.00	2.83	68.77	00.00	00.00	SERVPHY= 00.00	7968525 68.77	098	
1 CLAIM		1		75.00	2.83	68.77	00.00	00.00	00.00	68.77		

The Claims in Process Section of the RA

Introduction

Claims listed in the claims in process section of the RA are those under review. They should not be resubmitted. Disposition will appear on a future RA.

Claims in Process Section

The chart below describes each of the fields shown on the claims in process example on the following page:

Field #	Field Name	Description
1	Recipient ID	The recipient's 10-character identification number. This will be 9 digits with an alpha suffix.
2	Patient Name	The recipient's last and first name.
3	Service Dates	Format MMDDYY (Month, Day, Year) in "From" and "To" dates of service. "From" indicates the beginning date of service for this detail. "To" indicates the ending date of service.
4	Claim Number	The unique 13-digit number assigned to each claim form by EDS for internal control purposes. REFERENCE THIS INTERNAL CLAIM NUMBER (ICN) WHEN CORRESPONDING WITH EDS ABOUT A CLAIM.
5	Billed amount	The amount the provider bills on each claim detail line.
6	Medical Record Number	The medical record number as listed on the claim for identification of the recipient. The RA will show up to 9 digits and/or letters in this field. If no medical record number is entered on the claim, then the RA will show 0.
7	Explanation code	Numeric representation of messages which explain the reason the claim is in process.
8	Claim Summary	The total number of claims in process.
9	Total Billed	The billed amount for all claims listed in this section.

Continued on next page

Claims in Process RA Example

**MEDICAL ASSISTANCE
REMITTANCE AND STATUS REPORT**

GETWELL HOSPITAL
222 WELLNESS LANE
HEALTHY, NC 28299

PROVIDER NUMBER 3400000

REPORT SEQ NUMBER 2

DATE 05/17/98

PAGE 2

NAME RECIPIENT ID	SERVICE DATES FROM TO MMDDYY MMDDYY	DAYS OR UNITS	PROCEDURE/ACCOMMODATION/DRUG CODE AND DESCRIPTION	TOTAL BILLED	NON ALLOWED	TOTAL ALLOWED	PAYABLE CUTBACK	PAYABLE CHARGE	OTHER DEDUCTED CHARGES	PAID AMOUNT	EXPLAN- ATION CODES
CLAIMS IN PROCESS- THESE CLAIMS ARE BEING PROCESSED AS LISTED											
1 901180374P	2 POLLEN	REN	3 PROFESSIONAL 082297 082397 REC=000837002 CLAIM NUMBER=9095304991360	4 905.00	5 MED	6					7 101
900123456P	ROGERS	ROBER	091897 091997 REC=000837003 CLAIM NUMBER=9094305991370	75.00	MED						102
8 2 CLAIMS			*****2 CLAIMS IN PROCESS*****	9 980.00							

Financial Items Section of the RA

Introduction

The Financial Items section of the RA lists the financial items for claims covered during the statement period.

Fields

The chart below describes each of the fields shown on the Financial Items example.

Field #	Field Name	Description
1	Bene ID	The recipient's 10-digit Medicaid ID number.
2	Bene Name	Recipient's name.
3	From DOS	From Date of Service.
4	TXN dates	The date on which the transaction was entered into the system.
5	Control Number	The 10-digit number assigned to this transaction by EDS for control purposes.
6	Reference	Information that will help identify the transaction (ex. a corresponding claim or adjustment number).
7	Original Amount	The original amount of the transaction.
8	Beginning Balance	The amount remaining for this transaction prior to this action, e.g., if a recoupment had been initiated for \$1000.00, but only \$200.00 had been applied, the next RA would show a beginning balance of \$800.00 to be recouped.
9	Applied Amount	The amount applied on this RA to the beginning balance. (If the provider sent a refund check for two different claims, the amounts applicable to each claim would be displayed individually.)
10	New Balance	The amount left for the transaction after this RA.
11	Explanation Codes	The last page of the RA will give detailed descriptions.

Continued on next page

Financial Items Section of the RA, Continued

Explanation of Benefits The table below explains EOBs included in the Financial Items Section.

EOB	Message	Action/Meaning
111	Settlement Amount Added to Claims Payment	This EOB, found in Financial Items section, is used when a payout is authorized for a claim that cannot be processed through regular channels. A letter of explanation will follow. Reconcile by referencing letter.
112	Check Amount Reduced by Recoupment Amount	This EOB, found in Financial Items section, indicates that money is being recouped because of an adjustment. The paid claim total amount will be reduced by this amount. An example would be a duplicate claim payment recoupment. Using the name and reference number given, refer to the Adjustment section and compare name and ICN. The "Credit Adjustment" listed will give identifying information as to which claim to credit. NOTE: The "Credit Adjustment" shows that the adjustment has been set up to recoup the money and will appear on the current or preceding RA. The EOB 112 will not appear until the money is actually being recouped.
113	Refund Amount Applied to 1099 Liability	When a personal refund check is sent to EDS for an incorrect payment, claims history is corrected. To advise the provider that the check was received, it will appear in Financial Items section with claim information. The refund has been credited and the provider will not be taxed on this money.

