Transforming Lives

Trillium HEALTH RESOURCES

CIE – TRILLIUM HEALTH RESOURCES REMITTANCE ADVICE (RA) COMPANION GUIDE

The purpose of this guide is to outline the format and layout of the Remittance Advice (RA) to assist in reviewing claims status within a check write period.

WHAT IS AN RA?

The Remittance Advice (RA) is the documentation of adjudicated claims status. The RA should be used to post claim status to the Provider Agency's system.

When a claim is submitted to Trillium Health Resources a RA will be posted in the Provider Direct Portal to explain any payment, adjustment or denial to the claim.

The RA provides reason codes to identify any additional action on the claim. Example – a denied claim may need to be replaced with the correction as stated by the denial code.

WHAT TYPES OF RA'S ARE AVAILABLE?

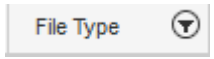
- A remittance Advice (RA) is available on PDF format so it can be printed for easy reading.
- A's are generated for Provider Direct Agency's who enter claims in the Provider Direct Portal.
  - RA's are also generated for Provider Agency's who submit 837 files for an easy to read downloadable RA.
- An electronic RA is sent back to the Provider Agency via the Third Party Billing Agency
  - An electronic copy of the RA is also posted on the Provider Direct Portal – an 835 file.
  - The 835 formatted RA is for Providers to post payments back to member accounts electronically.
  - 835 files are generated for Provider Agency's submitting electronic 837 files.

HOW TO LOCATE THE RA'S IN THE PROVIDER DIRECT PORTAL

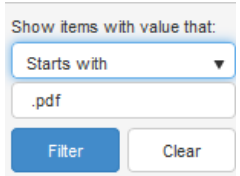
LOGIN TO THE PROVIDER DIRECT PORTAL

- Select File Transfers
- Select View File Repository from MCO
  - Numerous Reports are located in this Repository
  - The printable RA is a PDF File

- Select the funnel next to the File Type column



- In the open space type .pdf and select the filter button.



- Only the RA's in PDF format will appear when this function is selected.
- To select the Electronic RA type .txt and then Filter. Notice the file name ends in _og835

WHAT SHOULD BE DONE WITH AN RA?

When the RA is received it should be used to:

- Post Payments to Member accounts
- Balance the RA to the deposit in the bank
- Identify the reason for any denials
  - When the denial can be corrected submit a replacement claim to correct the error on the claim.
  - Replacement claims allow an extra 90 days for timely filing. This gives a total of 180 days from the date of service for a replacement claim to be received.
  - When claims are denied for the timely filing limit of 90 days (for an original claim) and beyond 180 days (for a replacement claim) the Provider Agency can submit a request to have the billing window opened. This can be done by filling out the Claims Request Form found on the Trillium website. (www.trilliumnc.org)
    - The reason for submitting claims beyond the original 90 days must be explained in the comments section of this form. Submitting a request for an open billing window may be approved or denied.

RA LAYOUT

The RA is grouped by Provider NPI Number and then alphabetical by member Last Name, First Name under the NPI number.

RA OUTLINED: Grouping is visualized as below

1. Provider NPI:
    a) Member
2. Member Subtotal Line
    a) Claimed Amount
    b) Credit Memo Amount
    c) Denied Amount
    d) Paid Amount
3. Provider NPI Subtotal
    a) Claimed Amount
    b) Credit Memo Amount
    c) Denied Amount
    d) Paid Amount
4. Grand Totals
    a) Claimed Amount
    b) Denied Amount
    c) Paid Amount
5. Fund Source Totals
    a) Medicaid
    b) State

RA BREAKDOWN

Header Information:

The RA header displays core information such as check number, check amount, check date, provider name, and process dates.

