Commonwealth of Massachusetts
Executive Office of Health and Human Services
Division of Medical Assistance
600 Washington Street
Boston, MA 02111
www.mass.gov/dma

MASSHEALTH
TRANSMITTAL LETTER AFC-8
January 2002

TO: Adult Foster Care Providers Participating in MassHealth

FROM: Wendy E. Warring, Commissioner

RE: *Adult Foster Care Manual* (Revised Billing Instructions)

The letter transmits updates to the billing instructions (Subchapter 5) of the *Adult Foster Care Manual* to accommodate the new rate structure, as described in Adult Foster Care Transmittal Letter AFC-7.

If you have any questions about these billing instructions, contact the MassHealth Provider Services Department as 671-628-4141 or 1-800-325-5231,

These revisions are effective for dates of service on or after October 1, 2001.

NEW MATERIAL
(The pages listed here contain new or revised language.)

Adult Foster Care Manual

Pages 5.3-1 through 5.3-8 and 5.5-1 through 5.5-12.

OBSOLETE MATERIAL
(The pages listed here are no longer in effect.)

Adult Foster Care Manual

Pages 5.3-1 through 5.3-8 and 5.5-1 through 5.5-18 transmitted by Transmittal Letter AFC-4.

Part 3. How to Submit Claims

All adult foster care providers must use claim form no. 9 to bill MassHealth for services. Providers can request supplies of claim form no. 9 from the appropriate address or fax number listed in Appendix A of this manual. This section explains how to complete this claim form.

Electronic Claims

Electronic billing offers an effective and convenient alternative to paper billing. For information on submitting electronic claims on tape, diskette, or in other electronic formats, contact Electronic Claims Services at the address or telephone number listed in Appendix A of this manual.

Entering Information on Claim Form No. 9

- Complete a separate claim form, or follow the applicable electronic media claim format, for each member for whom services were provided.
- Type or print all required information on the claim form **with black ink**, using high quality printer ribbons or cartridges. Be sure all entries are complete, accurate, legible, and within the respective claim boxes.
- Do not italicize, bold, or underline characters.
- Do not enter negative amounts into any boxes.
- For each claim line, enter all required information, repeating if necessary. Do not use ditto marks or words such as “same as above.”
- Attach any necessary reports or required forms to the claim form, but be careful not to staple in the bar code printed in the upper-left portion of the claim form.
- When the required entry is a date (such as the date of service or the member's date of birth), enter the date in month/day/year order.

  Example: For a member born on October 8, 1960, the entry in Item 11 should be as follows.

10	08	60

Time Limitations on the Submission of Claims

The period established by state law for the submission of claims is 90 days. For regulations governing time limitations on the submission of claims, see the provider regulations in Subchapter 3 of this manual.

The 90-day period is measured from the date of service to the date on which the claim is received. Since the 90-day billing deadline applies to each claim line, the claim must be received within 90 days from the earliest date of service on the claim. When a claim line contains consecutive dates of service, the 90-day period is measured from the last date in the range (the date entered in the column labeled "To" in Item 26 of claim form no. 9).

All services listed on a single claim line must have been provided in the same fiscal year. That is, dates of service in the months of June and July should not appear on the same claim line.

Claims for Members with Other Health Insurance Coverage

Instructions for submitting claims for services provided to members with other health insurance coverage are located in Part 8 of these billing instructions.

Further Assistance

If, after reviewing the item-by-item instructions in the following section, you need additional assistance, contact MassHealth Provider Services. See Appendix A in this manual for the appropriate address and telephone numbers.

Item-by-Item Instructions for Completing Claim Form No. 9

This section contains specific instructions for completing each item on claim form no. 9. Examples of properly completed claim forms for specific billing situations begin on page 5.3-8.

Item 1	PROVIDER'S NAME, ADDRESS & TELEPHONE NO.	Enter the provider's name, address, and telephone number.
Item 2	PAY TO PROVIDER NO.	Enter the provider's seven-digit MassHealth number.
Item 3	BILLING AGENT NO.	If this form is prepared by a billing agent, enter the seven-digit number assigned to the agent, if one was assigned. Otherwise, leave this item blank.
Item 4	PRIOR AUTHORIZATION NO.	Leave this item blank.
Item 5	SERVICING PROVIDER'S NAME	Leave this item blank.
Item 6	SERVICING PROVIDER NO.	Leave this item blank.
Item 7	REFERRING PROVIDER'S NAME	For members enrolled with a PCC, enter the name of the member's PCC. For all other members, leave this item blank.
Item 8	REFERRING PROVIDER NO.	For members enrolled with a PCC, enter the PCC's seven-digit referral number. For all other members, leave this item blank.
Item 9	MEMBER'S NAME	Enter the member's name.
Item 10	RECIPIENT ID NO.	Enter the complete 10-character member identification (ID) number that is printed on the MassHealth card below or beside the member's name. These characters may be all numbers or a combination of numbers and letters. The member ID on the temporary MassHealth card may include an asterisk as the 10th character.

