

Remittance Advices and Adjustments

The Remittance Advice

The remittance advice is the best tool providers have to determine the status of a claim. Remittance advices accompany payment for services rendered. The remittance advice provides details of all transactions that have occurred during the previous remittance advice cycle. Each line represents all or part of a claim and explains whether the claim or service has been paid, denied, or suspended/pending. If the claim was suspended or denied, the remittance advice also shows the reason.

Remittance advices are available electronically through the Montana Access to Health (MATH) web portal. To access the web portal and receive electronic remittance advices, providers must first complete an EDI Provider Enrollment Form and an EDI Trading Partner Agreement, and then register for the web portal.

Each provider must complete an EDI Trading Partner Agreement, but if there are several providers in one location who are under one tax ID number, they can use one submitter number. These providers should enter the submitter ID in both the provider number and submitter ID fields. Otherwise, enter the provider number in the provider number field.

After the forms have been processed, the provider receives a user ID and password to use to log into the MATH web portal. The verification process also requires a provider ID, a submitter ID, and a tax ID number.

Access the MATH web portal directly at <http://mtaccesstohealth.acs-shc.com> or through the MATH web portal link on the Provider Information [website](#).

Remittance advices are available in PDF format. Providers can read, print, or download PDF files using PDF reader software available online. Due to space limitations, each remittance advice is only available for 90 days. The remittance is divided into the following sections:

Remittance Advice Notice

This section is on the first page of the remittance advice. It contains important messages about rate changes, revised billing procedures, and many other items that may affect providers and claims.

Paid Claims

This section shows claims paid during the previous cycle. It is the provider's responsibility to verify that claims were paid correctly. If Medicaid overpays a claim and the problem is not corrected, it may result in an audit and the pro-



Remittance advices are available for only 90 days on the web portal.

vider having to return the overpayment plus interest. If a claim was paid at the wrong amount or with incorrect information, the claim must be adjusted. (See the Adjustments section later in this chapter.)

Denied Claims

This section shows claims denied during the previous cycle. If a claim has been denied, refer to the Reason/Remark column. The Reason and Remark Code description explains why the claim was denied and is located at the end of the remittance advice. See the section titled The Most Common Billing Errors and How to Avoid Them in the Billing Procedures chapter.

Pending Claims

All claims that have not reached final disposition will appear in this area of the remittance advice (pending claims are not available on X12 835 transactions). The remittance advice uses *suspended* and *pending* interchangeably. They both mean that the claim has not reached final disposition. If a claim is pending, refer to the Reason/Remark Code column. The Reason and Remark Code description located at the end of the remittance advice explains why the claim is suspended. This section is informational only and no action should be taken on claims displayed here. Processing continues until each claim is paid or denied.

Claims shown as pending with reason code 133 require additional review before a decision to pay or deny is made. If a claim is being held while waiting for member eligibility information, it may be suspended for a maximum of 30 days. If Medicaid receives eligibility information within the 30-day period, the claim will continue processing. If no eligibility information is received within 30 days, the claim will be denied. When a claim is denied for lack of eligibility, the provider should verify that the correct Medicaid ID number was billed. If the ID number was incorrect, resubmit the claim with the correct ID number.

Credit Balance Claims

Credit balance claims are shown in this section until the credit has been satisfied.

Gross Adjustments

Any gross adjustments performed during the previous cycle are shown in this section.

Reason and Remark Code Description

This section lists the reason and remark codes that appear throughout the remittance advice with a brief description of each.

Credit Balance Claims

Credit balances occur when claim adjustments reduce original payments causing the provider to owe money to the Department. These claims are considered in process and continue to appear on the remittance advice until the credit has been satisfied. Credit balances can be resolved in two ways:

- **By working off the credit balance.** Remaining credit balances can be deducted from future claims. These claims will continue to appear on consecutive remittance advices until the credit has been paid.
- **By sending a check payable to DPHHS for the amount owed.** This method is required for providers who no longer submit claims to Montana Medicaid. Please attach a note stating that the check is to pay off a credit balance and include your provider number. Send the check to the attention of the Third Party Liability unit.

Rebilling and Adjustments

Rebillings and adjustments are important steps in correcting any billing problems providers may experience. Knowing when to use the rebilling process versus the adjustment process is important.

Timeframe for Rebilling or Adjusting a Claim

Providers may resubmit, modify, or adjust any initial claim within the timely filing limits described in the Billing Procedures chapter.

The time periods do not apply to overpayments that the provider must refund to the Department. After the 12-month time period, a provider may not refund overpayments to the Department by completing a claim adjustment. The provider may refund overpayments by issuing a check or requesting a gross adjustment be made.

Rebilling Medicaid

Rebilling is when a provider submits a claim to Medicaid that was previously submitted for payment but was either returned or denied. Claims are often returned to the provider before processing because key information such as Medicaid provider number or authorized signature and date are missing or unreadable. For tips on preventing returned or denied claims, see the Billing Procedures chapter in this manual.

When to Rebill Medicaid

- **Claim Denied.** Providers may rebill Medicaid when a claim is denied. Check the reason and remark codes, make the appropriate corrections and resubmit the claim. **Do not attempt to adjust denied claims.**

- **Line Denied.** When an individual line is denied on a multiple-line claim, correct any errors and rebill Medicaid. For CMS-1500 claims, do not use an adjustment form. In the case of a UB-04, the line should be adjusted rather than rebilled. (See the Adjustments section.)
- **Claim Returned.** Rebill Medicaid when the claim is returned under separate cover. Occasionally, Medicaid is unable to process the claim and will return it to the provider with a letter stating that additional information is needed to process the claim. Correct the information as directed and resubmit the claim.

