

Section 5 – Payer Claim and Payment Processes

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Payer Claim and Payment Processes

This section will assist LHDs in understanding how claims are processed by payers and how payment occurs, along with follow-up topics such as balance billing and federal sequestration of funds.

Key Concepts:

- Claim process
 - Automated review
 - Claim resolution
- Payments
 - Patient notification documents
 - Remittance advice
 - Explanation of Benefits (EOB)
 - Medicare Summary Notice (MSN)
 - Claim numbers
 - Balance billing
 - Patient responsibility
 - Contractual obligation
 - Sequestration

Claim Process (Adjudication)

Once the claim is received by the payer, it will go through several steps to determine an outcome. All payers, public and private, utilize versions of the same process to adjudicate claims.

Automated Review

Payers' computer systems apply edits that reflect their benefit and payment policies. These reviews are generally automated based on standardized and proprietary algorithms or configuration. These reviews are done at the service line level for professional claims. The order starts broadly and becomes narrower. If a service fails the review, it is usually denied automatically, and the onus is on the patient and/or provider to provide additional information for another review.

1. Patient eligibility
 - If the patient isn't eligible on the date(s) of service, then no further review is required and the claim is denied.
2. Timely filing limits
 - If the claim is submitted after the submission time limit, as defined by the provider or member's contract/policy, then no further review occurs, and the claim is denied.
3. Preauthorization and referral
 - If the service is subject to a preauthorization or referral process, the system will look for the authorization information to match the service data – either through the use of an authorization number or matching the provider, diagnosis, procedures and dates/quantity of services to the authorization record. If there is no match, an automated denial could be issued. In many cases, the service is pended for manual review since often what is authorized and what is provided can be coded differently enough to fail an automated review.

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4. Duplicate dates of service

Each service line is reviewed against claim history to determine if it has been previously submitted. Duplicate logic usually looks for the same service being provided to the same patient by the same provider on the same date of service. Often modifiers are the key to a system recognizing that a service is not a duplicate. For example, modifiers RT (right) and LT (left) can distinguish the same code from a previously submitted code.

Payer logic is set to identify exact or “hard” duplicates as opposed to possible or “soft” duplicates. Exact or hard duplicates are usually true and denied automatically. National Correct Coding Initiative rules, applicable to all billers of health care claims, encourage the appropriate use of condition codes or modifiers to identify claims that may appear to be duplicates, but, in fact, are not.

Example: Medicare Professional exact duplicate criteria

- HIC Number;
- Provider Number;
- From Date of Service;
- Through Date of Service;
- Type of Service;
- Procedure Code;
- Place of Service; and
- Billed Amount.

Possible/suspect or soft duplicates are set with looser logic and are usually manually reviewed. Medicare does not release its “suspect” logic so as to avoid providers gaming the system.

5. Non-covered services:

If the services are not a covered benefit, they will be denied.

6. Valid code linkages

The system will be set up to recognize code combinations that are illogical. For example, the procedure code for a Pap smear is not done on male patients and would be denied. However, a mammogram could be appropriate for a male patient, so that combination might lead to a review. Immunization codes are often based on the age of the patient, so a code for an adult vaccine would look at the age of the patient and deny the service if it was given to a child.

7. Bundled codes

Another indicator of fraud can be “unbundling” of procedures to obtain added reimbursement. For instance, 80047 is the code for a Basic metabolic panel that includes:

- 82330 or Calcium, ionized
- 82374 or Carbon dioxide (bicarbonate)
- 82435 or Chloride
- 82565 or Creatinine
- 82947 or Glucose
- 84132 or Potassium
- 84295 or Sodium
- 84520 or Urea nitrogen (BUN)

To bill the included tests separately is “unbundling”. The payer may deny the unbundled services and add 80047 to the claim with appropriate payment.

8. Medical review

Every policy has some sort of medical necessity provision, and each payer has medical policies regarding certain medical necessity. Some of these are easily configured to automate the review by combining specific procedure codes with specific diagnosis codes. For instance, Dean Health

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Plan¹ has medical policy regarding continuous glucose monitoring (**Figure 1**). Their system could be configured to always look at the diagnosis code and the age whenever CPT code 95250 (ambulatory continuous glucose monitoring of interstitial fluid via a subcutaneous sensor for a minimum of 72 hours) is submitted. If the patient's age is 14 years or younger **and** the diagnosis code is 250.01 (diabetes mellitus) **and** there was no preauthorization on file, this procedure would be denied with Adjustment Reason Code 50 (These are non-covered services because this is not deemed a 'medical necessity' by the payer) because the first two criteria listed must both be true.