Item-by-Item Instructions for Completing Claim Form No. 9

Item 11	DATE OF BIRTH	Enter the member's date of birth in month/day/year order.
Item 12	SEX	Enter either an M for male or an F for female.
Item 13	OTHER INSUR.	If the member is covered by other health insurance, enter an X.
Item 14	PATIENT ACCOUNT NO.	Enter the patient account number or member's last name (no more than 10 characters). This patient account number or name will be printed on the remittance advice to help identify the claim.
Item 15	PLACE OF SERVICE	Enter the code from the list below that describes the place in which the service was provided. 01 - Office, facility, or business location 02 - Member's home 03 - Hospital, inpatient 04 - Hospital, outpatient 05 - Emergency department 06 - Nursing facility 07 - Rest home 99 - Other location
Item 16A	IS MEMBER BEING TREATED AS A RESULT OF AN ACCIDENT?	If the service was necessary because the member was involved in an accident, enter an X in the box labeled "Yes" and complete Items 16B and 16C. If the service was not accident-related or if the information is not available, enter an X in the box labeled "No" and leave Items 16B and 16C blank.
Item 16B	IF YES, TYPE &	If the Yes box is checked in Item 16A, enter the code from the list below that describes the type of accident. 1 - Automobile related 2 - Employment related 3 - Other
Item 16C	DATE OF ACCIDENT	If the Yes box is checked in Item 16A, enter the date of the accident in month/day/year order.
Item 17	IS MEMBER BEING TREATED AS A RESULT OF EPSDT SCREENING?	Leave this item blank.
Item 18	L.O.F.	Leave this item blank.
Item 19	PATIENT STATUS	Leave this item blank.

Item-by-Item Instructions for Completing Claim Form No. 9

Item 20	DISCHARGE DATE	Leave this item blank.
Item 21	DIAGNOSIS CODE	Leave this item blank
Item 22	DIAGNOSIS NAME	Leave this item blank
Item 23	DIAGNOSIS CODE	Leave this item blank
Item 24	DIAGNOSIS NAME	Leave this item blank
Item 25	LINE	Each letter (A through J) refers to one of the 10 claim lines contained on the claim form. This letter will appear as the last character of the claim's transaction control number (TCN) listed on the remittance advice.
Item 26	DATES OF SERVICE	For single dates of service, in the From column, enter, in month/day/year order, the date the service was provided. Leave the To column blank. Use a separate claim line for each date of service, except for consecutive dates. For consecutive dates of service, enter the first date of service in the From column and the last date of service in the To column. Indicate the number of days billed during this span of dates in Item 31.
Item 27	DESCRIPTION OF SERVICE	No entry is required. To complete this item for your records, enter a brief description of the service provided.
Item 28	PROCEDURE CODE-MODIFIER	Enter the service code that corresponds to the service provided. Obtain the service code from Subchapter 6 of this manual.
Item 29	TREAT. REL. TO DIAG.	Leave this item blank.
Item 30	TREAT. REL. TO FAM. PL.	Leave this item blank.
Item 31	UNITS OF SERVICE	Enter the number of days or units billed.
Item 32	USUAL FEE	Enter the usual and customary fee (the amount you charge a person who is not a MassHealth member) for each service provided. When billing for more than one unit, multiply the number of units in Item 31 by the usual and customary fee. Enter that product as the usual and customary fee.

Item-by-Item Instructions for Completing Claim Form No. 9

Item 33	OTHER PAID AMOUNT	Enter any amount received for the service from a source other than MassHealth, and attach to the claim form a copy of the notice of final disposition from the other payment source. Do not enter any previous payment received from MassHealth. See Part 8 of these billing instructions for submitting claims for services provided to members with other health insurance coverage. Any amount entered in Item 33 will be deducted from the MassHealth payment.
Item 34	EMERG. SERV.	Leave this item blank.
Item 35	REMARKS	Leave this item blank.
Item 36	TOTAL USUAL FEE	No entry is required. To complete this item for your records, calculate and enter the sum of the amounts entered in Item 32 (“Usual Fee”).
Item 37	TOTAL OTHER PAID AMOUNT	No entry is required. To complete this item for your records, calculate and enter the sum of the amounts entered in Item 33 (“Other Paid Amount”).
Item 38	AUTHORIZED SIGNATURE	The form must be signed by the provider or by the individual designated by the provider to certify that the information entered on the form is correct. Signatures other than handwritten signatures (for example, stamped, typewritten, or computer-generated) are also acceptable.
Item 39	BILLING DATE	Enter in month/day/year order the date on which the claim form is completed. The billing date may not precede any of the dates of service entered on the claim form.
Item 40	ADJUSTMENT/RESUBMITTAL	Enter an X in the Adjustment or Resubmittal box only when an entry is required by the instructions for correcting a claim. See the section on correcting claims elsewhere in these billing instructions. Do not make any entry in this item without completing Item 41.

Item-by-Item Instructions for Completing Claim Form No. 9

Item 41	FORMER TRANSACTION CONTROL NO.	When an entry is required in this item, enter the 10-digit transaction control number (TCN) assigned to the original claim. The TCN appears on the remittance advice that listed the original claim as paid or denied. When resubmitting or adjusting a claim, include all attachments that were required for the original claim.
Item 42	FOR OFFICE USE ONLY	Leave this item blank.

