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1. Remittance Advice Analysis

1.1. Introduction

This section covers the parts of the paper Medicaid remittance advice (RA) issued by the Department of Health and Welfare (DHW) for services offered by Medicaid. It addresses the following.

- Banner page
- Reversed, Paid, and/or Denied Details
- Summary Counts
- Warrant Data
- Earnings data
- Message Codes

The paper remittance advice, or RA, is a computer-generated notice sent to all Medicaid providers who have claims in the Medicaid system. Providers may elect to receive RAs electronically through their Trading Partner Account online. The RA shows providers the status of claims based on the system's most recent processing cycle. It also shows the breakdown of payment.

1.1.1. General Policy

If a provider renders two clearly different types of service, he or she will be issued more than one provider number. If a provider has more than one unique *pay to* provider number (NPI or atypical provider ID) under which they are billing, the provider will receive more than one RA, one for each *pay to* billing number. The RA is designed to simplify the provider's accounting and allows accurate reconciliation of Medicaid claims.

Remittance advices are produced weekly during the weekly claims cycle. All claims received and keyed into the system appear on the submitting provider's RA. If a claim was received late in the week and not entered into the system before the payment cycle or if the provider number is invalid, the claim will not appear on that week's RA.

Remittance advices are created only for providers who have claims or financial activity during the week. Providers must maintain a copy of their RAs for a minimum of five years.

1.1.2. Claim Status

Within each section of the paper RA, claims will be grouped by claim type. Crossover claims will be grouped with the appropriate claim type.

If a claim is submitted with multiple lines and some lines are paid and some are denied, the claim will be listed in the paid section. The claim is reported in the paid section because the provider received payment for a portion of the claim. The denied lines have an explanation of benefit codes listed in the detail message line.

For a claim to be adjusted, it will have to be reversed first. The claim will be listed in the RA as Reversed, with an R1 in the Claim Number. The claim will then show as an Adjusted claim listed in the Paid Claim section of the RA. It will have an A1 in the Claim Number. An Adjusted claim will not be seen without seeing a Reversed claim. However, a Reversed claim may be seen without an Adjusted claim.

All *processed* or *in-process* claims are placed into one of two categories within the section:

- Paid claims, or claims that have finalized but have no actual reimbursement because other insurance or Medicare reimbursed more than Medicaid allows.
- Denied claims, or claims which payment has been disallowed.

Additionally, the RA includes sections concerning:

- Warrant data – provider financial transactions that are not tied to a particular claim.
- Earnings data – details the amount of money that has been paid to the provider.

1.1.2.1. Receiving Electronic RAs

Providers may elect to receive the 835 electronic remittance advice and route the transaction to a vendor of choice by logging in to their Trading Partner Account on the Idaho DXC Technology Medicaid website and selecting **Manage Providers** under the *Account Maintenance* menu. For detailed instructions on setting up electronic RA preferences, refer to the *Trading Partner Account Registration and Maintenance Guide* at the **User Guides** link under the *Reference Material* menu at www.idmedicaid.com.

1.1.3. Internal Control Number (ICN)

An Internal Control Number (ICN) is a unique number assigned to all claims and identifies the claim on the provider's RA. In the new MMIS, the Internal Control Number (ICN) is known as the Claim ID number. It is made up of 13 characters in the following format.

YY = Julian Year (last two digits of the current year)
JJJ = Julian Day (from 001 to 365 or 366)
I = Indicator of how claim was received (W=Web, E=Electronic)
= Sequence numbers (seven characters)