Dean Health Plan (DHP) Medical Policy:

- 1.0 Continuous glucose monitoring beyond three days as an adjunct to standard care **requires** prior authorization through the Medical Affairs Division and is considered medically appropriate for patients with type 1 diabetes when the following criteria are met:
 - 1.1 Type 1 diabetes mellitus; and
 - 1.2 Age 25 years or older; and
 - 1.3 Use of continuous subcutaneous insulin infusion pump or is requiring 3 or more insulin injections each day; and
 - 1.4 Optimal glycemic control, which can be indicated by HbA1c less than 7%, has not been achieved; and
 - 1.5 Patient is able to monitor blood glucose 4 or more times a day.

Figure 1 - Dean Health Plan Medical Policy Example

9. Utilization review (UR)

UR looks at the frequency of services. For instance, for a specific diagnosis, physical therapy may only be appropriate for 10 or 20 visits. If the code is submitted for more than the limit, the system might automatically deny the claim as no longer medically necessary. Again, the patient or the provider can submit any supporting documentation required to appeal the decision.

Claim Resolution

For each service line on a claim, the payer will make one of the following decisions:

Pend – hold for review or request further supportive documentation

Pay – a benefit exists and all requirements for coverage have been met

Deny – there is no benefit available, or the service didn't meet the requirements for coverage

While claims are processed at the service line level, the majority of payers will not finalize the processing until all service lines on the claim have been adjudicated. In the past, payers would finalize by service line, and this was confusing to providers who were expecting a full claim resolution.

Claim Payments

Now that the claim has been submitted, the next expectation is that a payment will be made on the claim.

Reimbursement from the payer may not be payment in full for many reasons, which will require a decision of how to handle the balance due.

¹ DHP Medical Policy MP9091 - <http://www.deancare.com/app/files/public/4614/pdf-medicalpolicies-9091Glucose-Monitors.pdf>

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Payment Notification Documents

There are several notification documents that are used in understanding payments to either the patient or the provider.

Remittance Advice (RA) – provider document

This document is the notice to a provider regarding disposition of submitted claims providing the explanation reasons for payment, adjustment, denial and/or uncovered charges of a medical claim. This document can also be called an “explanation of payments” (EOP) or “explanation of remittance” (EOR). Remittance Advices usually have multiple claims for multiple patients, but only a single, bundled check accompanies the RA.

Wisconsin has statutory requirements for remittance advices:

Ins 3.651 Standardized explanation of benefits and remittance advice format.

(3) REMITTANCE ADVICE TO HEALTH CARE PROVIDERS

(b) *Information required.* The remittance advice form shall include, at a minimum, all of the following information:

The insurer's name and address and the telephone number of a section of the insurer designated to handle questions and appeals from health care providers.

The insured's name and policy number, certificate number or both.

The last name followed by the first name and middle initial of each patient for whom the claim is being paid, the patient identification number and the patient account number, if it has been supplied by the health care provider.

For each claim, all of the following on a single line:

The date or dates the service was provided or procedure performed.

The CPT-4, HCPCS or CDT-1 code.

The amount charged by the health care provider.

The amount allowed by the insurer.

The deductible amount.

The copayment amount.

The coinsurance amount.

The amount of the contractual discount.

Each claim adjustment reason code, unless the claim is adjusted solely because of a deductible, copayment or coinsurance or a combination of any of them.

The amount paid by the insurer toward the charge.

Grouping of claims required.

If an insurer includes claims for more than one policyholder or certificate holder on the same remittance advice form, all claims for the same policyholder or certificate holder shall be grouped together.

If an insurer includes claims for more than one patient on the same remittance advice form, all claims for the same patient shall be grouped together.

Format; exceptions. Notwithstanding par. (a) 1, and Appendix A:

An insurer may print its remittance advice form in either horizontal or vertical format.

A remittance advice form need not include a column for any item specified in par. (b) 4, which is not applicable, but the order of the columns that are included may not vary from the order shown in Appendix A, except as provided in subd. 3.

A remittance advice form may provide additional information about claims by including one or more columns not shown in Appendix A immediately before the column designated for the claim adjustment reason code.

4. An insurer may alter the wording of a column heading shown in Appendix A provided the meaning remains the same.

5. If necessary for clarity when claims for more than one insured or more than one patient are included on the same form, an insurer shall vary the location of the information specified in par. (b) 2, and 3, to ensure that it appears with the claim information to which it applies.

(e) An insurer shall send the remittance advice form to the payee designated on the claim form.