Trillium HEALTH RESOURCES

Remittance Advice

Check Write Date 12/5/2017

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Provider Name: ABC Provider Services

Provider ID: 012345

Process Dates Selected: 11/22/2017 to 11/28/2017

Type Key:
1: Payment
4: Denial
10: Partial Payment
22: Reversal of Payment

Questions - Contact your Claims Specialist

Check Number EFT000000 Check Dt 12/5/2017 Check Amt $15,960.40

NPI Number:

The RA is broken down by each NPI Number submitted on the claim and the payments made on that NPI number.

Provider NPI: 000111222

Claim Field Labels:

At the top of every page, there is a Header Description Table that identifies what each data element on the claim represents (shown below):

Client Last	Client First	Client Middle	Client MCD/SSN	CI Client ID	Claimed Date Range	Provider Direct/837#	Auth Number	Pat Cntrl #	POS	Other Pmt	CI Audit #	Funding Source *
Type	Service Code	Mod	Rev Code	CI Claim Num	Date of Service	Reason Codes	Units	Contract Rate	Claim Amt	Cr Memo Amount	Denied Amt	Whld Amt	Paid Amt

Claim Detail Rows:

The adjudication of each claim is explained per claim line. Use the claim field labels to identify each data element. Each claim line will have 2 detail rows:

Last	First	T	0123456780	000111	11/2/2017	11/2/2017		0	000001	11		$0.00	000123456	Medicaid
1	90847			000123	11/2/2017	1026, 292	1		$67.28	$100.00	$0.00	$32.72	$0.00	$67.28

Paid Claims (Professional)

Below is an example of a paid claim. Notice how both claims came in on the same claim header, but are broken down per claim line. Since adjudication is at the claim line level, then this claim is viewed as 2 separate claims on the RA. *(In the illustration below Type 1 reflects the payment of a claim).*

Client Last	Client First	Client Middle	Client MCD/SSN	CI Client ID	Claimed Date Range		Provider Direct/837#	Auth Number	Pat Cntrl #	POS		Other Pmt	CI Audit #	Funding Source *
Type	Service Code	Mod	Rev Code	CI Claim Num	Date of Service		Reason Codes	Units	Contract Rate	Claim Amt	Cr Memo Amount	Denied Amt	Whld Amt	Paid Amt
Last	First		012345678O	000111	11/2/2017	11/2/2017	00001		0	000001	11		$0.00	000123456	Medicaid
1	90847			000123	11/2/2017		1026, 292	1		$67.28	$100.00	$0.00	$32.72	$0.00	$67.28
Last	First		012345678O	000111	11/17/2017	11/17/2017	00001		0	000001	11		$0.00	000123456	Medicaid
1	90847			000123	11/17/2017		1026, 292	1		$67.28	$100.00	$0.00	$32.72	$0.00	$67.28
Last, First				Claimed Amount: **$200.00**			Cr Memo Amount: **$0.00**			Denied Amount: **$65.44**			Paid Amount: **$134.56**		

In the above example, notice that 1 unit was billed per day. The Paid Amount will equal the Claim Amount minus the Withheld Amount.

Paid Claims (Institutional)

Below is an example of a paid institutional claim. This claim does not show a breakdown of each date of service billed in the date range on the claim. There is one detail line only with the claim adjudication. *(In the illustration below Type 1 reflects the payment of a claim).*

Client Last	Client First	Client Middle	Client MCD/SSN	CI Client ID	Claimed Date Range		Provider Direct/837#	Auth Number	Pat Cntrl #	POS		Other Pmt	CI Audit #	Funding Source *
Type	Service Code	Mod	Rev Code	CI Claim Num	Date of Service		Reason Codes	Units	Contract Rate	Claim Amt	Cr Memo Amount	Denied Amt	Whld Amt	Paid Amt
Last	First	T	012345678O	000111	11/1/2017	11/30/2017			000001	99		$0.00	000123456	Medicaid
1	0100			000123			292,1023,1026	30	$125.00	$5000.00	$0.00	$32.72	$1250.00	$3750.00
Last, First				Claimed Amount: **$5000.00**			Cr Memo Amount: **$0.00**			Denied Amount: **$1250.00**			Paid Amount: **$3750.00**	

Denied Claims

Denied claims are shown in the same format as paid claim lines on the claim. A denial will show as Type 4 at the far left of the row. On the claim line that denied, the denial code is under the reason codes column.

