PROVIDER QUICK TIPS

#07

Are You Puzzled by Your Remittance Advice Statement?

The Remittance Advice (RA) Statement explains the actions taken and the status of claims and claims adjustments processed by DHS during a processing cycle. The **Cover Page** of the RA is used as a mailing label and contains the "Address" where the RA is being sent. This is followed by an optional Banner Page, the "Detail" page(s) that lists all claims processed during the PA PROMISe™ daily cycle, and a "Summary" page of activity from the detail page(s.) Finally, the last page(s) is the "Explanation of Edits Set This Cycle" page(s.)

Sample – Cover Page

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                              COMMONWEALTH OF PENNSYLVANIA                  Processing Date: 05/21/2004
                                DEPARTMENT OF PUBLIC WELFARE                            Page:     42,029
                                          PA PROMISe
                                PROVIDER REMITTANCE ADVICE                                          1

PROVIDER NUMBER  LOC  TYPE
  123456789      0001  24




                                                        CENTRAL PA MEDICAL ASSOCIATES LLP
                                                        PO BOX 9999
                                                        1234 W EAST ST N
                                                        SAMPLEVILLE, PA 17777-9999
```

A sample of an **RA Banner Page** is displayed below. The definitions of the items on the RA Banner page are on the second page of this Quick Tip. A PA PROMISe™ Banner Page will be included as part of the first page (or as an insert in the RA Statement) when DHS has a need to disseminate information quickly to the provider community. Please read these Banner Pages carefully as the information contained may affect your payments.

PROVIDER QUICK TIPS

#07

Sample – Banner Page

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                                COMMONWEALTH OF PENNSYLVANIA                Processing Date: 05/21/2004
                                DEPARTMENT OF PUBLIC WELFARE                Page:       42,030
                                        PA PROMISe
                                PROVIDER REMITTANCE ADVICE                                  2

     (1)          (2)   (3)
PROVIDER NUMBER  LOC   TYPE
  123456789      0001  24

                                PROVIDER BANNER MESSAGES  (4)

PA PROMISe Provider Conference Call Training
DPW is pleased to announce Conference Call Training for the PROMISe Provider Community beginning Wednesday,
May 19, 2004.

Each conference call will focus on one specific provider type and/or type of claim.  The call will last for
one and a half hours and address the following items:

     o   Provider Enrollment Review
     o   Suspense Processing and System Related Items
     o   Billing Tips and Helpful Tips
     o   Understanding the Remittance Advice
     o   Questions and Answers

Providers will have a chance to ask questions and raise additional questions at the conclusion of each
conference call.
Our goal is to make the calls as effective as possible.  Below is a schedule of upcoming call dates and
times; however, calls will occur on an "as needed" frequency.  Check future RA Banner messages for
additional dates and times.

Upcoming Teleconference Sessions:
     o   Tuesday, May 25, 2004 at 1:00 p.m. - Home Health Providers
     o   Wednesday, May 26, 2004 at 1:00 p.m. - Medical Suppliers

Register For Teleconference Session
```
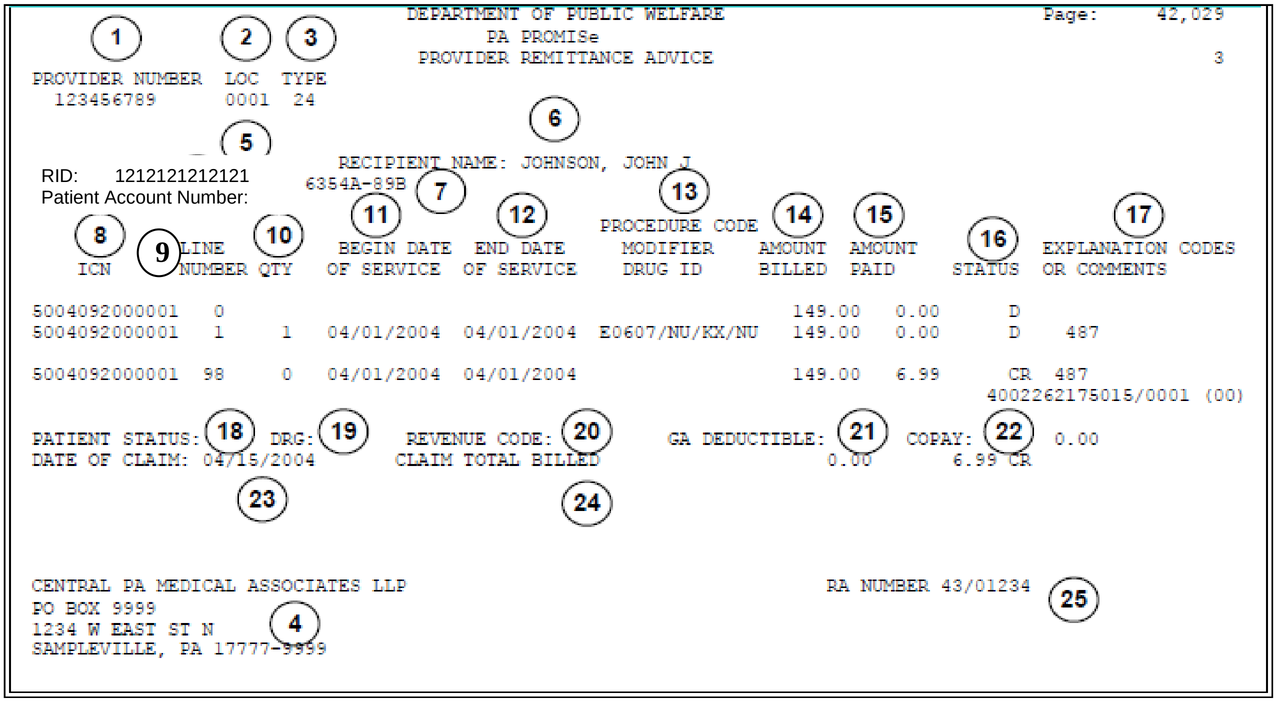