Note: If, on March 1, 1994, an insurer has a contract with a health care provider that governs the form and content of remittance advice forms, s. Ins 3.651 (3), as affected March 1, 1994, first applies to the insurer on the date the contract is renewed, but no later than December 31, 1994.

The format can be electronic or paper.

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Electronic Remittance Advice (ERA): an RA that is transmitted in the ASC X12N 835 electronic format.

Because electronic data transactions are not easily readable in their transmitted format (835 example below), a print application is required.

```
ISA*00*      *00*      *ZZ*5010TEST      *ZZ*835RECVR      *110930*1105*^*00501*000004592*0*T*~
GS*HP*5010TEST*835RECVR*20110930*100718*45920001*X*005010X221A1~
ST*835*0001~
BPR*I*57.44*C*CHK*****20110930~
TRN*I*123456789*1123456789~
REF*EV*5010835EXAMPLE~
DTM*405*20110930~
N1*PR*PAYER NAME~
N3*PAYER ADDRESS~
N4*CINCINNATI*OH*45206~
PER*CX**TE*8003030303~
PER*BL*TECHNICAL CONTACT*TE*8004040404*EM*PAYER@PAYER.COM~
PER*IC**UR*WWW.PAYER.COM~
N1*PE*PROVIDER NAME*XX*1122334455~
N3*PROVIDER ADDRESS~
N4*CITY*OH*89999~
REF*TJ*123456789~
LX*1~
CLP*EDI DENIAL*1*1088*0*1088*HM*CLAIMNUMBER1*21~
NM1*QC*1*LAST*FIRST****MI*1A2A1A2A1A2A~
NM1*IL*1*LAST1*FIRST1*G****MI*BBB1A2A1A2A1A2A~
NM1*82*1*PROVIDER*MR*A***XX*1234567898~
REF*EA*11223344~
REF*1L*123456~
DTM*232*20090113~           Claim Statement Period Start
DTM*233*20090113~           Claim Statement Period End
DTM*050*20110908~           Date Claim Received
SVC*HC:00220:P2*1088*0**8**76~
DTM*150*20090113~
DTM*151*20090113~
CAS*PR*29*1088~
CLP*EDI PAID*1*100*57.44*30*12*CLAIMNUMBER2*11~
NM1*QC*1*LAST2*FIRST2*A***MI*R123456789~
NM1*IL*1*LAST3*FIRST3*B***MI*R1234567~
NM1*82*1*PROVIDER1*MRS1*B***XX*1234567899~
REF*EA*11223344~
REF*1L*123456~
DTM*232*20110729~           Claim Statement Period Start
DTM*233*20110729~           Claim Statement Period End
DTM*050*20110927~           Date Claim Received
SVC*HC:97110*100*57.44**2~
DTM*150*20110729~
DTM*151*20110729~
CAS*PR*3*30~
CAS*CO*45*12.56~
AMT*B6*87.44~
SE*45*0001~
GE*1*45920001~
IEA*1*000004592~
```

Additionally, you need to understand how to interpret the code sets (**Figure 2**) that are part of the electronic transactions. By statute, these are maintained by the Washington Publishing Company and accessible free of charge on their website at <http://www.wpc-edi.com/reference/>:

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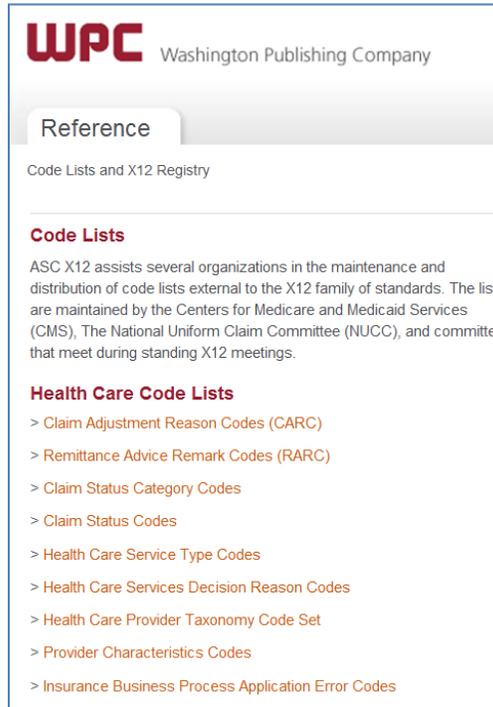


Figure 2 - Washington Publishing Company Reference Page

Picking the Claim Adjustment Reason Codes (CARC), you can access the Claim Adjustment Reason (Figure 3) and Adjustment Group Codes (Figure 4).