Examples of Completed Claim Forms

This section contains examples of completed claim forms for the billing situations described below. For assistance with a billing situation not explained in these examples, contact MassHealth Provider Services at the appropriate address or telephone numbers listed in Appendix A of this manual.

A. Adult Foster Care Daily Rate

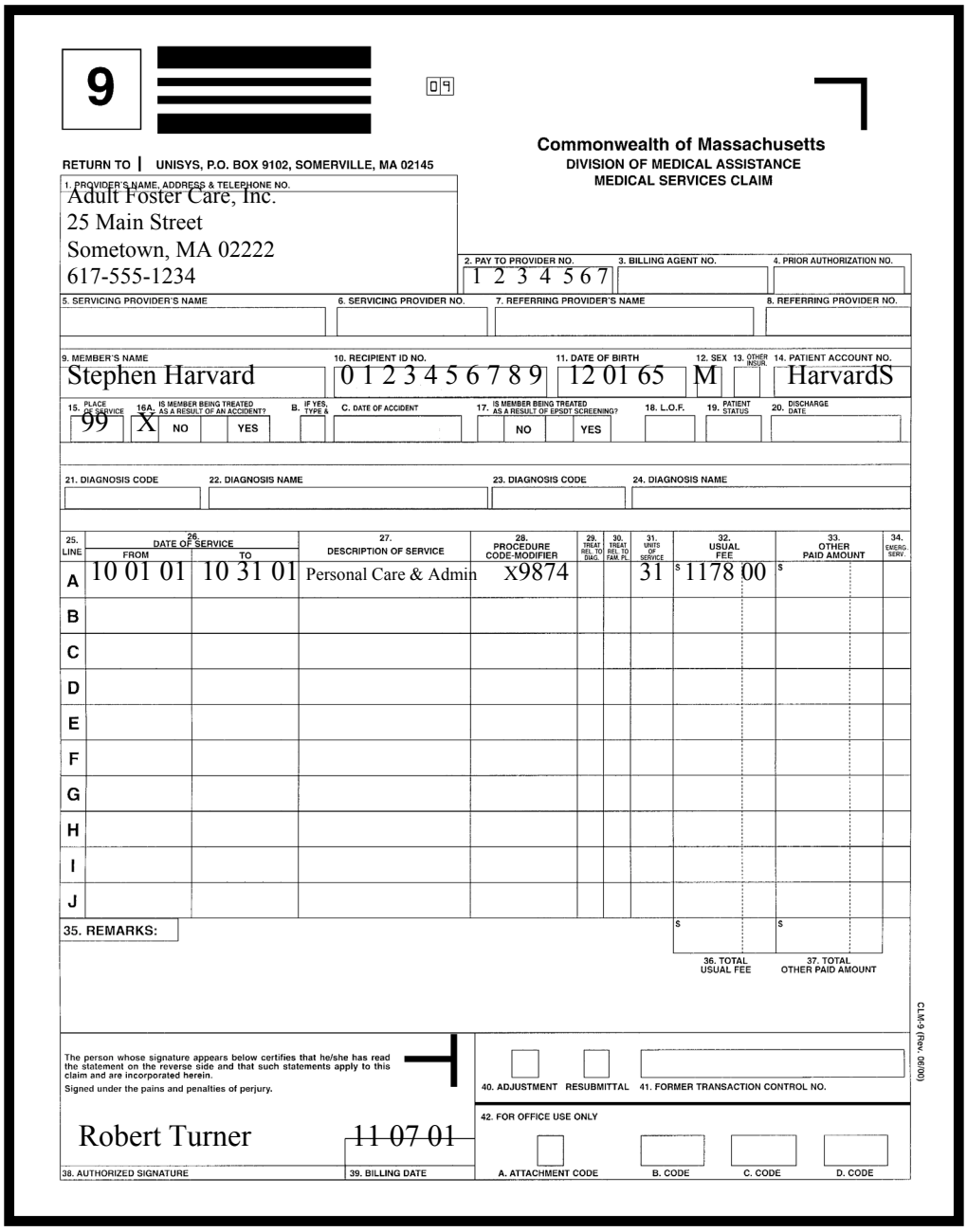
This example shows a claim for a daily rate for adult foster care services.

B. Adult Foster Care Daily Rate with Respite Care

This example shows a claim for a daily rate for adult foster care services with seven days of respite care.