Questions? Providers should call the section chief of DMA Rate Setting and Reimbursement with any questions about recoupments.

Continued on next page

Financial Items RA Example

MEDICAL ASSISTANCE REMITTANCE AND STATUS REPORT

HEALTHY HOSPITAL
222 WELLNESS LANE
COLUMBUS, NC 28289

PROVIDER NUMBER 3400000

REPORT SEQ NUMBER 22

DATE 02/15/98

PAGE 1

NAME RECIPIENT ID	SERVICE DATES FROM TO MMDDYY MMDDYY	DAYS OR UNITS	PROCEDURE/ACCOMMODATION/DRUG CODE AND DESCRIPTION			TOTAL BILLED	NON ALLOWED	TOTAL ALLOWED	PAYABLE CUTBACK	PAYABLE CHARGE	OTHER DEDUCTED CHARGES	PAID AMOUNT	EXPLANATION CODES
			FINANCIAL ITEMS										
1	2	3	4	5	6		7	8	9		10		11
BENE ID	BENE NAME	FROM	TXN	CONTROL/REFERENCE			ORIGINAL AMOUNT	BEGINNING BALANCE	APPLIED AMOUNT		NEW BALANCE		EOB
999999999T	EXAMPLE J	08019T	040897	4350751470	9095003100430		1000.00	1000.00	1000.00		00		112
321043289K	SAMPLE, T	083197	093097	4109350240	1094354208420		657.09	657.09	50.00		607.09		113
456789123T	SAMPLE, A	073197	093097	4109350240	1094357209320		657.09	657.09	607.09		50.00		113

Claims Payment Summary Page of the RA

Introduction

The Claims Payment Summary section summarizes all payments and credits made to the provider during the statement period, entitled “Current Processed” as well as for the year, entitled “Year to Date.”

The chart below describes each of the fields show on the claims payment summary page:

Field Name	Description
Check Number	The number of the check issued by EDS.
Claims Paid	Total number of claims paid by the Medicaid program.
Claims Amount	Total paid amount from Paid Claims Section plus any supplemental payouts (i.e., resulting from a “Debit To” adjustment listed in the Adjusted Claims section).
Withheld Amount	Total amount withheld from RA (i.e., resulting from “Credit To” adjustments). This amount is obtained from each “Applied Amount” field of the Financial Items section.
Net Pay Amount	Claims amount less withheld amount(s). This is the amount of the provider’s check.
Credit Amount	Total amount refunded to the Medicaid program by the provider
Net 1099 Amount	The provider’s income reported to federal and state governments for tax purposes. This amount is derived from the Net Pay Amount less the Credit Amount.
IRS Withheld Amount	Money amount withheld per IRS instructions.
Adjusted Net Pay Amount	Net pay amount (Block 5), less any IRS withheld amount (Block 8), and/or any Point of Sale service charges (Block 9).
1099 Information	Provider’s current 1099 information. This information is furnished to the IRS by EDS. Information includes the “Recipient Identifying Number” to identify the provider’s tax ID number and the “Payer ID” to identify EDS Corporation.
CLIA and UPIN Identification Numbers	Provider’s CLIA and UPIN numbers.
Message Code Summary	The explanation codes used in each section and their associated meanings appear at the end of the RA.

Common Denials And Their Resolution

Common Denials

The chart below lists the most common Explanation Of Benefits (EOB), a description of each, and the action needed for that EOB:

EOB	Description	Resolution
11	Recipient not eligible on service date	Verify eligibility on recipient's MID card or through the Voice Inquiry System. If information is correct, check RA for keying errors. If no errors are found on the RA, claim or MID Card, submit copy of the claim and RA along with a copy of the MID card to the Claims Analysis Unit at DMA.
18	Has exceeded Time Limitation	Submit claim with RA showing the 18-month time limit and show first filing within 365 days from date of service.
21	Duplicate of Claim-System	Reference RA date and claim number given under denied claims section. If this claim was not paid, call Provider Services at EDS for further information.
24	Revenue code is missing, invalid or invalid for this bill type. Correct and rebill denied detail as a new claim	See procedure/revenue code on the RA. If this information does not match the information on the claim, resubmit. If this information matches, verify the code and type of service billed and submit corrected claim.
27	Diagnosis code missing or invalid. Verify and enter the correct diagnosis code and submit as a new claim	<p>Possible reasons a claim may deny for this reason:</p> <ul style="list-style-type: none"> • Diagnosis code invalid • A zero is added to the end of the diagnosis code (If the files do not indicate a zero at the end of the diagnosis, the zero will cause the diagnosis to be invalid in EDS system). • When billing electronically, the provider includes the decimal point (The decimal is not included as part of the diagnosis code in the system). <p>Verify the diagnosis code(s) billed in Form Locators 67-76 and resubmit corrected claim.</p> <p>If claim is correct, contact the EDS Provider Services Unit to verify the diagnosis billed.</p>