Figure 3 shows a scrolling list of applicable codes. There is also the ability to view current, to-be-deactivated and deactivated codes. By clicking on the FAQ link, you can access the Adjustment Group codes seen on Figure 4.

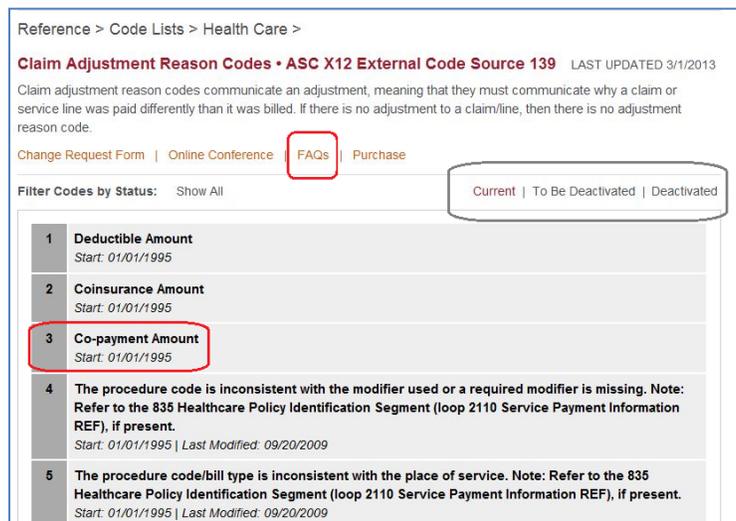


Figure 3 - Claim Adjustment Reason Codes

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What is a Claim Adjustment Group Code?

- CO - Contractual Obligations**
 This group code should be used when a contractual agreement between the payer and payee, or a regulatory requirement, resulted in an adjustment. Generally, these adjustments are considered a write off for the provider and are not billed to the patient.
- CR - Corrections and Reversals**
 This group code should be used for correcting a prior claim. It applies when there is a change to a previously adjudicated claim. When correcting a prior claim, CLP02 (claim status code) needs to be 22. See ASC X12N Health Care Claim Payment/Advice Implementation Guide (835) section 2.2.8 for complete information about corrections and reversals.
- OA - Other Adjustments**
 This group code should be used when no other group code applies to the adjustment.
- PI - Payer Initiated Reductions**
 This group code should be used when, in the opinion of the payer, the adjustment is not the responsibility of the patient, but there is no supporting contract between the provider and the payer (i.e., medical review or professional review organization adjustments).
- PR - Patient Responsibility**
 This group should be used when the adjustment represent an amount that should be billed to the patient or insured. This group would typically be used for deductible and copay adjustments.

Figure 4 - Claim Adjustment Group Codes

The highlighted example above shows two claims were submitted.

Claim	DOS	DOR	Proc Code	Modifier	Charge	Allowed	CO	PR	Paid
1	01/13/2009	09/08/2011	00220	P4	\$1,088	\$0	\$0	\$1,088	\$0
CAS*PR*29*1088 in the 835 code above indicates that the Patient Responsibility is the full amount based on Claims Reason Code 29 (<i>The time limit for filing has expired.</i>) since it took two years to submit the claim									
2	07/29/2011	09/27/2011	97110		\$100	\$87.44	\$12.56	\$30	\$57.44
SVC*HC:97110*100*57.44 indicates that CPT code 97110 with a charge of \$100 was reimbursed at \$57.44. CAS*PR*3*30~ indicates Patient Responsibility of \$30 based on Reason Code 3 (copayment amount) CAS*CO*45*12.56~ indicates Contractual Obligation of provider to write off \$12.56 due to Reason Code 45 (Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement) AMT*B6*87.44~ indicates allowed amount is \$87.44									

Commercial payers and clearinghouses will have information regarding their software on their websites. (**Appendix 23**) Additionally, most payers now utilize the code sets found on the WPS website on their paper as well as 835 Remittance Advices.

Medicare

Medicare Remit Easy Print (MREP) is a software application used to view and print HIPAA compliant 835 remittance advices for professional providers and suppliers. This software, which is available for free to Medicare providers and suppliers, can be used to access and print remittance advice information, including special reports, from the HIPAA 835. Go to: <http://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/AccessToDataApplication/MedicareRemitEasyPrint.html> to download the application and instructions.