Definitions of Items on Banner	
1. Provider Identification	Provider's 9-digit PA PROMISe™ provider number.
2. Service Location	Provider's 4-digit service location.
3. Provider Type	Provider type listed on the "Provider Notice Information Form."
4. Alert	From time to time, DHS may need to disseminate information quickly to providers. Unless specifically designated for a particular provider type, the information applies to all providers. Remittance Advice Alerts (PROMISe™Banner Pages) are now on the PROMISe™ site at:http://promise.dpw.state.pa.us. in the Provider Information section. New alerts will be added as they are finalized.

The detail page(s) of the RA statement contain information about the claims and claim adjustments processed during the daily cycles in the reporting period. The claim information is arranged alphabetically by recipient last name. If there is more than one provider service location code, claims will be returned on separate RA Statements for each service location. As part of this Quick Tip we have included a sample RA Detail Page. All items have been numbered and correspond with the matching definitions on the third, fourth, fifth and sixth pages of this Quick Tip.

Sample – Detail Page


DEPARTMENT OF PUBLIC WELFARE
PA PROMISe
PROVIDER REMITTANCE ADVICE
Page: 42,029
3

PROVIDER NUMBER 123456789 LOC 0001 TYPE 24

RID: 1212121212121
Patient Account Number: 6354A-89B
RECIPIENT NAME: JOHNSON, JOHN J

ICN	LINE NUMBER	QTY	BEGIN DATE OF SERVICE	END DATE OF SERVICE	PROCEDURE CODE MODIFIER DRUG ID	AMOUNT BILLED	AMOUNT PAID	STATUS	EXPLANATION CODES OR COMMENTS
5004092000001	0					149.00	0.00	D	
5004092000001	1	1	04/01/2004	04/01/2004	E0607/NU/KX/NU	149.00	0.00	D	487
5004092000001	98	0	04/01/2004	04/01/2004		149.00	6.99	CR	487 4002262175015/0001 (00)