Continued on next page

Common Denials And Their Resolution, Continued

Descriptions of EOBs and action needed to resolve denial (Continued)		
EOB	Description	Resolution
34	Indicate part B Medicare payment in form locator 54 and resubmit as a new claim.	This claim indicates Part B charges that need to be billed to Medicare Part B. After Medicare makes payment indicate Medicare's Part B payment in Form Locator 54. Indicate Medicare Part B as the payer in Form Locator 50.
36	Revenue code invalid on this type of bill	Verify the revenue code for accuracy and check RA for keying errors. Resubmit corrected claim.
40	Admission date/date of service missing or invalid. Verify and enter correct DOS and submit as a new claim.	Refile claim indicating admission date in form locator 17 on the UB-92.
79	This service is not payable to your provider type in accordance with Medicaid guidelines.	The revenue code billed is not valid for the provider type billed. Contact EDS Provider Services Unit to verify codes and provider numbers billed.
80	Units of service are not consistent with dates of service	Verify that the information in Block 6 matches the information in Block 7. Also, check the RA for keying errors
94	Indicate insurance payment or attach denial and submit as a new claim	The third party insurance company code, recipient's policy number and policyholder's name can be found on the RA. The insurance code can be found in the Third Party Insurance Code Book. Medicaid is always the payer of last resort, and all third party companies should be billed first. If that company denies the claim, submit a copy of the denial with the claim to EDS. If that company makes a payment, enter the amount of that payment in Block 54 of the UB-92. Medicaid will not make a payment unless the amount paid is less than the Medicaid-allowable.
143	Medicaid ID number not on state eligibility file	Verify that the number on the claim matches the number on the RA. If this information does not match, resubmit the claim. If this information matches, verify that the information is correct on the Medicaid ID card. If all the information is correct, send a copy of the MID card, claim and RA to the Claims Analysis Unit at DMA.

Continued on next page

Common Denials And Their Resolution, Continued

Descriptions of EOBs and action needed to resolve denial (Continued)		
EOB	Description	Resolution
191	Medicaid ID number does not match patient name	Verify that the information on the card matches the information on the claim and the RA. If all is correct, call Provider Services at EDS to verify the recipient's name on the eligibility file. EDS keys (for paper claims) the first two digits of the last name, the first digit of the first name and the MID number. If all three do not match, the result is a 191 denial.
609	UB-92 requires payer identification on Medicaid claims be designated by DNC00. Correct and rebill payer identifier.	In Form Locator 50 (either A, B, or C) please enter DNC00 to indicate Medicaid as the payer and refile corrected claim.
8918	Insufficient documentation to warrant time-limit override	Resubmit claim with proof of timely filing—a previous RA, time-limit override letter, or other insurance payment or denial letter within the previous six months.

Denials That Do Not Require Adjustments

EOBs Not Requiring Adjustment

Certain denial codes do not require an adjustment form or RA for reprocessing. If the denied claim or line item has a date of service within the past 12 months, the following procedures are sufficient for resubmission of the claim:

1. make the necessary corrections to the claim
2. attach requested information
3. send corrected claim and attachments to EDS for processing

Note: If the date of service is more than 12 months past the date of the adjustment form, follow the time-limit override instructions in *Chapter Eight, Reimbursement and Billing* under "Claims Submission."

The EOB denials on the following page do not require filing adjustments.

Continued on next page

Denials That Do Not Require Adjustments, Continued (Revised – 09/99),

0002	0085	0159	0221	0364	0590	0749	0932	1048
0003	0089	0160	0222	0394	0593	0755	0933	1049
0004	0093	0162	0223	0398	0604	0760	0934	1050
0005	0094	0163	0226	0424	0607	0777	0936	1057
0007	0095	0164	0227	0425	0609	0797	0940	1058
0009	0100	0165	0235	0426	0610	0804	0941	1059
0011	0101	0166	0236	0427	0611	0805	0942	1060
0013	0102	0167	0237	0428	0612	0814	0943	1061
0014	0103	0170	0240	0430	0616	0817	0944	1062
0017	0104	0171	0241	0435	0620	0819	0945	1063
0019	0105	0172	0242	0438	0621	0820	0946	1064
0023	0106	0174	0244	0439	0622	0822	0947	1078
0024	0108	0175	0245	0452	0626	0823	0948	1079
0025	0110	0176	0246	0462	0635	0824	0949	1084
0026	0111	0177	0247	0465	0636	0825	0950	1086
0027	0112	0179	0249	0505	0641	0860	0952	1087
0029	0113	0181	0250	0511	0642	0863	0953	1091
0033	0114	0182	0251	0513	0661	0864	0960	1092
0034	0115	0183	0253	0516	0662	0865	0967	1140
0035	0118	0185	0255	0523	0663	0866	0968	1141
0036	0120	0186	0256	0525	0665	0867	0969	1142
0038	0121	0187	0257	0529	0666	0868	0970	1152
0039	0122	0188	0258	0536	0668	0869	0972	1154
0040	0123	0189	0270	0537	0669	0875	0974	1170
0042	0126	0191	0279	0548	0670	0888	0986	1175
0041	0127	0194	0282	0553	0671	0889	0987	1177
0046	0128	0195	0283	0556	0672	0898	0988	1178
0047	0129	0196	0284	0557	0673	0900	0989	1181
0049	0131	0197	0286	0558	0674	0905	0990	1183
0050	0132	0198	0289	0559	0675	0908	0991	1184
0051	0133	0199	0290	0560	0676	0909	0992	
0058	0134	0200	0291	0569	0677	0910	0995	
0062	0135	0201	0292	0572	0679	0911	0997	
0063	0138	0202	0293	0574	0680	0912	0998	
0065	0139	0203	0294	0575	0681	0913	1001	
0067	0141	0204	0295	0576	0682	0916	1003	
0068	0143	0205	0296	0577	0683	0917	1008	
0069	0144	0206	0297	0578	0685	0918	1022	
0074	0145	0207	0298	0579	0688	0919	1023	
0075	0149	0208	0299	0580	0689	0920	1035	
0076	0151	0210	0316	0581	0690	0922	1036	
0077	0153	0211	0319	0584	0691	0925	1037	
0078	0154	0213	0325	0585	0698	0926	1038	
0079	0155	0215	0326	0586	0732	0927	1043	
0080	0156	0217	0327	0587	0734	0929	1045	
0082	0157	0219	0356	0588	0735	0931	1046	
0084	0158	0220	0363	0589			1047	