Wisconsin Medicaid

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The ForwardHealth portal contains the implementation guide for the 835 Electronic Remittance Advice (**Figure 5**) – go to: <http://www.dhs.wisconsin.gov/publications/P0/p00271.pdf>

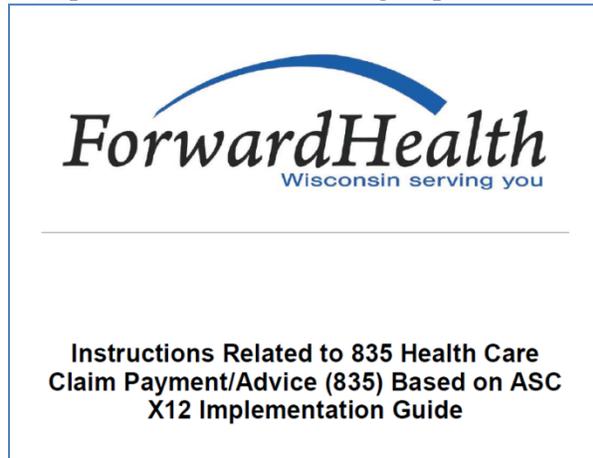


Figure 5 - Medicaid 835 Implementation Guide

Standard Remittance Advice (SRA): An RA that is submitted in a paper format. As with the electronic version, the SRA is usually attached to bulk payment for many claims for many patients. Most payers will have a “how to read” document on their website. **Figure 6** shows how Anthem provides a simple key in a one page document.

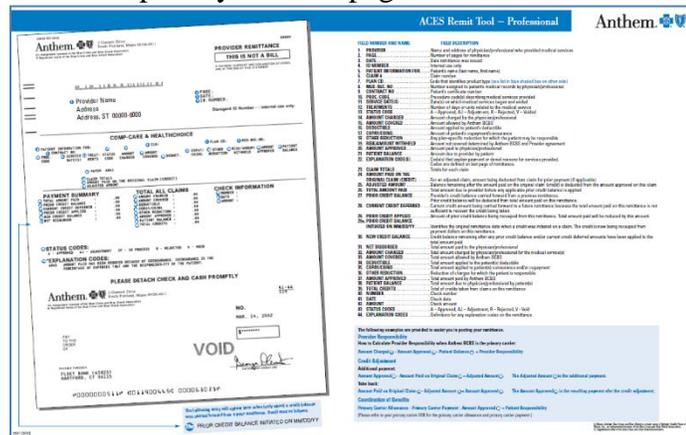


Figure 6 - Anthem's Remit Tool

Other payers, like iCare Health Plan (**Figure 7**), have multi-page booklets. Go to: <http://www.icare-wi.org/providers/claimsprocessing.aspx> to download a copy of their Remittance Education Package.



Figure 7 - iCare Remittance Advice Guide

The payer instructions will give you a key to read various sections of the RA as in iCare’s manual on page 6 (**Figure 8**):

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REMITTANCE ADVICE - EXPLANATION OF BENEFITS (EOB)

Service	Dates of Service	Procedure or Revenue	Units	Amt Billed	Amt Allowed	Primary Payor Pmt	Patient Responsibility				Medicare Allowed	Medicare Paid	Interest Owed	Plan Payment	Reason Codes
							Copay	Co-Ins	Deduct	Not Cvr'd					
001	01/26/12-01/26/12	99213	1	\$160.00	\$30.30	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$30.30	R217
Claim Totals:				\$160.00	\$30.30	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$30.30	

Label/number the terms defined below on the actual remit example above:

1. **Service-** A service code used internally to identify the services provided to our members.
2. **Date of Service-** The date the insured was seen by a health care practitioner or given medical treatment.
3. **Procedure or Revenue-** Codes that describe a particular procedure. Also known as CPT codes. A code that represents a specific type of charge on a UB92 claim.
4. **Units-** The number of units on the provider billed on the claim form.
5. **(Amount) Amt Billed-** It is the amount charged for each service performed by the provider.
6. **(Amount) Amt Allowed-** The maximum reimbursement the member's health policy allows for a specific service. It is the maximum dollar amount assigned for a procedure based on various pricing mechanisms.
7. **Primary Payer Amt (Amount)-** The payment from the primary payer, and then the balance is crossed over to the secondary if applicable.
8. **Co-pay-** The cost associated with receiving benefits or services from providers who are paid directly by members.
9. **Co-Ins-** The portion of covered healthcare costs for which the covered person has a financial responsibility, usually according to a fixed percentage. Often coinsurance applies after first meeting a deductible requirement.
10. **Deduct-** The amount of expensed that must be paid out of pocket before an insurer will pay any expenses.
11. **Not Cvr'd (Covered)-** Health care service that are not covered.
12. **Medicare Allowed-** This is the amount a provider that accepts assignment can be paid. The 80/20 Rule. It may be less than the actual amount a provider charges. Medicare pays part of this amount and the secondary is responsible for the difference.
13. **Medicare Paid-** The amount of your bill paid by Medicare.
14. **Interest Owed-** This is the amount owed if iCare fails to pay a claimant (provider or insured) within the time frames specified in the contract. We must pay a late payment adjustment equal to one percent of the amount due.
15. **Plan Payment-** Payment to a health care provider.
16. **Reason Codes-** They are used to communicate an adjustment or denial on a claim. It also corresponds why a claim or service line was paid differently than it was billed. If there is no adjustment to a claim/line, then there is no adjustment reason.