PATIENT STATUS: DRG: REVENUE CODE: GA DEDUCTIBLE: COPAY: 0.00
DATE OF CLAIM: 04/15/2004 CLAIM TOTAL BILLED 0.00 6.99 CR

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SAMPLEVILLE, PA 17777-9999
RA NUMBER 43/01234

Definition of Items on Detail Page	
1. Provider Identification Number	Provider's 9-digit PA PROMISe™ provider number.
2. Service Location	Provider's 4-digit service location.
3. Provider Type	Provider type listed on the "Provider Notice Information Form".
4. Name and Mailing Address of Provider	Address on DHS's provider files designated to receive payment for services.
5.Recipient Identification Number (RID)	Recipient's 10-digit ID number.
6. Recipient Name	Recipient name as identified by the Recipient ID Number. Recipients are listed alphabetically within each service location. If the recipient ID on the claim form does not match with a number in the system's files, a blank space appears instead of name.
7. Patient Account Number	Alpha and/or numeric identifier supplied by you. This information is especially helpful to you in identifying a patient if the Recipient's Name appears as a blank space.

8. Internal Control Number (ICN)	The 13-digit number assigned by DHS to each claim. The first two digits represent the Region Code, the third through the seventh digits represent the Year and Julian Date (the day of the year the claim was received for processing), the eighth through the tenth digits represent the Batch Number, and the eleventh through the thirteenth digits represent the Claim Sequence within the batch.
9. Line Number	Number of the claim line on the claim form.
10. Quantity	Number of services provided as indicated on the claim line.
11. Begin Date of Service	Beginning date that the service was performed, as indicated on the claim form.
12. End Date of Service	Ending date that the service was performed, as indicated on the claim form.
13. Procedure Codes, Modifier, Drug ID, and Drug Code	Codes used to identify the types of services that were rendered. Please consult your provider specific fee schedule for compensable procedure code/modifier combinations.
14. Amount Billed	Your usual and customary charge for the service provided as submitted on the claim.
15. Amount Paid	Amount approved by MA for payment. Please note that MA pays the lesser of the following: the provider's usual charge or the established MA fee for the service/item.

16. Status
 	
(16. Cont'd)
	Disposition of the claim line as of the processing date for this RA. The status column of the RA indicates whether the claim has been paid, denied, or suspended:
	• **(P) Paid** - A claim, or claim line, that is approved for payment. The amount paid by the Commonwealth is listed. If the amount paid is not correct, follow the instructions in the Billing Guide to submit a Claim Adjustment.
	• **(D) Denied** – A claim, or claim line, that is rejected (denied.) Explanation code for the denial is listed in the explanation code column. Look up the code's meaning on the Explanation of Edits Set This Cycle page(s) at the end of the RA.
	  ○ Check the file copy of the claim submitted to locate the error.
	  ○ If the service is compensable, submit a new corrected claim form for the denied claim. Include the Internal Control Number (ICN) (or the Claim Reference Number (CRN) if the claim was submitted prior to 3/1/2004) of the rejected claim. Please refer to the appropriate billing guide for location on the claim form to

	enter the ICN or CRN or enter the applicable area when electronically billing. • **(S) Suspended** - A claim, or claim line, that is suspended and is being held for manual review by DHS. The explanation code for the suspended claim is listed in the Explanation Code column. Look up the code's meaning on the "Explanation of Edits Set This Cycle" page(s) found at the end of the RA. If your claim has multiple lines, the following should be taken in to consideration when reviewing your RA. • If you see that some of the lines have an "S" for suspense, that means the whole claim is in a Suspend status. Please wait until the claim has been fully adjudicated (paid or denied) before deciding to take further action. • If you see that line 0 (claim header line) is "D" denied, that means the entire claim is denied. If you believe the claim should not have denied, you may resubmit the claim. **[Note: Do not submit a denied claim as an adjustment. A denied claim cannot be adjusted since no payment was made.]** • If you see that line 0 (claim header line) is "P" (Paid) and some lines have a "D" (denied,) the claim is considered paid, but the specific line(s) with the status "D" are denied. If you believe the claim or claim line should not have denied, you may resubmit that denied claim line. **[Note: If you resubmit the whole claim, the lines that previously paid on the first claim will be denied as a duplicate.]**