1186	2911	5228	7740	7935	7972	8905	9221	9259
1197	2912	5229	7741	7936	7973	8906	9222	9260
1198	2913	5230	7788	7937	7974	8907	9223	9261
1204	2914	5400	7794	7938	7975	8908	9224	9263
1232	2915	5401	7900	7939	7976	8909	9225	9264
1233	2916	5402	7901	7940	7977	9036	9226	9265
1275	2917	5403	7904	7941	7978	9054	9227	9266
1278	2918	5404	7905	7942	7979	9101	9228	9267
1307	2919	5405	7906	7943	7980	9102	9229	9268
1324	2920	5406	7907	7944	7981	9103	9230	9269
1350	2921	5407	7908	7945	7982	9104	9231	9272
1351	2922	5408	7909	7946	7983	9105	9232	9273
1355	2923	5409	7910	7947	7984	9106	9233	9274
1380	2924	5410	7911	7948	7985	9174	9234	9275
1381	2925	6703	7912	7949	7986	9175	9235	9291
1382	2926	6704	7913	7950	7987	9180	9236	9295
1400	2927	6705	7914	7951	7988	9200	9237	9600
1404	2928	6707	7915	7952	7989	9201	9238	9611
1442	2929	6708	7916	7953	7990	9202	9239	9614
1443	2930	7700	7917	7954	7991	9203	9240	9615
1502	2931	7701	7918	7955	7992	9204	9241	9625
1506	2944	7702	7919	7956	7993	9205	9242	9630
1513	3001	7703	7920	7957	7994	9206	9243	9631
1866	3002	7704	7921	7958	7996	9207	9244	9633
1868	3003	7705	7922	7959	7997	9208	9245	9642
1873	5001	7706	7923	7960	7998	9209	9246	9684
1944	5002	7707	7924	7961	7999	9210	9247	9801
1949	5201	7708	7925	7962	8174	9211	9248	9804
1956	5206	7709	7926	7963	8175	9212	9249	9806
1999	5216	7712	7927	7964	8326	9213	9250	9807
2024	5221	7717	7928	7965	8327	9214	9251	9919
2027	5222	7733	7929	7966	8400	9215	9252	9947
2235	5223	7734	7930	7967	8401	9216	9253	9993
2236	5224	7735	7931	7968	8901	9217	9254	
2237	5225	7736	7932	7969	8902	9218	9256	
2238	5226	7737	7933	7970	8903	9219	9257	
2335	5227	7738	7934	7971	8904	9220	9258	

The Adjustment Request Form

Instructions

The Adjustment Request Form should only be used to adjust a previously paid claim or to inquire denials not listed on EOBs on the preceding page. This form should not be used to inquire about a claim or to submit a claim for services which exceed filing time limit.

Always attach the RA(s) related to the adjustment when filling out this form, as well as any medical records that justify the reason for paying a previously denied claim/detail.

The following are instructions for completing the Adjustment Request Form:

- provider number—indicate the billing provider number
- provider name—enter the name of the billing provider
- recipient's name—enter the recipient's name as it appears on the Medicaid card
- recipient ID #—enter the recipient ID number as appears on the Medicaid card
- date of service—indicate the beginning date of service and ending date of service covered on the original claim
- claim number—enter the internal claim number (ICN) as indicated on the RA. Reference the original ICN, even with a subsequent denied adjustment. For an adjustment that has a payment on a detail, reference the adjustment ICN as the claim number
- type of adjustment—indicate the reason for the adjustment, i.e., overpayment, underpayment, full recoupment, or any other reason
- billed amount—indicate the amount billed on the original claim
- paid amount—enter the amount paid on the original claim
- RA date—enter the date the original claim was paid
- changes or corrections to be made—indicate the reason for the adjustment, i.e., incorrect units processed and paid, incorrect date of service, third party liability (TPL), etc.
- specific reason for adjustment—indicate the specific reason for adjustment. If the adjustment is necessitated by incorrect units, indicate total number of correct units as it should have appeared on the original claim and the correct date of service
- signature of sender
- date—indicate the date the adjustment request is submitted/mailed
- phone number—indicate the phone number of the person filling out form

Continued on next page

The Adjustment Request Form, Continued

Tips for Filing Adjustments

The following tips will assist in completing the adjustment form. This list also references common oversights that delay adjustment processing.