Sample: 10075W0000125

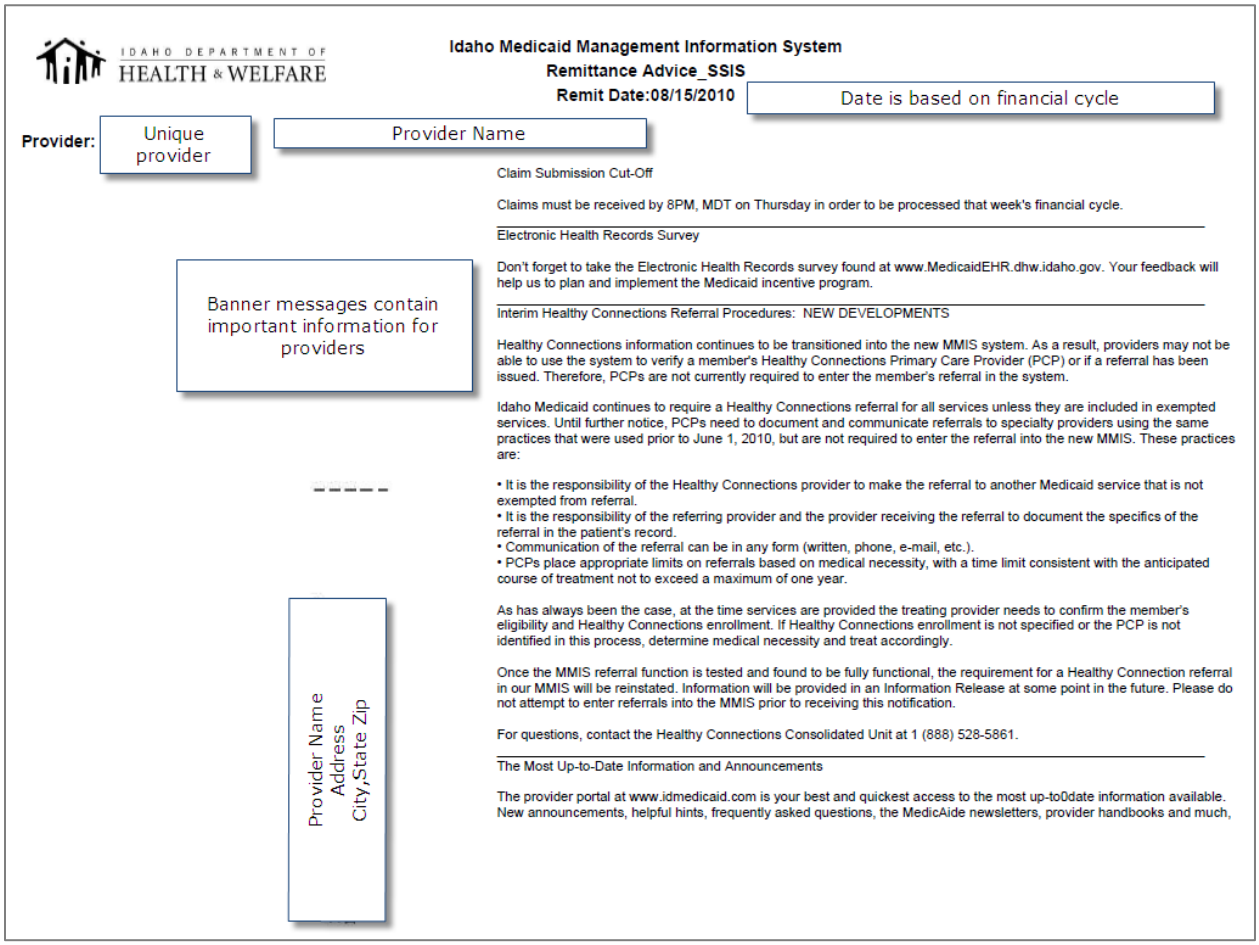
If a claim was adjusted or reversed, two additional characters will be added to the end of the ICN number. For reversed numbers an R1 will be added and for adjusted claims an A1 will be added.

Sample: 10075W0000125A1 – Adjusted Claim
10075W0000125R1 – Reversed Claim

1.2. Banner Page for Paper RA

The RA banner section is the first page of the paper RA report. This page displays messages from DHW regarding policy information and general notices.