This code is defined at the end of the RA to assist in working denials. In this example the denial reason is 330 which is for "Patient not enrolled on date of service". *(In the illustration below Type 4 reflects the denial of a claim).*

Client Last	Client First	Client Middle	Client MCD/SSN	CI Client ID	Claimed Date Range		Provider Direct/837#	Auth Number	Pat Cntrl #	POS		Other Pmt	CI Audit #	Funding Source *
Type	Service Code	Mod	Rev Code	CI Claim Num	Date of Service		Reason Codes	Units	Contract Rate	Claim Amt	Cr Memo Amount	Denied Amt	Whld Amt	Paid Amt
Last	First		012345678O	000111	11/7/2017	11/7/2017	000001		0	11		$0.00	1244405954	Medicaid
4	90837			000123	11/7/2017		330	1	$74.57	$120.00	$0.00	$120.00	$0.00	$0.00
Last, First			Claimed Amount: **$120.00**			Cr Memo Amount: **$0.00**			Denied Amount: **$120.00**			Paid Amount: **$0.00**		

Recoupments (Credit Memos)

Recoupments create credit memos when claims are replaced and/or voided.

- The claim(s) may have been paid on a previous RA. The replacement and/or voided claim(s) will create the credit memo which will recoup the originally paid claim(s).
- When a claim(s) is replaced and recoups the original payment and the new claim(s) is denied the recoupment will show up on the RA while a denial is generated on the new claim(s).
- The new denial will have to be corrected and resubmitted before the repayment of the claim(s) will occur. If this happens the Provider will temporarily have a recouped original claim(s) while awaiting a successful adjudication of the new claim(s).
- When a claim(s) (unpaid or paid) is replaced during the check write period for an RA, both the original, reverted claim(s) and the new claim(s) will be populated in the RA.
- When the credit memo is split to pay claim(s) on two different checks, only the applied credit memo amount will be included on each respective RA, not the full amount of the reverted claim.

Negative Credit Memo Amount is the Recouped Claim

Last	First		012345678O	000111	11/3/2017	11/3/2017	00001			11		$0.00	1244241981	Medicaid
22	90791			000123	11/3/2017		1026, 292, 1231	1	$94.04	($140.00)	($94.04)	($45.96)	$0.00	$0.00
Last, First			Claimed Amount: **($140.00)**			Cr Memo Amount: **($94.04)**			Denied Amount: **($45.96)**			Paid Amount: **$0.00**		

Positive Credit Memo Amount is the Claim used to satisfy the Recouped Claim

Last	First	T	0123456780	000111	11/1/2017	11/1/2017		000001	11		$0.00	000123456	Medicaid
1	90847			000123		1026,292	1	$67.28	$100.00	$94.04	$5.96	$0.00	$0.00
Last, First				Claimed Amount: **$100.00**			Cr Memo Amount: **$94.04**			Denied Amount: **$5.96**		Paid Amount: **$0.00**	

- See the instructions on How to Apply a Credit Memo at the end of this Companion Guide.

Grand Totals

The Grand Total Section of the RA will appear at the bottom of the RA.

- The Grand Total Claimed Amount
- The Grand Total Denied Amount
- The Grand Total Paid Amount
- Funding Sources – Grand Totals are shown for each Fund Source paid on this RA. The fund source totals do no reflect any denials.