- complete one adjustment form per claim—EDS does not need a request for each line item on a single claim
- reference only one claim number per adjustment request form
- if review of a previously denied adjustment is requested, reference the original claim number and resubmit with all supporting documentation pertaining to the adjustment
- include the appropriate RA with each adjustment request. If multiple RAs are involved in the claims payment, include copies of each RA
- include a copy of the claim referenced on the adjustment request (not applicable for electronic claims)
- when the adjustment request involves a corrected or revised claim, send both the original and revised claim. Do not remove previous paid details on the claim
- include pertinent information on a separate sheet of paper. Do not submit information on back of copies since these documents are microfilmed on the front side only
- be certain any information submitted with the adjustment request is legible
- send only the medical records which pertain to the services rendered. If other information is attached, explain why it is with the request for an adjustment
- do not send other claims with the adjustment request; send only those claims which pertain to the payment/denial in question. *Service dates which have not been submitted should be filed as a new day claim (this includes late charges for codes not previously filed)*
- when submitting an adjustment to Medicaid because of a Medicare-adjusted voucher, attach both the original and the adjusted Medicare vouchers, and reference the claim number of the original voucher
- keep the back page of the RA containing the explanation of benefits (EOB) message with records

Once an Adjustment Request Form has been filed, the status of the claim should appear on the RA within 30 days as pending. If the adjustment request does not appear as pending, verify that the recipient MID and the claim number referenced are complete and correct. If the MID or claim number is incorrect, refile the adjustment request with the correct information.

Filing Tips for Specific Adjustments

Combining charges	Should be filed indicating the combined Revenue Code (RC) and the corrected billed amount.
Units	Check the units field on the adjustment form and indicate the correct number of units.
Billed amounts	Indicate on the adjustment request form the correct billed amount. Do not submit the difference in the two billed amounts.
Duplicate outpatient	Should be filed with outpatient hospital records. Do not submit with front and back copies because these documents are microfilmed on the front side only.

Continued on next page

The Adjustment Request Form, Continued

Filing Tips for Specific Adjustments,
(continued)

Inpatient LTC duplicates	Inpatient and long-term care facilities should submit duplicate denial adjustments with records only for dates in question. These records may be daily progress notes or admission discharge reports.
Cross over duplicate	Must contain all related Medicare vouchers. If the adjustment is necessitated by Medicare processing and paying two separate claims, the provider should send both claim copies and both Medicare vouchers. The referenced claim must be the duplicate denied ICN.
Medicare adjustment	Attach both vouchers, the original and the adjusted Medicare vouchers. The referenced claim must be the previously processed and paid ICN.
Time-limit denials	Should not be submitted as adjustments. If a denial that does not require an adjustment needs to be corrected but it is beyond the 12-month time limit for filing, refer to time-limit override section of this document.
Patient liability	Should include the latest DMA-5016 form pertaining to date of service (DOS) and all related RAs showing a liability amount applied to the claim. DMA reviews these requests for clarity. If the following message appears on the RA: Explanation of Benefits (EOB) 9607 “Adjustment being reviewed for change in patient liability, do not refile your adjustment; it will be processed for you,” do not resubmit the adjustment. DMA resubmits these adjustments for processing.
TPL adjustments	Should indicate the Third Party Liability (TPL) amount on the form. Submit a copy of the TPL voucher showing payment.
Review for under-payment	Should include the medical record, operative notes, anesthesia records, etc. Submit only the records that may affect the claims payment. These records are reviewed by medical staff who make the decision to either reimburse the provider or to deny the adjustment as paid correctly.

Adjustment Filing Errors

The following is a list of the most commonly identified adjustment filing errors:

- incomplete forms, incomplete/invalid MID, incomplete ICN
- multiple ICNs on same form
- nonspecific reason for adjustment request
- related RAs not included
- referencing a denied adjustment ICN
- failure to reference a partially paid or partially recouped adjustment number as the original ICN
- filing adjustments beyond 18-month time limit
 - ◆ if provider waits until the 17th month from the date of payment to file the adjustment, EDS may no longer have history on file to adjust the original claim.
 - ◆ submit the adjustment as soon as possible so that it can be processed within the 18-month time limit
- filing adjustment requests without required documentation, i.e., Medicare vouchers, medical records, operative records, etc.

Adjustment Form

Attachment A on the following page is the Medicaid Adjustment Form that is sent to EDS.