How to Rebill

- Check any reason and remark code listed and make corrections on a copy of the claim, or produce a new claim with the correct information.
- When making corrections on a copy of the claim, remember to line out or omit all lines that have already been paid.
- Submit insurance information with the corrected claim.

Adjustments

If a provider believes that a claim has been paid incorrectly, the provider may call Provider Relations. Once an incorrect payment has been verified, the provider should submit an Individual Adjustment Request form to Provider Relations. If incorrect payment was the result of a Xerox keying error, contact Provider Relations.

When adjustments are made to previously paid claims, the Department recovers the original payment and issues appropriate repayment. The result of the adjustment appears on the provider's remittance advice as two transactions. The original payment will appear as a credit transaction. The replacement claim reflecting the corrections will be listed as a separate transaction and may or may not appear on the same remittance as the credit transaction. The replacement transaction will have nearly the same ICN number as the credit transaction, except the 12th digit will be a 2, indicating an adjustment. Adjustments are processed in the same time frame as claims.

When to Request an Adjustment

- Request an adjustment when the claim was overpaid or underpaid.
- Request an adjustment when the claim was paid but the information on the claim was incorrect (e.g., member ID, provider number, date of service, procedure code, diagnoses, units).
- Request an adjustment when an individual line is denied on a multiple-line UB-04 claim. The denied service must be submitted as an adjustment rather than a rebill.

How to Request an Adjustment

To request an adjustment, use the Individual Adjustment Request form available on the Forms page of the [website](#). Requirements for adjusting a claim are:

- Adjustments can only be submitted on paid claims; denied claims cannot be adjusted.
- Claims Processing must receive individual claim adjustments within 12 months from the date of service. (See the Timely Filing section in the Billing Procedures chapter in this manual.) After this time, gross adjustments are required.
- Use a separate adjustment request form for each ICN.
- If correcting more than one error per ICN, use only one adjustment request form, and include each error on the form.
- If more than one line of the claim needs to be adjusted, indicate which lines and items need to be adjusted in the Remarks section.

Completing an Adjustment Request Form

1. Download the Individual Adjustment Request form from the Provider Information website. Complete Section A with provider and member information and the claim's ICN (see following table).
2. Complete Section B with information about the claim. Remember to fill in only the items that need to be corrected (see following table):
 - Enter the date of service or the line number in the Date of Service or Line Number column.
 - Enter the information from the claim form that was incorrect in the Information on Statement column.
 - Enter the correct information in the Corrected Information column.
3. Attach copies of the remittance advice and a corrected claim if necessary.
 - If the original claim was billed electronically, a copy of the remittance advice will suffice.
 - If the remittance advice is electronic, attach a screen print of it.
4. Verify the adjustment request has been signed and dated.
5. Send the adjustment request to Claims Processing.
 - If an original payment was an underpayment by Medicaid, the adjustment will result in the provider receiving the additional payment amount allowed.
 - If an original payment was an overpayment by Medicaid, the adjustment will result in recovery of the overpaid amount from the provider. This can be done in two ways, by the provider issuing a check to the Department, or by maintaining a credit balance until it has been satisfied with future claims. (See Credit Balance earlier in this chapter.)
 - Direct questions regarding claims or adjustments to Provider Relations.

Completing an Individual Adjustment Request Form

Field	Description
Section A	
1. Provider Name and Address	Provider's name and address (and mailing address if different).
2. Name	The member's name
3. Internal Control Number (ICN)	There can be only one ICN per Adjustment Request Form. When adjusting a claim that has been previously adjusted, use the ICN of the most-recent claim.
4. Provider number	The provider's NPI/API.
5. Member Medicaid Number	Member's Medicaid ID number.
6. Date of Payment	Date claim was paid.
7. Amount of Payment	The amount of payment from the remittance advice.
Section B	
1. Units of Service	If a payment error was caused by an incorrect number of units, complete this line.
2. Procedure Code/NDC Revenue Code	If the procedure code, NDC, or revenue code are incorrect, complete this line.
3. Dates of Service (DOS)	If the date of service is incorrect, complete this line.
4. Billed Amount	If the billed amount is incorrect, complete this line.
5. Personal Resource (Nursing Facility)	If the member's personal resource amount is incorrect, complete this line.
6. Insurance Credit Amount	If the member's insurance credit amount is incorrect, complete this line.
7. Net (Billed - TPL or Medicare Paid)	If the payment error was caused by a missing or incorrect insurance credit, complete this line. Net is billed amount minus the amount TPL or Medicare paid.
8. Other/Remarks	If none of the above items apply, or if unsure what caused the payment error, complete this line.

Mass Adjustments

Mass adjustments are done when it is necessary to reprocess multiple claims. They generally occur when:

- Medicaid has a change of policy or fees that is retroactive. In this case federal laws require claims affected by the changes to be mass adjusted.
- A system error that affected claims processing is identified.

Providers are informed of mass adjustments on the first page of the remittance advice, the monthly *Claim Jumper*, or provider notices. Mass adjustment claims shown on the remittance advice have an ICN that begins with a 4.

Payment and the Remittance Advice

Medicaid payment and remittance advices are available weekly. Payment is via electronic funds transfer (EFT). Direct deposit is another name for EFT. The electronic remittance advices (ERAs) are available on the web portal for 90 days.

With EFT, the Department deposits the funds directly to the provider's financial institution account. Holidays may delay payments until the next business day.

Other Programs

The information in this chapter also applies to the Mental Health Services Plan (MHSP), and Healthy Montana Kids (HMK) dental and eyeglasses benefits.