Grand Total: Claimed Amount: $123,456.10 Denied Amount: $497.20 Paid Amount: $122,958.90

Funding Sources*: Medicaid: $103,211.33 State: $19,747.57

**Funding Sources reported on individual claims may be inaccurate due to split funding sources across multiple dates of service. The Funding Source Summary at the end of the RA should be considered the definitive reference for funding source breakdown on any check.*

***Process dates selected designate the denied and fully adjusted claims included in this RA. Paid approved claims included in this RA are all claims paid by check number EFT000000*

Reason Code Key

At the end of the RA, immediately under the grand totals for the RA, is a reason code key that assists in identifying why a claim denied. The listed denial reasons are not all of the Trillium denial reasons, but a list of denial reasons included on the RA being reviewed. An example would look like the below:

Reason Code Key:	
62	Service is not authorized
77	Missing/incomplete/invalid place of service.
287	Adjustment represents the estimated amount the primary payer may have paid.
330	Patient not enrolled on the date of service.
765	Duplicate Claim
1018	Claim received after billing period
1026	Approved
1073	Client has other covered insurance (COB)
1130	Clinician not licensed to provide the service or license has expired
1165	Readju-Auto RetroMedicaid
1167	The taxonomy code for the billing provider is missing.

Field Descriptions /Definition Guide:

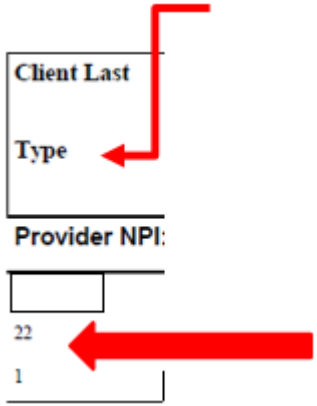
Client Last	Client's Last Name
Client First	Client's First Name
Client Middle	Client's Middle Initial
Client MCD/SSN	Clients Medicaid or Social Security Number
CI Client ID	ID number assigned to patient by the MCO system
Claimed Date Range	The Date Range on a claim
Provider Direct #	The claim # assigned by Provider Direct
Auth Number	The authorization number generated by a Treatment Authorization Request and used for claim processing
Pat Cntrl #	Patient ID number submitted by the Provider Agency
POS	Place of Service
Other Pmt	Any other payment submitted on the claim by the Provider Agency (i.e.: a Third Party Benefit payment or the Patient Liability amount).

CI Audit #	Claim detail number assigned to specific service line within the claim.
Funding Source	The Fund Source the claim has adjudicated against (i.e.: Medicaid, State)
Type	Type Key… this key explains the claim line amount (i.e.: (1) Payment, (4) Denial, (22) Reversal of Payment
Service Code	Procedure Code submitted on the claim
Mod	Modifiers submitted on the claim
Rev Code	Revenue code submitted on the claim. (Used for claims submitted on 837 Institutional or UB04 claim)
CI Claim Num	Claim number assigned to the claim upon adjudication of the claim.
Date of Service	The individual date of service submitted on the claim. Each date of service within a claim will have its own detail line.
Reason Codes	The detailed explanation of the reason the claim denied.
Units	The amount of units submitted on the claim
Contract Rate	Rate associated with provider contract for service rendered
Claim Amt	The total amount of the claim submission
Cr Memo Amount	A Credit Memo is the result of a replaced or voided claim.
Denied Amt	Total Denied amount for the claim
Whld Amt	The total of any withheld amount from the claim
Paid Amt	Total amount paid for the claim

REMITTANCE ADVICE - CREDIT MEMO APPLICATION

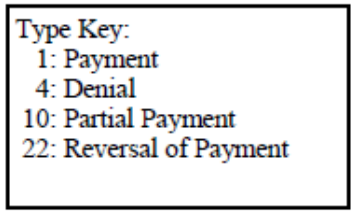
WHAT IS THE CLAIM STATUS?

The first step in identifying a claim payment and/or a claim recoupment is to find the Status of the claim. The status of the claim is the first column on the Remittance Advice under the Header name "Type"



Recoupments are shown as Type 22 - Reversal of Payment

The Type Key is located in the right hand corner of the RA will let you know the type of status the claim is in.



HOW TO APPLY A CREDIT MEMO:

When the status of a claim is Type 22 Reversal of Payment there will be a negative amount in the Credit Memo column. Credit Memos are generated from a recoupment.