Examples of Completed Claim Forms

A. Adult Foster Care Daily Rate



9 [redacted] 09

Commonwealth of Massachusetts
DIVISION OF MEDICAL ASSISTANCE
MEDICAL SERVICES CLAIM

RETURN TO | UNISYS, P.O. BOX 9102, SOMERVILLE, MA 02145

1. PROVIDER'S NAME, ADDRESS & TELEPHONE NO.
Adult Foster Care, Inc.
25 Main Street
Sometown, MA 02222
617-555-1234

2. PAY TO PROVIDER NO.: 1 2 3 4 5 6 7
3. BILLING AGENT NO.:
4. PRIOR AUTHORIZATION NO.:
5. SERVICING PROVIDER'S NAME:
6. SERVICING PROVIDER NO.:
7. REFERRING PROVIDER'S NAME:
8. REFERRING PROVIDER NO.:
9. MEMBER'S NAME: Stephen Harvard
10. RECIPIENT ID NO.: 0 1 2 3 4 5 6 7 8 9
11. DATE OF BIRTH: 12 01 65
12. SEX: M
13. OTHER INSUR.:
14. PATIENT ACCOUNT NO.: HarvardS
15. PLACE OF SERVICE: 99
16A. IS MEMBER BEING TREATED AS A RESULT OF AN ACCIDENT? X NO YES
B. IF YES, TYPE &
C. DATE OF ACCIDENT
17. IS MEMBER BEING TREATED AS A RESULT OF EPSDT SCREENING? NO YES
18. L.O.F.
19. PATIENT STATUS
20. DISCHARGE DATE
21. DIAGNOSIS CODE
22. DIAGNOSIS NAME
23. DIAGNOSIS CODE
24. DIAGNOSIS NAME

25. LINE	26. DATE OF SERVICE FROM	TO	27. DESCRIPTION OF SERVICE	28. PROCEDURE CODE-MODIFIER	29. TREAT REL. TO DIAG.	30. TREAT REL. TO FAM. PL.	31. UNITS OF SERVICE	32. USUAL FEE	33. OTHER PAID AMOUNT	34. EMERG. SERV.
A	10 01 01	10 31 01	Personal Care & Admin	X9874			31	$ 1178 00	$	
B										
C										
D										
E										
F										
G										
H										
I										
J										

35. REMARKS:

$ 36. TOTAL USUAL FEE
$ 37. TOTAL OTHER PAID AMOUNT

CLM 6 (Rev. 06/00)

The person whose signature appears below certifies that he/she has read the statement on the reverse side and that such statements apply to this claim and are incorporated herein.
Signed under the pains and penalties of perjury.

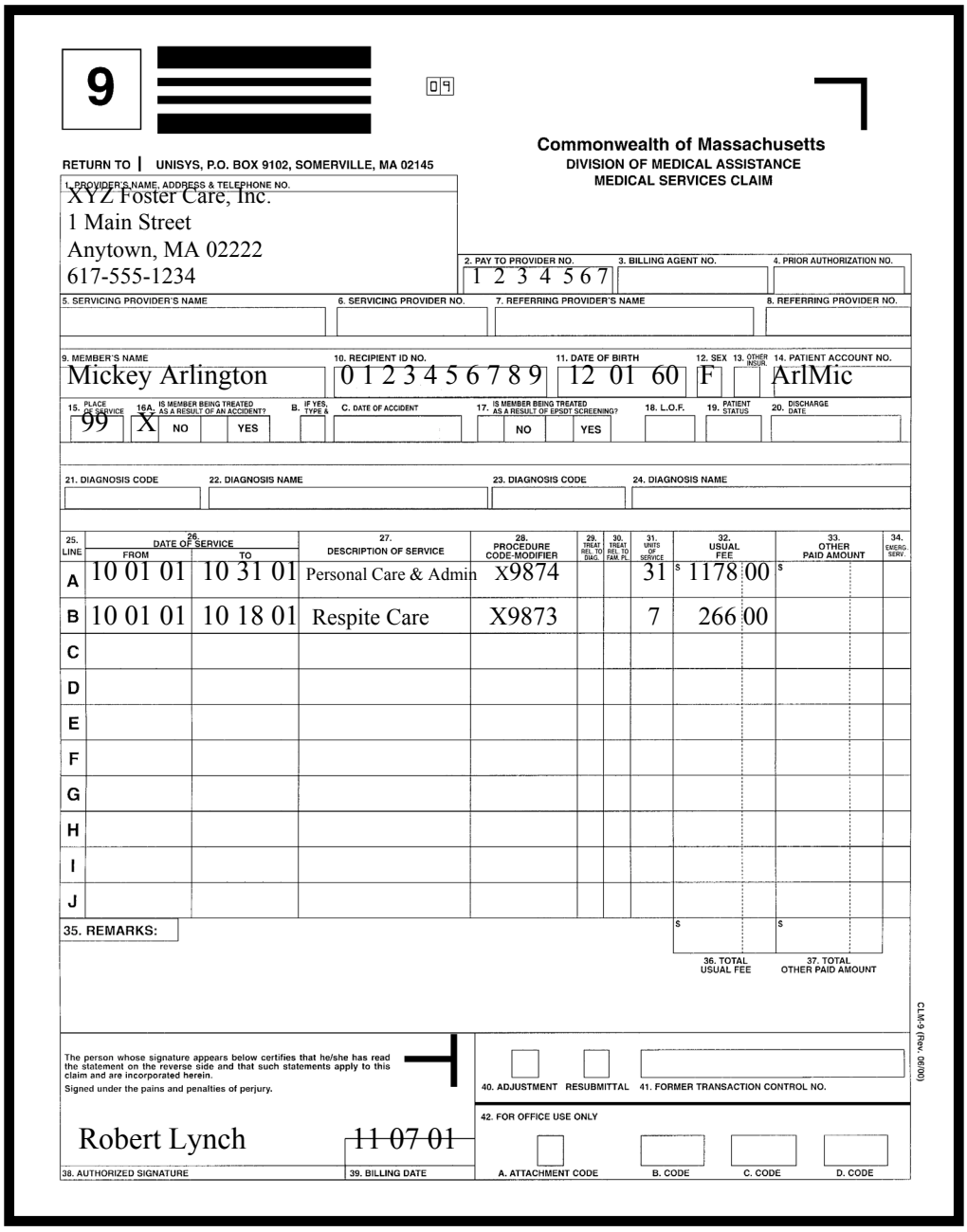
Robert Turner — 38. AUTHORIZED SIGNATURE
11 07 01 — 39. BILLING DATE