17. Explanation Codes or Comments	Messages to the provider. The code numbers help identify what was incorrect on the claim form (denial codes) or explain why DHS is manually reviewing the claim (suspended codes.) The description of each code is found on the "Explanation of Edits Set This Cycle" page(s) at the end of the RA. These messages used in conjunction with the claim status notify you what happened to your claim and if there are actions that need to be taken. Please note that there are several codes that are for informational purposes only. These explanation codes do not cause your claim to deny. For example, you may see the code 9000 (Billed Amount Exceed Allowed Amount) setting with the status of "P" for paid on your claim. This is letting you know that the claim or claim line has been paid and that the system has reduced the payment to correspond to the Medical Assistance Fee Schedule. You do not need to take any action when receiving these informational related explanation codes. Please review the sample reconciliation method found in the Remittance Advice section of each Provider Handbook for information on setting up your own accounts receivable method.
18. Patient Status	Indicates the status of the recipient as of the ending service date of the period covered on an institutional claim.
19. DRG	Identifies a diagnosis related grouping. The DRG code is used to determine the payment amount for hospital inpatient claims.
20. Revenue Code	Code that identifies a specific accommodation or ancillary service. Revenue codes are established by CMS.
21. GA Deductible	General Assistance Deductible amount. This is the dollar amount for this claim that was applied to the General Assistance deductible set for this client by DHS.
22. Copay Deducted	The amount of recipient copayment deducted for the service.
23. Date of Claim Form	Date the claim form was signed by the provider or the date the claim was transmitted electronically.
24. Claim Total Billed	Total amount billed for the claim.
25. RA Number XX/00000	First two digits identify the processing cycle. The five digits following the slash (/) identify the particular RA within the cycle. The RA number should be used when making inquiries about the information contained on the RA Statement.

PROVIDER QUICK TIPS

#07

The **RA Summary Page(s)** contains information summarizing all action taken on your claims during the processing cycle. See Sample Summary Page below. All items have been numbered and correspond with the matching definitions below and on the eigthth and ninth pages of this QuickTip.

Sample – Summary Page

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE
PA PROMISe
PROVIDER REMITTANCE ADVICE

Processing Date: 05/21/2004
Page: 42,037

9

PROVIDER NUMBER LOC TYPE
123456789 0001 24

	(1)	(2)	(3)	(4)	(5)	(6)
	NUMBER				AMOUNT	
SUMMARY	PROCESSED	DENIED	SUSPENDED	APPROVED	BILLED	PAID
CLAIM / ADJUSTMENTS (7)	2	2	0	0	149.00	0.00
CLAIM DETAILS (8)	1	1	0	0	0.00	0.00
ADJUSTMENT DETAILS (9)	1	1	0	0	149.00	6.99
SYSGEN CLAIM ADJ DETAILS (10)	0	0	0	0	0.00	0.00
CREDITS (11)	1	1	0	0	149.00	6.99 (CR)
NET GROSS ADJUSTMENT (12)	0			0		0.00
LIEN PAYMENT (13)	0			0		0.00
BEGINNING CREDIT BALANCE (14)						0.00
PAYMENT AMOUNT (15)						0.00
COPAY DEDUCTED (16)						0.00
GA DEDUCTIBLE (17)						0.00
UPDATE TO CR BALANCE (18)						0.00
NEW CREDIT BALANCE (19)						0.00
BEGINNING YTD BALANCE (20)						87.49
NEW YTD TOTAL (21)						87.49