Figure 1-1: Paper RA Banner Page



1.2.1. Field Descriptions for the Banner Page

Figure 1-2: Field Descriptions - Banner

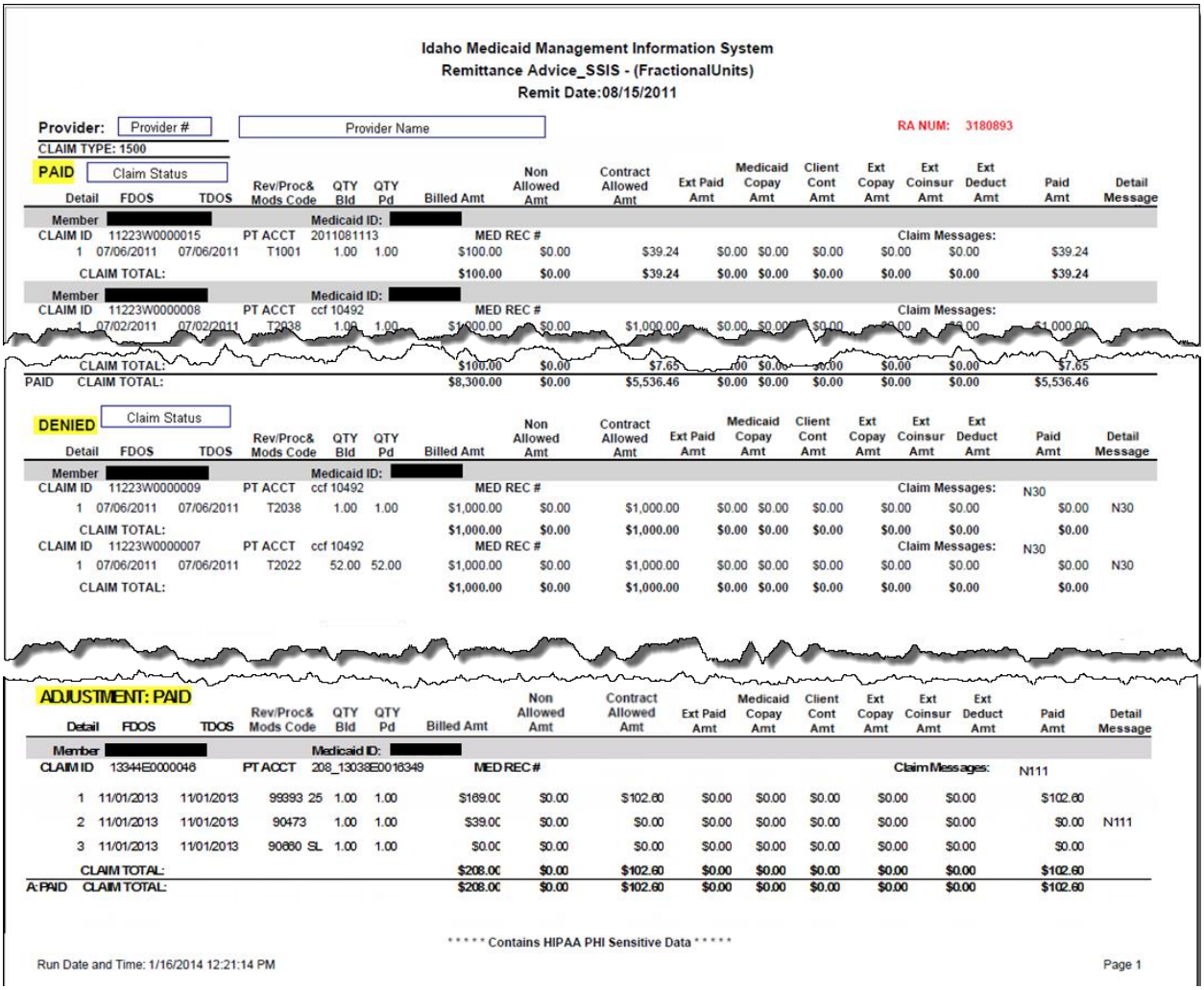
Field	Description
Provider	The unique number of the provider who is receiving the RA.
Provider Name	The name of the provider receiving the RA
Banner messages	This field provides text for DHW/Idaho Medicaid to display messages to providers.
Provider Name	This field is the name corresponding to the provider number.
Provider Address Line 1	This field corresponds to the, pay-to-provider, address located on the provider file.
Provider Address Street	This field corresponds to the, pay-to-provider, street address.
Provider Address City	This field corresponds to the, pay-to-provider, city.
Provider Address State	This field corresponds to the, pay-to-provider, state.
Provider Address Zip Code	This field corresponds to the, pay-to-provider, zip code.

1.3. Claim Details

The remittance advice contains paid and denied claim detail information. Beginning in March 2014, it will also contain adjusted claims based on third party and overpayment recoveries.

They will be seen in "Adjustment: (paid or reversed)" groups at the end of the claim detail section of the RA. These adjustments do not impact your payment and are for informational purposes only.