40. ADJUSTMENT RESUBMITTAL 41. FORMER TRANSACTION CONTROL NO.

42. FOR OFFICE USE ONLY
A. ATTACHMENT CODE B. CODE C. CODE D. CODE

Examples of Completed Claim Forms

B. Adult Foster Care Daily Rate with Respite Care



9 [redacted] 09

RETURN TO | UNISYS, P.O. BOX 9102, SOMERVILLE, MA 02145

Commonwealth of Massachusetts
DIVISION OF MEDICAL ASSISTANCE
MEDICAL SERVICES CLAIM

1. PROVIDER'S NAME, ADDRESS & TELEPHONE NO.
XYZ Foster Care, Inc.
1 Main Street
Anytown, MA 02222
617-555-1234

2. PAY TO PROVIDER NO.: 1 2 3 4 5 6 7
3. BILLING AGENT NO.:
4. PRIOR AUTHORIZATION NO.:
5. SERVICING PROVIDER'S NAME:
6. SERVICING PROVIDER NO.:
7. REFERRING PROVIDER'S NAME:
8. REFERRING PROVIDER NO.:
9. MEMBER'S NAME: Mickey Arlington
10. RECIPIENT ID NO.: 0 1 2 3 4 5 6 7 8 9
11. DATE OF BIRTH: 12 01 60
12. SEX: F
13. OTHER INSUR.:
14. PATIENT ACCOUNT NO.: ArlMic
15. PLACE OF SERVICE: 99
16A. IS MEMBER BEING TREATED AS A RESULT OF AN ACCIDENT? X NO YES
B. IF YES, TYPE &
C. DATE OF ACCIDENT
17. IS MEMBER BEING TREATED AS A RESULT OF EPSDT SCREENING? NO YES
18. L.O.F.
19. PATIENT STATUS
20. DISCHARGE DATE
21. DIAGNOSIS CODE
22. DIAGNOSIS NAME
23. DIAGNOSIS CODE
24. DIAGNOSIS NAME

25. LINE	26. DATE OF SERVICE FROM	TO	27. DESCRIPTION OF SERVICE	28. PROCEDURE CODE-MODIFIER	29. TREAT REL. TO DIAG.	30. TREAT REL. TO FAM. PL.	31. UNITS OF SERVICE	32. USUAL FEE	33. OTHER PAID AMOUNT	34. EMERG. SERV.
A	10 01 01	10 31 01	Personal Care & Admin	X9874			31	$ 1178 00	$	
B	10 01 01	10 18 01	Respite Care	X9873			7	266 00		
C										
D										
E										
F										
G										
H										
I										
J										

35. REMARKS:

$ 36. TOTAL USUAL FEE
$ 37. TOTAL OTHER PAID AMOUNT

CLM 6 (Rev. 06/00)

The person whose signature appears below certifies that he/she has read the statement on the reverse side and that such statements apply to this claim and are incorporated herein.
Signed under the pains and penalties of perjury.

Robert Lynch — 38. AUTHORIZED SIGNATURE
11 07 01 — 39. BILLING DATE

40. ADJUSTMENT RESUBMITTAL 41. FORMER TRANSACTION CONTROL NO.

42. FOR OFFICE USE ONLY
A. ATTACHMENT CODE B. CODE C. CODE D. CODE

Part 5. How to Read the Remittance Advice

The remittance advice is sent to providers to explain the disposition of MassHealth claims. The remittance advice lists claims in the following order: paid claims, denied claims, and suspended claims. Items within each category of claims are sorted by date of service, patient account number, and then by member last name. Three-digit errors for denied and suspended claims, amounts paid, and claim identification information are also listed. See the section on errors and descriptions elsewhere in these billing instructions for an explanation of the errors.

The first page of each remittance advice is a message page. This page provides timely information from the Division about MassHealth billing, regulation, and payment, as well as other topics. These updates must be communicated to all applicable staff, and should be kept for future reference.

Sample Remittance Advice

Pictured below is a claim form no. 9 remittance advice. An item-by-item explanation begins on the next page.