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RA NUMBER 43/01234
VT/ITEM NUMBER 31207777/000000

pennsylvania
DEPARTMENT OF HUMAN SERVICES

PROVIDER QUICK TIPS #07

Definitions of Items on Summary Page	
1. Number Processed	Total of all claim line items, adjustment line items, claim details, system-generated adjusted line items, credits and/or net gross adjustments and lien payments that were acted upon by PA PROMISe™ during the daily cycle.
2. Number Denied	Number of line items and number of adjustments denied.
3. Number Suspended	Number of claim line items or adjustment claim line items held for further processing. These claims are awaiting approval or rejection.
4. Number Approved	Number of items that were accepted for payment during the processing cycle.
5. Amount Billed	Total of the usual charges less third party payments billed as shown on the claim lines and/or claim adjustments.
6. Amount Paid	Dollar amount authorized for payment
7. Claim / Adjustments	Total number of processed and billed amount on all the claims and claim adjustments for this cycle.
8. Claim Details	Number of line items and actual dollar amounts on processed, denied, approved, suspended, billed and paid on claim line items
9. Adjustment Details	Number of claim adjustment lines and actual dollar amounts for the daily cycle.
10. Systems Generated Adjustment Line Items	Number of systems generated claim adjustment lines and actual dollar amounts for the daily cycle. Usually the item relates to DHS initiated Third Party Liability (TPL) recoveries.
11. Credits	Amount originally paid on claims that are being adjusted during the daily cycle.
12. Net Gross Adjustment	Amounts debited (DB) and credited (CR) to a provider's account. CR indicates an amount of money owed to the Commonwealth, and this amount will be subtracted from the approved claim amount. DB indicates an amount of money owed to the provider and this amount will be added to the approved claim amount. Gross adjustments are transactions affecting a provider's account that are not processed by way of a claim form.
13. Lien Payment	Amount of the payment taken from a provider to pay the lien holder for this cycle.
14. Beginning Credit Balance	Amount owed to the Commonwealth as of the last Remittance Advice (RA) Statement.
15. Payment Amount	Actual dollar amount the provider will receive for the RA.
16. Copay Deducted	Amount of copayment deducted during this daily cycle.
17. GA Deductible **(17. Cont'd)**	Amount a General Assistance recipient is required to pay toward his/her healthcare. GA Deductible ($150.00 per year, assessed on a fiscal year basis) may be applied to general hospitals (inpatient and outpatient, non-diagnostic services,) hospital short procedure units (SPUs,) ambulatory surgical centers (ASCs,) rehabilitation hospitals (inpatient and outpatient,) private psychiatric hospitals and extended acute psychiatric inpatient care providers claims. Not applicable to providers who submit claims on the 837P or

	CMS-1500 claim form or the ADA dental claim form.
18. Update to Credit	Dollar amount on the Remittance Advice to be applied against the "Beginning Credit Balance". This may be a positive or negative amount.
19. New Credit Balance	Balance owed to the Commonwealth by the provider after this weekly financial cycle.
20. Beginning Year to Date Balance	Cumulative amount paid to the provider in the current calendar year, not including this weekly financial cycle.
21.New Year to Date Total	Cumulative amount paid to the provider for the current calendar year, including the current RA Check Amount.

The **"Explanation of Edits This Cycle" Page(s)** is always the last page(s) of the RA Statement. This page contains a list of the Explanation Codes or Comments that appear on the RA Detail page(s) for the daily cycle. To the right of each Explanation Code is the description of the code. You may access more complete descriptions of the Error Status Codes (ESCs) on the DHS website: www.dhs.pa.gov in the Provider and PROMISe™ Information Sections.

Sample – "Explanation of Edits this Cycle" Page(s)

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                                COMMONWEALTH OF PENNSYLVANIA          Processing Date: 05/21/2004
                                DEPARTMENT OF PUBLIC WELFARE                    Page:     42,037
                                        PA PROMISe
                                 PROVIDER REMITTANCE ADVICE                                   10

PROVIDER NUMBER  LOC  TYPE
  123456789      0001  24

                                EXPLANATION OF EDITS SET THIS CYCLE

487           CLAIM SUBMITTED TO THE DEPT AS A MEDICARE CROSSOVER
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Thank you for your service to our Medical Assistance Recipients.
We value your participation.
Check the Department of Human Services; Web site often at www.dhs.pa.gov