1/28/2013 6

Figure 8 - iCare's Remittance Advice sample page

A guide may have explanations when non-standard information is given, such as this iCare example of a claim that required an interest payment (**Figure 9**):

2.4 INTEREST PAID ON A CLAIM

Payee Name: [REDACTED]		Payee Provider ID: [REDACTED]		Payee Tax ID: [REDACTED]											
Patient And Services Information															
Patient Name: [REDACTED]		Member ID: [REDACTED]		DRG: [REDACTED]											
Patient Control #: [REDACTED]		Claim ID: [REDACTED]		Claim Explanation: [REDACTED]											
Service	Dates of Service	Procedure or Revenue	Units	Amt Billed	Amt Allowed	Primary Payor Pmt	Copay	Co-Ins	Deduct	Not Cvr'd	Medicare Allowed	Medicare Paid	Interest Owed	Plan Payment	Reason Codes
001	06/30/12-06/30/12	99233	1	\$310.00	\$97.10	\$0.00	\$0.00	\$19.42	\$0.00	\$0.00	\$0.00	\$0.00	\$0.14	\$77.68	R0102 R217
Claim Totals:				\$310.00	\$97.10	\$0.00	\$0.00	\$19.42	\$0.00	\$0.00	\$0.00	\$0.00	\$0.14	\$77.68	
Provider Totals:				\$310.00	\$97.10	\$0.00	\$0.00	\$19.42	\$0.00	\$0.00	\$0.00	\$0.00	\$0.14	\$77.68	

Plan	Amt Billed	Amt Allowed	Primary Payor Pmt	Patient Responsibility				Medicare Allowed	Medicare Paid	Interest Owed	Plan Payment
				Copay	Co-Ins	Deduct	Not Cvr'd				
Medicare Contracted	\$53322.00	\$8333.83	\$0.00	\$0.00	\$1632.05	\$115.53	\$0.00	\$0.00	\$0.00	\$0.14	\$6586.25
GRAND TOTAL:	\$53322.00	\$8333.83	\$0.00	\$0.00	\$1632.05	\$115.53	\$0.00	\$0.00	\$0.00	\$0.14	\$6586.25
GRAND TOTAL Amounts Recovered:											\$0.00

Figure 9 - iCare example of interest payment on RA

Explanation of Benefits (EOB) – patient document

An EOB (**Appendix 24**) is a single patient document, although it may have multiple dates of service represented.

Wisconsin also has statutory requirements for EOBs.

Ins 3.651 Standardized explanation of benefits and remittance advice format.

(4) EXPLANATION OF BENEFITS FOR INSURED.

The explanation of benefits form for insureds shall include, at a minimum, all of the following:

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The insurer's name and address and the telephone number of the section of the insurer designated to handle questions and appeals from insureds relating to payments.

The insured's name, address and policy number, certificate number or both.

A statement as to whether payment accompanies the form, payment has been made to the health care provider or payment has been denied.

The last name followed by the first name and middle initial of each patient insured under the policy or certificate for whom claim information is being reported, and the patient account number, if it has been supplied by the health care provider.

For each patient listed, all of the following that are applicable, using a single line for each procedure or service:

The health care provider as indicated on the claim form.

The date the service was provided or procedure performed.

The CPT-4, HCPCS or CDT-1 code.

The amount charged by the health care provider if the insured may be liable for any of the difference between the amount charged and the amount allowed by the insurer.

The amount allowed by the insurer. An insurer may modify this requirement if necessary to provide information relating to supplemental insurance.

Each claim adjustment reason code, unless the claim is for a dental procedure for which there is no applicable code, in which case the insurer shall provide an appropriate narrative explanation as a replacement for the information required under subd. 7.

The applicable deductible amount, if any.

The applicable copayment amount, if any.

The amount paid by the insurer toward the charge.

A general description of each procedure performed or service provided.

A narrative explanation of each claim adjustment reason code. An insurer may provide information in addition to the narrative accompanying the code on form OCI 17-007.

Any of the following that apply:

The total deductible amount remaining for the policy period.

The total out-of-pocket amount remaining for the policy period.