Figure 1-3: Paper RA Paid and Denied Claims



Idaho Medicaid Management Information System
Remittance Advice_SSIS - (FractionalUnits)
Remit Date:08/15/2011

Provider: Provider # Provider Name RA NUM: 3180893
CLAIM TYPE: 1500

PAID Claim Status

Detail	FDOS	TDOS	Rev/Proc& Mods Code	QTY Bld	QTY Pd	Billed Amt	Non Allowed Amt	Contract Allowed Amt	Ext Paid Amt	Medicaid Copay Amt	Client Cont Amt	Ext Copay Amt	Ext Coinsur Amt	Ext Deduct Amt	Paid Amt	Detail Message
Member [redacted]				Medicaid ID: [redacted]												
CLAIM ID 11223W0000015			PT ACCT 2011081113			MED REC #							Claim Messages:			
1	07/06/2011	07/06/2011	T1001	1.00	1.00	$100.00	$0.00	$39.24	$0.00	$0.00	$0.00	$0.00	$0.00		$39.24	
CLAIM TOTAL:						$100.00	$0.00	$39.24	$0.00	$0.00	$0.00	$0.00	$0.00		$39.24	
Member [redacted]				Medicaid ID: [redacted]												
CLAIM ID 11223W0000008			PT ACCT ccf 10492			MED REC #							Claim Messages:			
1	07/02/2011	07/02/2011	T2038	1.00	1.00	$1,000.00	$0.00	$1,000.00	$0.00	$0.00	$0.00	$0.00	$0.00		$1,000.00	
CLAIM TOTAL:						$100.00	$0.00	$7.65	$0.00	$0.00	$0.00	$0.00	$0.00		$7.65	
PAID CLAIM TOTAL:						$8,300.00	$0.00	$5,536.46	$0.00	$0.00	$0.00	$0.00	$0.00		$5,536.46	

DENIED Claim Status

Detail	FDOS	TDOS	Rev/Proc& Mods Code	QTY Bld	QTY Pd	Billed Amt	Non Allowed Amt	Contract Allowed Amt	Ext Paid Amt	Medicaid Copay Amt	Client Cont Amt	Ext Copay Amt	Ext Coinsur Amt	Ext Deduct Amt	Paid Amt	Detail Message
Member [redacted]				Medicaid ID: [redacted]												
CLAIM ID 11223W0000009			PT ACCT ccf 10492			MED REC #							Claim Messages:		N30	
1	07/06/2011	07/06/2011	T2038	1.00	1.00	$1,000.00	$0.00	$1,000.00	$0.00	$0.00	$0.00	$0.00	$0.00		$0.00	N30
CLAIM TOTAL:						$1,000.00	$0.00	$1,000.00	$0.00	$0.00	$0.00	$0.00	$0.00		$0.00	
CLAIM ID 11223W0000007			PT ACCT ccf 10492			MED REC #							Claim Messages:		N30	
1	07/06/2011	07/06/2011	T2022	52.00	52.00	$1,000.00	$0.00	$1,000.00	$0.00	$0.00	$0.00	$0.00	$0.00		$0.00	N30
CLAIM TOTAL:						$1,000.00	$0.00	$1,000.00	$0.00	$0.00	$0.00	$0.00	$0.00		$0.00	

ADJUSTMENT: PAID

Detail	FDOS	TDOS	Rev/Proc& Mods Code	QTY Bld	QTY Pd	Billed Amt	Non Allowed Amt	Contract Allowed Amt	Ext Paid Amt	Medicaid Copay Amt	Client Cont Amt	Ext Copay Amt	Ext Coinsur Amt	Ext Deduct Amt	Paid Amt	Detail Message
Member [redacted]				Medicaid ID: [redacted]												
CLAIM ID 13344E0000046			PT ACCT 208_13038E0016349			MED REC #							Claim Messages:		N111	
1	11/01/2013	11/01/2013	99393 25	1.00	1.00	$169.00	$0.00	$102.60	$0.00	$0.00	$0.00	$0.00	$0.00		$102.60	
2	11/01/2013	11/01/2013	90473	1.00	1.00	$39.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00		$0.00	N111
3	11/01/2013	11/01/2013	90680 SL	1.00	1.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00		$0.00	
CLAIM TOTAL:						$208.00	$0.00	$102.60	$0.00	$0.00	$0.00	$0.00	$0.00		$102.60	
A:PAID CLAIM TOTAL:						$208.00	$0.00	$102.60	$0.00	$0.00	$0.00	$0.00	$0.00		$102.60	