(09) MEDICAL SERVICES (9) REMITTANCE ADVICE — RUN 5 — MM/DD/YY 6

COMMONWEALTH OF MASSACHUSETTS
DIVISION OF MEDICAL ASSISTANCE
MEDICAL ASSISTANCE PROGRAM

PROVIDER NAME
ATTENTION LINE
STREET ADDRESS
CITY, STATE ZIP
1

PROVIDER NUMBER 4
PROVIDER PAGE 2
REPORT PAGE 3

PATIENT ACCOUNT NUMBER 7	RECIPIENT NAME 8	RECIPIENT ID 9	TCN 10	FROM DATE 11	TO DATE 12	SERV-ICING PROV NO 13	PROC CODE/ MOD 14	PLACE OF SERV 15	UNITS 16	AMOUNT REQUEST 17	OTHER PAID AMOUNT 18	AMOUNT PAID BY MEDICAID 19	STATUS 20	REMARKS 21

DIAG 22 | PA 23 | OTH INS 24 | ERRORS 25

Item-by-Item Explanation of the Remittance Advice

The following list explains the items found on the remittance advice as depicted in the sample on the previous page.

1	TO	This is the provider's name and address.
2	PROVIDER PAGE	This is the page number of the remittance advice.
3	REPORT PAGE	This is the page number of the entire claims processing pay cycle for all MassHealth providers.
4	PROVIDER NUMBER	This is the pay-to provider number that was entered in Item 2 on the claim form.
5	RUN	This is the number identifying the specific pay cycle. The first digit of the run number designates the claim type: 1 - MassHealth 3 - CommonHealth 5 - Massachusetts Commission for the Blind.
6	DATE	This is the date the remittance advice was printed.
7	PATIENT ACCOUNT NUMBER	This is the patient account number that was entered in Item 14 on the claim form.
8	RECIPIENT NAME	This is the member's name. If the member identification (ID) number is not on the MassHealth member eligibility file, or if the ID entered on the claim form was incorrect, this item states that the name is not available (NM NOT AVAIL).
9	RECIPIENT ID	This is the ID number entered on the claim form.
10	TCN	This transaction control number (TCN) is a unique 10-character number assigned to each claim line. The TCN is assigned when a claim is received. It is used to identify a claim for adjustments, resubmittals, and research. The following chart details each character of the sample TCN 130902744A.

Last Digit of Current Calendar Year	Julian Date Received	MMIS Batch Number	Claim Number Within Batch	Line on Claim Form
1	309	027	44	A
(2001)	(November 5)	(Batch #27)	(Claim #44)	(Claim Line A)

Item-by-Item Explanation of the Remittance Advice

11	FROM DATE	This is the date on which the service was provided.
12	TO DATE	The To date entered on the claim form appears here, if applicable. Otherwise, this is the same as the From date.
13	SERVICING PROV NO.	This is the MassHealth provider number entered in Item 6 of the claim form.
14	PROC CODE/MOD	This is the code for the service that was provided.
15	PLACE OF SERV	This is the code indicating where the service was provided.
16	UNITS	This is the number of service units (days, items, number of times performed, or time increments) that were billed.
17	AMOUNT REQUEST	This is the usual and customary fee entered on the claim form.
18	OTHER PAID AMOUNT	This is the amount entered on the claim form that was paid by other health insurance.
19	AMOUNT PAID BY MEDICAID	Positive amounts are paid by the Division resulting from the approval of a claim for payment or from an approved adjustment of a previously paid claim. Negative amounts are owed by the provider to the Division resulting from an adjustment or void of a previously paid claim.
20	STATUS	This reports the status of the claim, adjustment, or void. PAID - claim is paid DENIED - claim is not paid SUSPEND - claim must be reviewed prior to payment determination ACCEPTED - void claim is accepted

Item-by-Item Explanation of the Remittance Advice

21 REMARKS

This contains additional information about the claim.

- CRADJ - on an adjustment claim, the amount previously paid is recalculated
- DBADJ - on an adjustment claim, the amount previously paid is debited
- FISCPEND - payment is pending for fiscal reasons
- ORIG - original claim
- PRRUXXX - indicates action taken by postpayment and provider review (PPRU) pend ("XXX" indicates the log number assigned to the case)
- RECOUP - payment amount subtracted to satisfy an amount owed to the Division
- RELFISC - claim is released from fiscal pended status
- RELXXX - released from postpayment and provider review unit pend ("XXX" indicates the sanction log number)
- RESUB - resubmittal of a previously denied claim
- TAPE - claim was submitted electronically
- TPL-INS - collection from other health insurance
- VOID - void to a previously paid claim

An additional character may appear in the last position in the Remarks section under the following conditions.

- M - claim was manually reviewed and adjudicated
- P - claim was pended
- S - claim was suspended

22 DIAG

This is the ICD-9-CM diagnosis code that was entered on the claim form.

23 PA

This is the prior-authorization number that was entered on the claim form.

24 OTH INS

If an explanation of benefits (EOB) from a primary insurance carrier was attached to the claim form, the third-party-liability (TPL) carrier code corresponding to that insurer appears in this field.