The remaining amount of the policy's lifetime limit.

The annual benefit limit.

Unless requested by the insured, an insurer is not required to provide an explanation of benefits if the insured has no liability for payment for any procedure or service, or is liable only for a fixed dollar copayment which is payable at the time the procedure or service is provided.

Again, every payer has their own version of an EOB, but the requirements enacted above mean they all contain the minimum critical information.

ForwardHealth lists their EOB codes online

at https://www.forwardhealth.wi.gov/WIPortal/Tab/42/icscontent/Provider/Medicaid/EOB_Messages.htm

Medicare Summary Notice (MSN) – beneficiary document

This is a notice or statement listing the services or items received by a beneficiary in Original Medicare. The MSN (**Appendix 25**) provides information about the health care provider who provided the service or item and what was paid. People enrolled in Medicare Advantage plans do not receive a Medicare Summary Notice, but may receive an Explanation of Benefits from the MA plan.

Claim Numbers

Any communication with a payer about a specific claim(s) should refer to the claim number. These numbers are unique to the payer and often contain information that may be useful in troubleshooting any problems. In order to accurately calculate items such as interest, payers often use a Julian date within the claim number. These day digits come from the Julian calendar (see **Appendix 26**) and are used by most payers as a more accurate date indicator. Each day is assigned a three digit number, January 1st is 001 and December 31st is either 365 or 366 (to accommodate leap year).

Commercial plans

Every payer has their own version of a claim number. Anthem BCBS has a “document control number” (DCN), which is the number Anthem assigns for each claim received. The first five numbers are the Julian date.

Other elements that might be included in a claim number are the adjuster’s user ID (for auditing purposes), a batch number, type of claim (professional or institutional) and some sort of unique sequence number.

Medicare

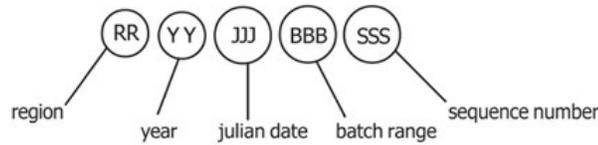
Internal Control Number (ICN) - This field displays the Internal Control Number (ICN). The 14-digit ICN is a unique number assigned to the claim at the time it is received by the Medicare Contractor. It is used to track and monitor the claim. The first six digits reflect when the claim was received. The first digit is a century code (“1” indicates 1900-1999 and “2” indicates 2000 and after). The second two digits indicate the last two digits of the year that the claim was received. The next three digits indicate the day of the year the claim was submitted, out of 365 days (366 in a leap year). The last eight digits are a unique set of numbers assigned by Medicare Contractors. An example of an ICN number would be 20905302000001, indicating it was received on **February 22, 2009**.

Medicaid

ForwardHealth assigns a unique claim number (also known as the ICN). The ICN format is defined in **Figure 10** below.

Section 5 – Payer Claim and Payment Processes

Each claim and adjustment received by ForwardHealth is assigned a unique claim number (also known as the internal control number or ICN). This number identifies valuable information about the claim and adjustment request. The following diagram and table provide detailed information about interpreting the claim number.



Type of Number and Description	Applicable Numbers and Description
Region — Two digits indicate the region. The region indicates how ForwardHealth received the claim or adjustment request.	10 — Paper Claims with No Attachments 11 — Paper Claims with Attachments 20 — Electronic Claims with No Attachments 21 — Electronic Claims with Attachments 22 — Internet Claims with No Attachments 23 — Internet Claims with Attachments 25 — Point-of-Service Claims 26 — Point-of-Service Claims with Attachments 40 — Claims Converted from Former Processing System 45 — Adjustments Converted from Former Processing System 50-59 — Adjustments 80 — Claim Resubmissions 90-91 — Claims Requiring Special Handling
Year — Two digits indicate the year ForwardHealth received the claim or adjustment request.	For example, the year 2008 would appear as 08.
Julian date — Three digits indicate the day of the year, by Julian date, that ForwardHealth received the claim or adjustment request.	For example, February 3 would appear as 034.
Batch range — Three digits indicate the batch range assigned to the claim.	The batch range is used internally by ForwardHealth.
Sequence number — Three digits indicate the sequence number assigned within the batch range.	The sequence number is used internally by ForwardHealth.

Figure 10 - WI Medicaid Claim Number Format

Balance Billing

Except for self-pay patients, most providers are not reimbursed for their full charge in this age of networks and capitation. What to do with the balance is usually driven by contract obligations. “Balance billing” is when the provider sends a bill for any remaining, unreimbursed amount for the charge on the service.