***** Contains HIPAA PHI Sensitive Data *****

Run Date and Time: 1/16/2014 12:21:14 PM Page 1

1.3.1. Field Descriptions for the Paper Remittance Advice (RA)

Figure 1-4: Field Descriptions - RA

Field	Description
Provider	The unique number of the provider who is receiving the RA.
Provider Name	The name of the provider receiving the RA.
RA NUM	The cash transaction ID that is on the check.
RA Title	The type of RA generated (*e.g.* CLAIM TYPE: 1500, UB04, Dental).
Claim Status	The status of the claims in this section (e.g. PAID, DENIED, REVERSED, Adjustment: PAID, Adjustment: REVERSED)
Member	The participant's full name sorted by last name, first name.

Field	Description
Medicaid ID	The participant's unique Medicaid identification (MID) number as it appears on the claim.
CLAIM ID	The unique number assigned to the claim.
PT ACCT	The participant account number that appears on the claim.
MED REC #	The medical record number that appears on the claim.
Claim Messages	The explanation of benefits (EOB) message codes, indicates the reasons for payment or denial of the claim at the header and the detail level.
Detail	Detail Number - corresponds to the line number on the claim.
FDOS	The *from* date of service that was rendered as it appears listed on the claim.
TDOS	The *to* date of service that was rendered as it appears listed on the claim.
Rev/Proc& Mods Code	The procedure code
QTY Bld	The Billed units of service
QTY PD	The Paid units of service
Billed Amt	The amount billed by the provider for service
Non Allowed Amt	The non-allowed amount for the claim
Contract Allowed Amt	The Medicaid contracted allowed amount for the claim detail
Ext Paid Amt	The amount paid by another insurance carrier for this claim detail
Medicaid Copay Amt	The copay amount to be paid by the participant for this claim detail
Client Cont Amt	The amount paid by participant for specific procedure
Ext Copay Amt	The copay amount paid by another insurance carrier for this claim detail
Ext Coinsur Amt	The coinsurance amount paid by another insurance carrier for this claim detail
Ext Deduct Amt	The amount applied to the deductible to the other insurance carrier for this claim detail
Paid Amt	The dollar amount paid for each line detail
Detail Message	The explanation of benefits (EOB) message codes, indicates the reasons for payment or denial of the claim on the detail level (lower portion of the claim).
CLAIM TOTAL	The sum of all billed amounts, non-allowed amounts, allowed amounts, other insurance amounts, Medicaid co-pay amounts, participant contribution amounts, co-pay amounts, coinsurance amounts, deductible amounts, and paid amounts for the claim type appearing in this section of the provider's RA. This value is equal to the sum of the amounts appearing on the detail level.
PAID / DENIED CLAIM TOTAL	The sum of all the claim totals.
Run Date & Time	Date and time report was run
Page Number	Number of page of the report

1.4. Summary Information

The summary information of the paper RA contains a summary of provider earnings, both current and year to date. This information is calculated per provider and is not separated by service location. A list of Explanation of Benefit (EOB) codes and descriptions, for all claims

referencing an EOB in other sections of the RA, are reported in alphabetical order at the end of this section.

The summary information page contains summary values for the following.

- Summary Counts
- Co-Pay Summary
- Warrant Data
- Earnings Data
- Message Codes

1.4.1. Summary Counts

The summary counts contain the number of claims paid, denied, reversed, and adjusted for the current RA and for year-to-date.

1.4.2. Co-Pay Summary

The Co-Pay Summary contains the total Co-Pay amounts for the current RA and for year-to-date.

1.4.3. Warrant Data

The warrant data contains provider financial activity for the current RA and year-to-date.

The following information is included.

- Claims Paid Amount
- Increase Due To Claim Adjustments
- Non-Claim Payout Amount-for example, a non-claim interim payment or a Healthy Connections Case Management Payment
- Recoupment Amount Withheld
- Amount Withheld Due To Claim Adjustments
- Lien, penalty and interest withheld
- Total warrant payment amount