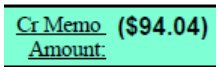
- When a claim is replaced, voided and/or re-adjudicated the line detail will show the recoupment as a negative amount. Example: ($74.57)

- A Negative Credit Memo is the amount "due" back to Trillium from the original paid claim on a previous RA. The amount "due" is deducted from this RA.
- When the claim is voided the Negative Credit memo will appear as only one line detail on the RA.
- When the claim is replaced and/or re-adjudicated the Negative credit memo will appear as the first detail line.
- The second detail line will appear as "Type 1" this is the repayment of the claim which may be more, less or the same as the recouped amount depending on the correction of the claim.
- A credit memo is usually applied to a separate paid claim on the same RA.
- When this detail line shows a repayment in the Paid Amount column it does not recoup the amount due from detail line 1, it is a second payment for this member on this date of service. Example: $74.57
- A negative credit memo (the payback amount due) may or may not be applied to the exact claim/member that was recouped.

When a claim is Type 1 Payment this type reflects a Paid claim. This payment is the paid amount of the claim by Trillium.

- The Paid Amount column will show the amount of the cash payment for this claim included in the check amount deposited into the Providers account.
- Recoupments due from the Type 22 are "paid back" to Trillium from a paid claim (Type 1). When this occurs the check amount due to the Provider is reduced by this amount.
- The payback is also shown in the Credit Memo column and is shown as a Positive Credit Memo amount. Example: $74.57
- The Paid Amount column may show as a $0.00 payment when the claim is reduced by the credit memo; however, the claim is a payment (remember it is a Type 1) and should be posted by the Provider Agency as a payment.
- When the credit memo applied to the paid amount only needs a partial amount to satisfy the recoupment, the paid amount column will reflect the partial payment amount remaining.
- When the line detail shows a positive credit memo amount along with a partial payment, it will be necessary to add these amounts together when posting the amount paid on the claim.
- The Positive Credit Memo amount is the actual recoupment of the previously paid claim.

When the Remittance Advice shows a Negative Credit memo amount on the Member's summary line, this is a recoupment.



To balance the Remittance Advice and match the Check Amount deposited in the Providers account:

Look for the Positive Credit memo amount on the Member's summary line as this is the actual payback of the recouped claim, which reduces the check amount due to the Provider Agency, but is a paid claim amount.

Please note that a recouped claim can be withheld from more than one paid claim.
Example:

Cr Memo Amount: **$67.28** + Cr Memo Amount: **$26.76** = $94.04.

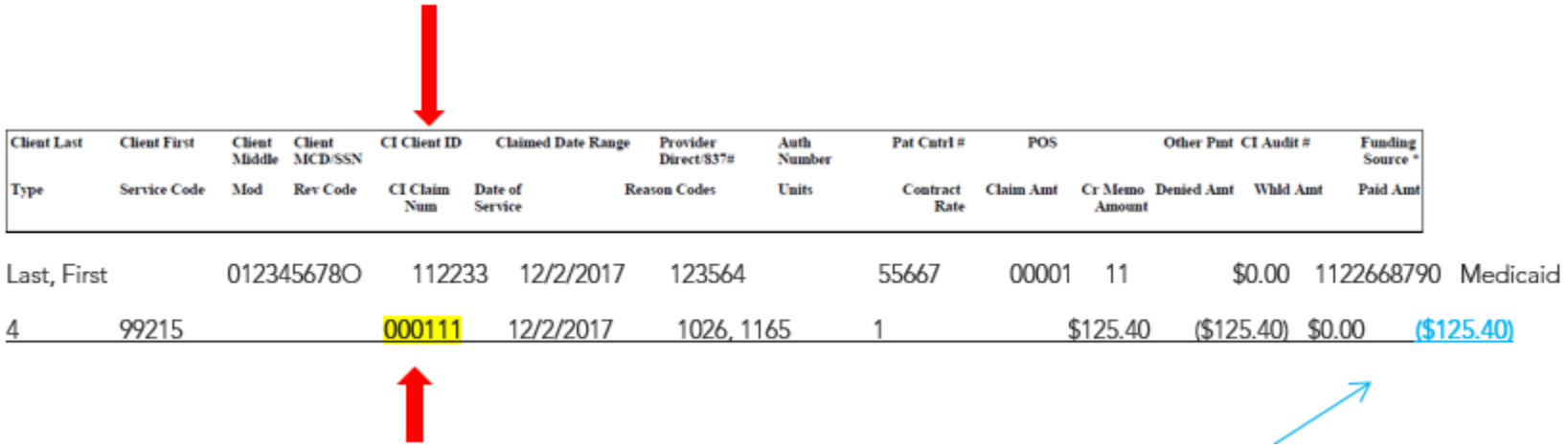
Two claims were used to balance out a recouped claim of $94.04. When multiple claims are recouped on the same RA there will not be an identifiable one to one match to determine which paid claim was withheld for the recouped claim.