Continued on next page

Medicaid Adjustment Form

MAIL TO:
EDS ADJUSTMENT UNIT
P O BOX 300009
RALEIGH, NC 27622

Provider Number: _____

Provider Name: _____

Recipient Name: _____ Recipient ID #: _____

Date of Service: From: / / to / / Claim Number: _____

Please Check (): Billed Amount: Paid Amount: RA Date:
____ Overpayment _____ _____ _____

NOTE: **THIS FORM IS FOR CLAIM ADJUSTMENT ONLY.**

____ Underpayment A CORRECTED CLAIM AND RA MUST BE ATTACHED.

____ Full Recoupment

____ Other

CLAIM INQUIRIES (i.e., time-limit overrides) WILL NOT BE PROCESSED FROM THIS FORM

Please Check () changes or corrections to be made:

____ Units _____ Procedure/Diagnosis Code _____ Billed Amount

____ Dates of Service _____ Patient Liability _____ Further Medical Review

____ Third Party Liability _____ Medicare Adjustments

Please Specify Reason for Adjustment Request:

Signature of Sender: _____ Date: _____ Phone #: _____

TO BE USED BY EDS ONLY

Remarks:

Medicaid Adjustment Form, Continued

Automatic Recoupments

If previously paid charges would cause a current claim to deny during the audit review, EDS initiates an adjustment to recoup the charges paid in history. This procedure insures proper payment of services rendered. Some examples of situations where automatic recoupments are initiated:

- charges included in dialysis treatment
 - lab codes are paid in history, current claim is filed for dialysis treatments, which include the lab charges previously paid. EDS would initiate the adjustment to recoup the lab payments to pay the dialysis treatment code
 - outpatient hospital charges filed on the same date of service as inpatient claim
 - inpatient hospital claim denies as duplicate due to payment made to outpatient services. EDS would initiate the adjustment to recoup the outpatient hospital payments
 - charges billed by both the independent lab and the attending physician
 - charges paid by Medicaid that should be paid by Medicare
-

The Medicaid Resolution Inquiry Form

Instructions

Use the Medicaid Resolution Inquiry Form (Attachment B on the following page) only to submit claims for time-limit overrides, TPL overrides, and other claims requiring overrides prior to processing, i.e., Medicare Part A, Medicare Part B, etc. After completing this form, attach the claim, RAs, and any other related information.

Complete the Medicaid Inquiry Form as follows:

1. Provider number—indicate the billing provider number
 2. Provider name and address—indicate the billing provider name and address
 3. Recipient name—enter the recipient name, as it appears on the Medicaid card
 4. Recipient ID—enter the recipient ID, as it appears on the Medicaid card
 5. Date of Service—indicate the specific date(s) of service
 6. Claim number—indicate the ICN if the claim was previously processed
 7. Billed amount—enter the total amount billed on the claim
 8. Paid amount—enter the amount paid on the original claim
 9. RA date—enter the date the original claim was paid
 10. Specific reason for inquiry—indicate the specific reason for adjustment. If the adjustment is the result of procedures not being combined, indicate the code which are being combined. If the adjustment is necessitated by incorrect units, indicate total number of correct units as it should have appeared on the original claim and the correct date of service.
 11. Signature of sender
 12. Date—indicate the date the adjustment request is submitted/mailed
 13. Phone number—indicate the phone number of the person filling out form
-

Medicaid Resolution Inquiry Form

MAIL TO:
EDS PROVIDER SERVICES
P O BOX 300009
RALEIGH, NC 27622

Please Check: Claim Inquiry Time-limit Override

NOTE: PLEASE USE THIS FORM FOR **TIME-LIMIT OVERRIDES AND INQUIRIES ONLY**. CLAIM, RAs, AND ALL RELATED INFORMATION MUST BE ATTACHED.

ADJUSTMENTS WILL NOT BE PROCESSED FROM THIS FORM.

Provider Number: _____

Provider Name : _____

Provider Address _____

Patient's Name: _____

Recipient ID #: _____

Date of Service: From: / / to / / Claim Number: _____

Billed Amount: _____ Paid Amount: _____ RA Date: _____

Please Specify Reason for Inquiry Request:

Signature of Sender:

Date:

Phone #:

TO BE USED BY EDS ONLY

Remarks:

Refunds (When to Refund)

Introduction

When processing Medicaid claims, the following can occur: overpayments, third party reimbursements, and incorrect claim submissions. Two methods correct these occurrences: refunds or adjustments/recoupments. This section defines the requirements for issuing refunds to the Medicaid program and how these show on the RA.

Medicaid Regulations

Hospitals are required to complete a Medicaid Credit Balance report quarterly (*Chapter Eight, Reimbursement and Billing*). If the provider reimburses by refund, at the latest, the refund should be filed with the quarterly report. Refunds should be remitted back to the Medicaid program as soon as any incorrect payment is found. If not, recoupments could be processed against future Medicaid payments.

Refunds Versus Adjustments

Both refunds and adjustments are acceptable means to reimburse the Medicaid program, the primary difference being where the cash outlay occurs. If adjustments are used, then payments on future RAs are reduced by the requested adjustment amount. Refunds do not affect future Medicaid payments in any way since the reimbursement is made directly from the provider's available funds.

Other Health Insurance Payments

If the provider is not aware of other insurance coverage or liabilities for the recipient until after the receipt of the Medicaid payment, the provider must still file a claim with the health insurance company (but not the liability carrier as discussed in *Chapter Eight, Reimbursement and Billing*, "Third Party Payers") and then refund the Medicaid program the appropriate amount as described under "Refund Calculation."

Provider Medicaid Checks

If a provider receives a Medicaid check with the following errors:

1. The Medicaid check has the wrong provider number.
2. Payments are made for recipients who have not received services from the provider.