1.4.4. Earnings Data

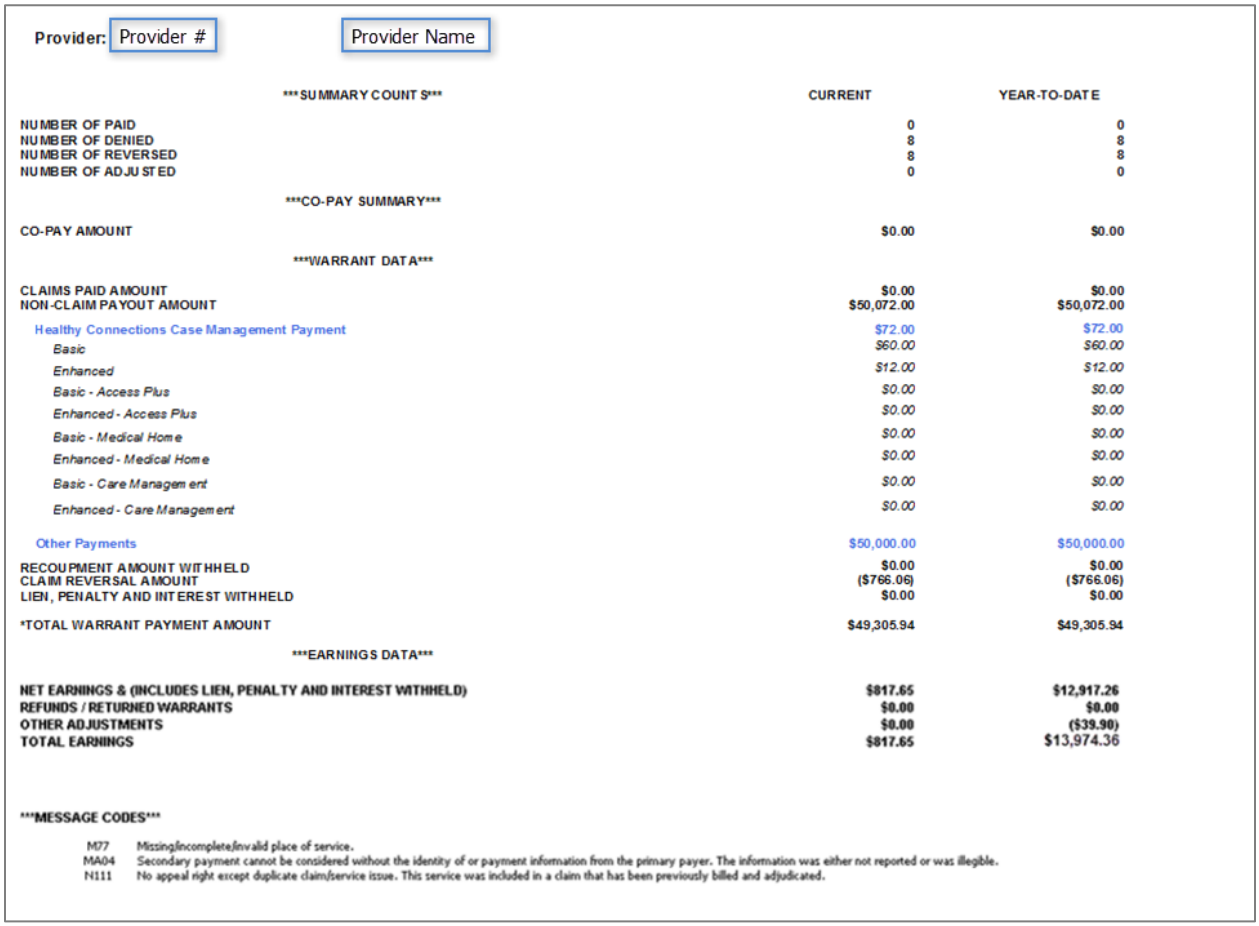
The earnings data contains provider earnings for the current RA and year-to-date. The following information is included.

- Net earnings (includes lien, penalty, and interest withheld)
- Refunds / Returned warrants
- Other Adjustments
- Total taxable earnings

1.4.5. Message Codes

The Message Codes contains the reason remark codes and descriptions of denied claims for the current RA.