25 ERRORS

The error(s) that caused the claim to suspend or deny appears here. See the section on errors and descriptions elsewhere in these billing instructions for an explanation of the error(s).

Sample Remittance Advice Total Page

Pictured below is a sample remittance advice total page. An item-by-item explanation begins on the next page.

(09) MEDICAL SERVICES (9) REMITTANCE ADVICE
COMMONWEALTH OF MASSACHUSETTS
DIVISION OF MEDICAL ASSISTANCE
MEDICAL ASSISTANCE PROGRAM
RUN MM/DD/YY

PROVIDER NAME
ATTENTION LINE
STREET ADDRESS
CITY, STATE ZIP

REMITTANCE ADVICE TOTAL PAGE — PROVIDER PAGE — REPORT PAGE

PROVIDER NUMBER

PAYMENT STATUS

	1 NUMBER OF CLAIMS	2 PROVIDER BILLED AMOUNT	3 UNITS	4 OTHER PAID AMOUNT	5 MEDICAID PAID AMOUNT
PAID CLAIMS					
ADJUSTED CLAIMS					
VOIDED CLAIMS					
DENIED CLAIMS					
SUSPENDED CLAIMS					
PENDED CLAIMS					
6 TOTALS					

PROVIDER VOUCHER AMOUNT $ 7
VOUCHER NUMBER 8
RETURN CHECK AMOUNT $ PROVIDER RETURNS $ OTHER RETURNS $

RECOUPMENT ACTIVITY

RECOUPMENT ACCOUNT 9	DESCRIPTION 10	CASE LOG NUMBER 11	OPENING BALANCE 12	TRANSACTIONS APPLIED 13	CLOSING BALANCE 14

SANCTION ACTIVITY

CASE LOG NUMBER 15	OPENING BALANCE 16	TRANSACTIONS APPLIED 17	CLOSING BALANCE 18

Item-by-Item Explanation of the Remittance Advice Total Page

The following explains the items found on the remittance advice total page.

Payment Status

1	NUMBER OF CLAIMS	These are the total number of claims within each of the six categories of claim status. ▪ paid claims ▪ adjusted claims ▪ voided claims ▪ denied claims ▪ suspended claims ▪ pended claims
2	PROVIDER BILLED AMOUNT	These are the totals of the amounts billed by the provider for each of the six categories of claims.
3	UNITS	These are the totals of the number of payable units for each of the six categories of claims.
4	OTHER PAID AMOUNT	These are the totals of the amounts paid by other health insurers for each of the six categories of claims.
5	MEDICAID PAID AMOUNT	These are the totals of the amounts paid by the Division for each of the six categories of claims.
6	TOTALS	These are the totals for Items 1 through 5 listed above.
7	PROVIDER VOUCHER AMOUNT	This is the amount of the payment.
8	VOUCHER NUMBER	This is the payment reference number of the check or deposit issued by the state treasurer's office.
9	RECOUPMENT ACCOUNT	This is the code for the recoupment account with activity this pay cycle.

Recoupment Activity

10	DESCRIPTION	This is a description of the recoupment account with activity this pay cycle.
11	CASE LOG NUMBER	This is the case log number assigned to the recoupment account with activity this pay cycle.
12	OPENING BALANCE	This is the balance of the recoupment account at the beginning of this pay cycle.

Item-by-Item Explanation of the Remittance Advice Total Page

13	TRANSACTIONS APPLIED	This is the amount of claims activity applied to the recoupment account this pay cycle.
14	CLOSING BALANCE	This is the balance of the recoupment account at the end of this pay cycle.
15	CASE LOG NUMBER	This is the case log number assigned to the provider review activity during this pay cycle.

Sanction Activity

16	OPENING BALANCE	This is the balance of the provider review account at the beginning of this pay cycle.
17	TRANSACTIONS APPLIED	This is the amount of claims activity applied to the provider review account this pay cycle.
18	CLOSING BALANCE	This is the balance of the provider review account at the end of this pay cycle.

Examples of Claim Lines on the Remittance Advice

A Paid Claim

In this example, adult foster care services (Service Code X9874) were provided to eligible MassHealth member John Doe from October 1, 2001 to October 31, 2001. The provider's usual fee is $1,178.00. The remittance advice claim line identifies the claim line by the transaction control number 130902744A, and lists the claim as paid and the amount paid as $1,178.00.

PATIENT ACCOUNT NUMBER	RECIPIENT NAME	RECIPIENT ID	TCN	FROM DATE	TO DATE	SERV-ICING PROV NO	PROC CODE/ MOD	PLACE OF SERV	UNITS	AMOUNT REQUEST	OTHER PAID AMOUNT	AMOUNT PAID BY MEDICAID	STATUS	REMARKS
DOEJ85	DOE JOHN	0123456789	130902744A	100101	103101	0123456	X9874	99	31	1178.00		11178.00	PAID	(ORIG)
DIAG		PA	OTH INS		ERRORS									

A Denied Claim

In this example, adult foster care services (Service Code X9874) were provided to eligible MassHealth member Helen Doe from October 1, 2001 to October 31, 2001. The claim is denied with error 103, meaning "Duplicate Claim," because a claim for the same service provided to the same member on the same date was already paid. This previously paid claim appears on the following line with the message "Conflicting Claim" and the run number of the remittance advice on which the claim was paid.