Note The Remittance Advice should be posted by each detail line that reflects the status of the claim (Type Key). When this procedure is followed, the RA should balance to the Check Amount deposited.

FREQUENTLY ASKED QUESTIONS:

My Claims Specialists said I could find the claim number for my replacement claim on the RA. Where is it located?

The CIE claim number is shown on the claim field label in the second row. Please look at the second row on the claim detail row to find the claim number.



Client Last	Client First	Client Middle	Client MCD/SSN	CI Client ID	Claimed Date Range	Provider Direct/837#	Auth Number	Pat Cntrl #	POS		Other Pmt	CI Audit #	Funding Source *
Type	Service Code	Mod	Rev Code	CI Claim Num	Date of Service	Reason Codes	Units	Contract Rate	Claim Amt	Cr Memo Amount	Denied Amt	Whld Amt	Paid Amt
Last, First		012345678O		112233	12/2/2017	123564		55667	00001	11	$0.00	1122668790	Medicaid
4	99215			000111	12/2/2017	1026, 1165	1		$125.40	($125.40)	$0.00		($125.40)

The Remittance Advice shows a negative amount. Where is this coming from?

Negative payments are the recoupment of an originally paid claim. This can happen when a claim is replaced and/or voided by the Provider Agency or re-adjudicated by Trillium Health Resources.

When Trillium Health Resources has updates to rates and services, etc. claims may be re-adjudicated to correct the claim to the updated status. This will recoup the original amount paid and will repay the claim with the corrections.

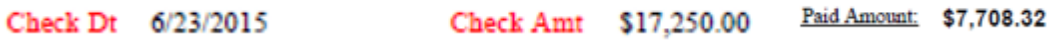
Replacement claim(s) will recoup the claim creating a credit memo and will repay the claim. The replacement will be reflected with a "Type Key" of 22 which is a reversal of a payment. When a type 22 occurs there may also be a type 1 behind it that is the repayment of the claim. If the replacement claim denies it will be reflected with by a type 4. If a type 4 (denial) happens it will be necessary to submit a corrected claim.

Void claim(s) will recoup the original payment of the claim. Unlike a replacement claim there will not be a repayment of a voided claim.

Audit Denial(s) if any kind of Trillium Health Resources audit has been done and the results of the audit are to recoup the payment of the audited claim, these recoupments will also appear as a type 22 recoupment. There will not be any repayments when this occurs.

The check amount does not match the Paid Amount on the last page of the RA. Why is this?

Recoupments can reduce the check amount shown on the RA header. The Check Amount is listed at the top of the RA header. The Paid Amount is located at the end of the RA.



When claims are recouped and repaid for the same amount on the same RA these two amounts should match.

When claims are recouped and repaid for a different amount (i.e. a denial or a voided claim) the paid amount will be decreased by the amount of recoupments. This will cause the check amount and the paid amount to not match.