Patient Responsibility

There are charges that are not covered under almost every health plan, public or private. Unless some sort of agreement has been made prior to the service, the patient is usually responsible for these uncovered services. These charges will be clearly identified on the Remittance Advice or the patient’s EOB (**Figure 11**). Additionally, most plans have some sort of cost-sharing (deductible, coinsurance or copayment), which is also the patient’s responsibility. Again, these amounts should be clearly identified.

Section 5 – Payer Claim and Payment Processes

Dates of Service	Service Code	Total Amount	Not Covered	Reason Code	Discount Amount	Covered By Plan	Deductible Amount	Co-Pay Amount	Balance	Paid At	Payment Amount
03/01-03/01/2000	MD	50.00	0.00		0.00	50.00	50.00	0.00	0.00	100%	0.00
03/01-03/01/2000	MD	400.00	336.00	03	0.00	64.00	64.00	0.00	0.00	100%	0.00
03/01-03/01/2000	MD	100.00	24.55	03	0.00	75.45	75.45	0.00	0.00	100%	0.00
Totals		550.00	360.55		0.00	189.45	189.45	0.00	0.00		0.00
Other Insurance Credits or Adjustments											0.00
Total Net Payment											0.00
Total Patient Responsibility											189.45

The amount the patient is responsible to pay to a provider when a service is rendered

Charges not eligible, which could be a discount written off by the provider, or a charge the patient is responsible to pay

The amount applied to the deductible on this claim.

This could include an amount applied to your deductible, a co-pay amount paid to a provider, coinsurance (your %) a charge excluded by the plan, or a charge previously considered

Figure 11 - Non-covered or cost share on EOB or RA

Contractual Obligation

In most cases, there will be a discount amount that the provider is *not allowed to balance bill* to the patient.

In **Figure 12**, there are two service lines. The first, for code 97001, shows the billed amount of \$480 has been reduced to an “allowed” or contracted amount of \$217.68, which has been paid in full. The adjusted amount (ADJ column) uses Adjustment Reason Code 42 (charges exceed our fee schedule or maximum allowed amount) to explain the \$262.32 remaining balance. Notice the Patient Responsibility is \$0 because the provider may not balance bill the patient. The second service line has been listed as not covered. A reason is not given, but since there is no patient responsibility, it must be due to a contractual item that doesn’t allow the use of an unlisted code.

DOS	CPT	Units	Billed	ADJ	Paid	Reason	Pat Resp
10/05/12	97001	12	480.00	262.32	217.68	42	0.00
			<input checked="" type="checkbox"/> Apply	262.32	217.68	then	Close session
10/05/12	99499.GP	3	120.00	120.00	0.00	96	0.00
			<input checked="" type="checkbox"/> Apply:		0.00	then	Send to insurance invoice area

42 Charges exceed our fee schedule or maximum allowable amount. (Use CARC 45)

96 Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)

Figure 12 - Adjusted bill with no patient responsibility

Figure 13 is an example of a reduction and cost sharing. The billed amount is \$219, but the contract allowed amount is \$200. A \$10 copay has been applied to the allowed amount, resulting in a payment of \$190. The provider may bill the patient for \$10 copay, but not for the \$19 contract discount.

Billed Amount	Contract Discount	Allowed Amount	Co-pay	Coinsurance	Ded	Paid Amount
\$219.00	\$19.00	\$200.00	\$10.00	\$0.00	\$0.00	\$190.00

Figure 13 - Adjusted bill with contract reduction and cost-sharing

Section 5 – Payer Claim and Payment Processes

Sequestration Reduction

The current sequestration order signed by the President on March 1, 2013, covers payments for services with dates of service or dates of discharge from April 1, 2013, through March 31, 2014. The 2% reduction is taken from the calculated payment amount, after the approved amount is determined and the deductible and coinsurance are applied.

Example: A provider bills a service with an approved amount of \$100.00, and \$50.00 is applied to the deductible. A balance of \$50.00 remains. Medicare would normally pay 80% of the approved amount after the deductible is met, which is \$40.00 ($\$50.00 \times 80\% = \40.00). The patient is responsible for the remaining 20% coinsurance amount of \$10.00 ($\$50.00 - \$40.00 = \10.00). However, due to the sequestration reduction, 2% of the \$40.00 calculated payment amount is not paid, resulting in a payment of \$39.20 instead of \$40.00 ($\$40.00 \times 2\% = \0.80).

Adjustment Reason Code 223 is an adjustment code for mandated federal, state or local law/regulation that is not already covered by another code and is mandated before a new code can be created. It is used for this reduction amount on remittance advices or EOBs.

