



Billing 101—Part 2: Understanding Remittance Advice



Webinar Question and Answer List

HP and RI Medicaid hosted a webinar titled “Billing 101—Part 2: Understanding Remittance Advice” on April 3, 2014.

During the event, the presenters answered questions from participants in a question and answer segment. Below is a summary of the questions and answers.

Please note: *Not all questions are included in this list. In addition, similar questions have been combined.*

Q: Since ICD-10 may be delayed, do I have to begin using the new CMS 1500 (02/12)?

A: Yes, claims arriving at HP on or after April 1, 2014 must be on the new form. Version 08/05 will no longer be accepted and will be returned to the provider.

Q: When will the new financial calendar be available?

A: The new calendar will be available late June, at the earliest. The current calendar can be found at: http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/MA%20Providers/SFY2014_payment_schedule.pdf

Q: Is the Remittance Advice document available in Excel?

A: No

Q: Where can I get my paper Remittance Advice document?

A: Providers must first get a Trading Partner ID by completing a [Trading Partner Agreement](#). Once Providers have a Trading Partner ID, they can use it to log into the Interactive Web Services and access the RA document.

Q: Does RI Medicaid assign the taxonomy?

A: No. When applying for an NPI, the Provider must choose the taxonomy that best fits their specialization. That code must be sent to HP to add to the provider’s Medicaid profile. The correct NPI taxonomy combination is necessary for claims to be paid correctly.

Q: Can secondary claims be billed electronically?

A: Yes, they must be coded to show Other Insurance, payment or denial date, the payment amount if applicable, and the reason for submission to Medicaid. (i.e. co-pay, co-insurance, not covered, benefits exhausted.)

Q: What are the timely filing requirements for a secondary claim?

A: Claims must be submitted within one year from the date of service (DOS). Claims with primary insurance other than Medicaid must be submitted within 90 days of the process date of the other payer.

Q: How can I get help with replacements and voids?

A: You may be able to find the answer you are looking for on the “cheat sheet” posted on the web. You can find that at: http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/replacements_voids.pdf . For additional assistance, contact your Provider Representative.

Q: How do I correct a claim that was denied for 552: This service requires split billing for managed care recipients?

A: Providers should verify recipient eligibility on the Interactive Web Services. The request will return Medicaid eligibility and Managed Care eligibility. Claim should be billed based on the split in dates for Managed Care eligibility. Ex. Client has Medicaid from 1/1-1/15 and Managed Care from 1/16-1/31. The claim should be split into two lines using those dates.

Q: Is timely filing determined from the date received or the date processed?

A: Neither. It is based on date of service. Claims should be submitted within one year from date of service. If claim was previously denied, then it must be submitted on paper to your Provider Representative within 90 days of the RA date.

Q: Can a specific detail be replaced/adjusted or voided/recouped electronically?

A: Yes

Replacements/Adjustments

When submitting a replacement/adjustment for a multiple detail claim, change only the detail that needs to be adjusted. The other details will remain on the claim as they were originally submitted. Change Claim Frequency to 7.

This will recoup the entire claim then reprocess the all the details again. The adjusted detail will pay the new amount and the other details will process and pay the same amount as the original claim.

VOIDS/RECOUPMENTS

When submitting a void/recoupment for a multiple detail claim, delete only the details of the claim you want to void. The other details will remain on the claim as they were originally submitted.

Change Claim Frequency to 7. This will recoup the entire claim then reprocess the new claim with only the details that were not deleted. Those details will pay the same amount as the original claim.