Then do the following:

- if the Medicaid check is for the wrong provider number, then the Medicaid check, along with the RA, should be returned to EDS for voiding. All claims payments will be voided, which takes approximately two Medicaid checkwrite cycles; then the claims can be resubmitted for correct provider payment
 - if the Medicaid check is for recipients who are not the provider's, return the Medicaid check with the RA to EDS for voiding. All claims payment will be voided, which takes approximately two Medicaid checkwrite cycles; then the claims can be resubmitted for correct provider payment
 - if the Medicaid check includes both recipients who are not patients of the provider and those who are patients of the provider do the following:
 - ◆ cash the check and refund the payments or submit an adjustment for the incorrect payments
-

Refund Calculation

Overview This section covers the calculation of refund amounts due to Medicaid.

Refund Calculation

Refund the amount as based on the following criteria:

- Duplicate payment—refund the full amount of the duplicate payment
 - Overpayment due to incorrect filing of claim, (e.g., billing amount error)—refund the amount of the overpayment (i.e., incorrect Medicaid payment less correct Medicaid payment) or refund the full Medicaid payment and resubmit the claim for repayment
 - Recipient liability—refund the amount Medicaid paid for which the recipient is responsible
 - Overpayment due to Medicare and Medicaid both paying as the primary insurer—refund the amount of the Medicaid payment that exceeds the coinsurance and deductible of Medicare.
 - Other health insurance payment—refund the lesser of the two amounts received not to exceed the Medicaid payment amount, for example:
 - ◆ Amount billed by the provider to Medicaid \$150.00
 - ◆ Amount paid by Medicaid \$140.00
 - ◆ Amount paid by other health insurance \$145.00
 - ◆ Amount to be reimbursed to Medicaid \$140.00
 - ◆ Amount kept by provider \$145.00
-

Refund Submission

Overview This section describes the documentation needed for refunds to ensure the proper application of a provider’s Medicaid refund.

RA Documentation

Refunds submitted to the Medicaid program must have supporting documentation for application to the correct recipient claim history. Always attach a copy of the RA to the refund check, highlighting the appropriate recipient and claim information along with the dollar amount of the refund to apply to that recipient. When refunding a particular line item of a recipient claim paid, highlight that specific line item for application of the refund. Without this RA documentation, EDS cannot apply a timely or correct refund. As a result, correct claims payment can be delayed and/or adjustments/recoupments may be processed.

Continued on next page

Refund Submission, Continued

**No RA
Documentation**

If a copy of the RA cannot be supplied, the following information is required to properly apply the refund against the recipient claim history:

- Provider number
- Recipient name and Medicaid identification number (MID)
- Claim number (claim line item number if applicable)
- Date(s) of service
- Dollar amount paid
- Dollar amount of refund
- Reason for refund (brief explanation)

This documentation can be supplied on the Medicaid refund form (DMA-7058) or any available means to the provider.

**Action Taken
When Refunds
Lack Adequate
Documentation**

When refunds are sent without adequate documentation as indicated above, EDS will send a letter to the provider requesting such documentation. If the documentation is not received within 30 days, EDS will apply these refunds to the determined provider number without detailed recipient claim history. If the refund was sent in error or was adjusted/recouped on a subsequent RA, then researching and resolving these refund inquiries without this documentation is further complicated and delayed. To ensure timely application and to avoid delay in correct claims payment, the required documentation needs to be supplied with each refund.

**Where to Send
the Refund**

Refund checks must be made payable to EDS. Mail the refund, along with the required documentation to the address listed in Appendix B.

Note: If DMA notifies the provider to refund monies, those funds are made payable to DMA and sent to the DMA address indicated in the letter of request.

Refund Application/Reflection

Overview

This section details the application/reflection of refunds on the Medicaid RA.

How Refunds Are Reflected on the RA

Once refunds are entered into the Medicaid system, the following data appears on the RA sent to the provider:

- the Financial Items Section contains a listing of the refunds applied and processed against the recipient claims history as indicated on the refund documentation
 - the EOB 113 is displayed for each refund transaction applied stating “refund amount applied to 1099 liability”
 - the Claims Payment Summary (last page of RA) indicates the total amount of refund(s) applied in the “credit amount” field, i.e., to give the provider credit for returning those funds
 - as a result of returning those funds, the “net 1099 amount” field is decreased by the “credit amount” to ensure the IRS is informed of the correct amount of monies earned and kept by the provider
 - refund transactions do not affect the “claims paid,” “claims amount,” “withheld amount,” or “net pay” amount fields of this section (i.e., refunds do not affect the amount paid to the provider but only the amount reported to the IRS)
-

Resubmitting Claims That Have Been Refunded

If a refund is sent due to a claim billing error, check for credit on the RA as noted above before resubmitting the claim. This will eliminate any possibility of the resubmitted claim being denied.