Figure 1-5: Paper RA Summary Section



Provider: Provider # Provider Name

SUMMARY COUNTS	CURRENT	YEAR-TO-DATE
NUMBER OF PAID	0	0
NUMBER OF DENIED	8	8
NUMBER OF REVERSED	8	8
NUMBER OF ADJUSTED	0	0
CO-PAY SUMMARY		
CO-PAY AMOUNT	$0.00	$0.00
WARRANT DATA		
CLAIMS PAID AMOUNT	$0.00	$0.00
NON-CLAIM PAYOUT AMOUNT	$50,072.00	$50,072.00
Healthy Connections Case Management Payment	$72.00	$72.00
Basic	*$60.00*	*$60.00*
Enhanced	*$12.00*	*$12.00*
Basic - Access Plus	*$0.00*	*$0.00*
Enhanced - Access Plus	*$0.00*	*$0.00*
Basic - Medical Home	*$0.00*	*$0.00*
Enhanced - Medical Home	*$0.00*	*$0.00*
Basic - Care Management	*$0.00*	*$0.00*
Enhanced - Care Management	*$0.00*	*$0.00*
Other Payments	$50,000.00	$50,000.00
RECOUPMENT AMOUNT WITHHELD	$0.00	$0.00
CLAIM REVERSAL AMOUNT	($766.06)	($766.06)
LIEN, PENALTY AND INTEREST WITHHELD	$0.00	$0.00
*TOTAL WARRANT PAYMENT AMOUNT	$49,305.94	$49,305.94
EARNINGS DATA		
NET EARNINGS & (INCLUDES LIEN, PENALTY AND INTEREST WITHHELD)	$817.65	$12,917.26
REFUNDS / RETURNED WARRANTS	$0.00	$0.00
OTHER ADJUSTMENTS	$0.00	($39.90)
TOTAL EARNINGS	$817.65	$13,974.36

MESSAGE CODES

M77 Missing/incomplete/invalid place of service.
MA04 Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible.
N111 No appeal right except duplicate claim/service issue. This service was included in a claim that has been previously billed and adjudicated.

1.4.5.1. Field Descriptions for the Summary Section

Figure 1-6: Field Descriptions - Summary

Field	Description
Provider	The unique number of the provider who is receiving the RA.
PROVIDER NAME	The name of the provider receiving the RA.
SUMMARY COUNTS	The current RA and year-to-date summary counts for: NUMBER OF PAID CLAIMS NUMBER OF DENIED CLAIMS NUMBER OF REVERSED CLAIMS NUMBER OF ADJUSTED CLAIMS
Co-Pay Summary	Current and Year-to-Date amounts for Co-Pay

Field	Description
WARRANT DATA	The current RA and year-to-date warrant data for: CLAIM PAID AMOUNT NON-CLAIM PAYOUT AMOUNT Healthy Connections Case Management Payment Basic Enhanced Basic – Extended Enhanced – Extended Other Payments RECOUPMENT AMOUNT WITHHELD CLAIM REVERSAL AMOUNT LIEN, PENALTY AND INTEREST WITHHELD TOTAL WARRANT PAYMENT AMOUNT
EARNINGS DATA	The current RA and year-to-date earnings data for the provider, including: NET EARNINGS REFUNDS/RETURNED WARRANTS/OTHER ADJUSTMENTS TOTAL EARNINGS
MESSAGE CODES	These relate to the message codes printed under the detail information. They are EOB codes and indicate the reasons for denial of the claim on the detail level (lower portion of the claim).
FOOTER	Run Date and Time report was printed and page number.

Remittance Advice Analysis, Provider Handbook Modifications

This table lists the last three years of changes to this handbook as of the publication date.

Remittance Advice Analysis, Provider Handbook Modifications				
Version	**Section**	**Modification Description**	**Date**	**SME**
11.0	All	Published version	12/29/2020	TQD
10.1	2.3 Claim Details and 2.3.1 Field Descriptions for the Paper Remittance Advice (RA)	Updated sections based on CR63531.	12/16/2020	M Payne J Kennedy-King W Deseron E Garibovic
10.0	All	Published version	11/1/2018	TQD
9.1	All	Removed Molina references	11/1/2018	D Baker E Garibovic
9.0	All	Published version	3/8/2018	TQD
8.2	2.3.1 Field Descriptions for the Paper Remittance Advice (RA)	Changed "member" to "participant"	3/8/2018	W Deseron D Baker E Garibovic
8.1	2.1.1 General Policy	Changed "legacy ID" to "atypical provider ID"	3/8/2018	A Ramirez D Baker E Garibovic
8.0	All	Published version	1/6/2018	TQD
7.1	2.1.2.1 Receiving Electronic RAs	Updated for TPA upgrade	1/6/2018	T Humpherys D Baker E Garibovic