Erroneous Refunds

Erroneous Refunds

When processing refunds, the provider may refund incorrectly, and as a result, is due all or a portion of the refunded amount from Medicaid. In such cases, submit an adjustment/inquiry form to EDS at the address noted above, with the following information for verification:

- provider number
 - recipient name and Medicaid identification number (MID number)
 - claim number (claim line item number if applicable)
 - date(s) of service
 - dollar amount paid
 - dollar amount of refund
 - date refund was made
 - copy of refund check (front and back)
 - reason for refund error and amount due back to provider (brief explanation)
-

Continued on next page

Erroneous Refunds, Continued

Reasons for Requesting Refunds Back

The most common reasons for requesting refunded monies back are as follows:

- miscalculated refund amount
 - other health insurance or Medicare payments recouped/adjusted on same recipient claim history
 - Medicaid recouped/adjusted full amount due back because only a partial refund was made
-

Recoupments

Introduction

Recoupments can be initiated by several entities. They will always be processed as credits because they are a credit to the provider's 1099. Recoupments will always appear on the financial item page with an EOB of 112 "Check amount reduced by recoupment amount" applying the credit amount to the 1099.

System Recoupments

System recoupments are any type of recoupment not initiated by the provider. These occur for a variety of reasons as described below:

DMA recipient service recoupments:

- to correct previously paid claim that did not process and pay with a patient liability amount
- to correct claims that processed and paid as straight Medicaid when they should have been processed as a crossover
- to recoup when claims processed and paid with the incorrect recipient ID

DMA quality assurance recoupments:

- when claims are processed and paid in error due to failing to suspend limitation audits
- when claims are processed and paid with an invalid rate on file

DMA and EDS Medical Policy:

- to recoup payment of lesser procedures so a more extensive procedure can be paid (i.e. services included in a delivery recouped to pay the global package code or services in dialysis treatment to pay the dialysis treatment)
 - to recoup outpatient hospital services billed on the same date of service as hospital inpatient services
-

Manual Recoupments

Manual recoupments are authorized by DMA to collect:

- cost settlement payments
 - outstanding DMA accounts receivables and/or advances to providers
-

Continued on next page

Recoupments, Continued

Recoupments on the RA

System recoupments are reflected as follows:

- on the first RA as an adjustment in the Adjustment Section
 - on the first and all subsequent RAs as a Financial Items with EOB 112 indicating the amount withheld until the full adjustment is collected.
-

Payouts

Introduction

Payouts are payments used by the Medicaid program to reimburse the provider for monies due. Sending refunds and/or requesting adjustments can result in payouts. The purpose of this section is to define the guidelines for generating payouts to the Medicaid provider.

Common Reasons for Payouts

Payouts are a result of any of the following:

- Medicaid provider adjustment inquiry requesting a correction of payment which results in monies due to the provider in addition to the original payment
 - Medicaid provider adjustment inquiry requesting only an adjustment to claim/recipient history which always requires a payout of the full original amount and full recoupment of the original payment (i.e., both transactions are reflected on the RA; however, the net effect is no additional monies are paid to the provider. The history is only information adjusted.)
 - adjustment required by DMA or system review which results in monies due to the provider in addition to the original payment
 - Medicaid provider miscalculated refund amount (i.e., refunded too much money). Payout will be made for the excess refund amount
 - Medicaid provider refunded monies; however, provider refunded only a portion of amount due to Medicaid. Medicaid will recoup the full amount due and a payout will be made to the provider for the refund amount upon provider inquiry
 - other health insurance or Medicare payments recouped/adjusted and provider refunded Medicaid payment. Upon provider inquiry a payout will be made to the provider for the refunded amount
-

State-Authorized Payouts

State-authorized payouts are a payment mechanism whereby DMA will authorize a payout to a Medicaid provider when payment cannot be made through regular Medicaid eligibility processing. Situations requiring this action include:

- a Medicaid provider verified status through a valid recipient card, but the recipient was no longer eligible for Medicaid
 - Medicaid recipient's eligibility history is no longer maintained on Medicaid system
-

Continued on next page

Payouts, Continued

How Payouts Are Reflected on RA

When a payout is processed and payment is generated to the provider, it will appear on the RA and payment will be included in that RA payment.

State-Authorized Payouts On RA

State-authorized payouts are reflected only in the Financial Items section of the RA with the EOB 111, "Settlement amount added to claims payment." Payment is included in the "Claims amount" column on the Claims Payment Summary (last page of RA).

Other Payouts On RA

When payouts are a result of provider, DMA, and/or system adjustment inquiry, the following will appear on the RA:

- the payout will be reflected in the RA adjustments section
 - the RA adjustment transaction will use "adjustment debit" for the description rather than payout
 - the EOB will be reason for adjustment
 - if the payout is the result of a history change, the corresponding recoupment will be reflected in the Financial Items section with the EOB 112, "Check amount reduced by recoupment amount." If a payout is in a Medicaid cycle, the RA Adjustments section total will equal the total amount of payout debits processed only. It will not include any reduction in the total of the RA Adjustments section as a result of recoupments processed.
 - the adjustment recoupment total will be reflected in the Financial Items section of the RA and should agree with the "Withheld amount" column on the Claims Payment Summary (last page of RA)
 - the total amount of payouts is included in the "Claims amount" column on the Claims Payment summary (last page of RA)
 - if the payout is the result of a history change, the payout amount is included in the "Claims amount" column and the corresponding recoupment amount will be included in the "Withheld amount" column resulting in the zero additional monies paid in the "Net pay" column
-

Payout Resolution Assistance

Questions regarding state-authorized payouts should be directed to DMA. See number in Appendix B.

For other payments, contact EDS Provider Services.