PATIENT ACCOUNT NUMBER	RECIPIENT NAME	RECIPIENT ID	TCN	FROM DATE	TO DATE	SERV-ICING PROV NO	PROC CODE/ MOD	PLACE OF SERV	UNITS	AMOUNT REQUEST	OTHER PAID AMOUNT	AMOUNT PAID BY MEDICAID	STATUS	REMARKS
DOEH85	DOE HELEN	0123456789	132302744A	100101	103101	1234567	X9874	99	31	1178.00			DENIED	(ORIG)
DIAG		PA	OTH INS		ERRORS 103									
DOEH85	DOE HELEN	0123456789	130902744A	100101	103101	1234567	X9874	99	31	1178.00				(ORIG)
DIAG		PA	OTH INS		CONFLICTING CLAIM RUN 1460									

A Suspended Claim

In this example, adult foster care services (Service Code X9874) were provided to John Smith from October 1, 2001 to October 31, 2001. The claim was suspended with error 246, meaning "Member Ineligible on Service Date." The claim was suspended because the MassHealth member eligibility file did not list the member as eligible for the date of service. The claim will remain suspended, for a period of up to 60 days, to allow for possible updates to the MassHealth member eligibility file.

PATIENT ACCOUNT NUMBER	RECIPIENT NAME	RECIPIENT ID	TCN	FROM DATE	TO DATE	SERV-ICING PROV NO	PROC CODE/ MOD	PLACE OF SERV	UNITS	AMOUNT REQUEST	OTHER PAID AMOUNT	AMOUNT PAID BY MEDICAID	STATUS	REMARKS
SMIJ85	SMITH JOHN	0123456789	130911172A	100101	103101	0123456	X9874	99	31	1178.00			SUSPEND	(ORIG)
DIAG		PA	OTH INS		ERRORS 246									

Examples of Claim Lines on the Remittance Advice

Adjustments

An adjustment is indicated on a remittance advice by a debit-credit transaction. The debit (DBADJ) line reflects the original claim information, and the corresponding status field contains the amount originally paid. The credit (CRADJ) line reflects the current claim information, and the corresponding status field contains the amount that has now been paid. The amount in the "Amount Paid by Medicaid" column represents the difference between these two amounts. This amount will be zero if the adjustment did not change the original payment. If the amount is negative, it will be deducted from current and future payments made to the provider until collected in full. If the amount is positive, it will result in an additional payment for the claim.

A Positive Adjustment

In this example, a change in the number of days billed resulted in a payment increase of $38.00.

PATIENT ACCOUNT NUMBER	RECIPIENT NAME	RECIPIENT ID	TCN	FROM DATE	TO DATE	SERV-ICING PROV NO	PROC CODE/ MOD	PLACE OF SERV	UNITS	AMOUNT REQUEST	OTHER PAID AMOUNT	AMOUNT PAID BY MEDICAID	STATUS	REMARKS
DOEJ85	DOE JOHN	0185133789	132302845A	100301	101001	0123456	X9874	99	8	30400		3800	30400	(CRADJ)
DIAG		PA	OTH INS		ERRORS									
DOEJ85	DOE JOHN	0185133789	130902744A	100301	100901	0123456	X9874	99	7	26600			26600-	(DBADJ)
DIAG		PA	OTH INS		ERRORS									

A Negative Adjustment

In this example, a change in the number of days billed resulted in a payment decrease of $38.00.

PATIENT ACCOUNT NUMBER	RECIPIENT NAME	RECIPIENT ID	TCN	FROM DATE	TO DATE	SERV-ICING PROV NO	PROC CODE/ MOD	PLACE OF SERV	UNITS	AMOUNT REQUEST	OTHER PAID AMOUNT	AMOUNT PAID BY MEDICAID	STATUS	REMARKS
DOEJ85	DOE JOHN	0185133789	132302845A	100401	100901	0123456	X9874	99	6	22800		3800-	22800	(CRADJ)
DIAG		PA	OTH INS		ERRORS									
DOEJ85	DOE JOHN	0185133789	130902744A	100301	100901	0123456	X9874	99	7	26600			26600-	(DBADJ)
DIAG		PA	OTH INS		ERRORS									

Examples of Claim Lines on the Remittance Advice

A Zero Adjustment Claim

In this example, the claim was adjusted to show the correct dates, resulting in no change in payment by the Division.

PATIENT ACCOUNT NUMBER	RECIPIENT NAME	RECIPIENT ID	TCN	FROM DATE	TO DATE	SERV-ICING PROV NO	PROC CODE/ MOD	PLACE OF SERV	UNITS	AMOUNT REQUEST	OTHER PAID AMOUNT	AMOUNT PAID BY MEDICAID	STATUS	REMARKS
DOEJ85	DOE JOHN	0185133789	132302845A	100401	101001	0123456	X9874	99	7	26600			26600	(CRADJ)
DIAG		PA	OTH INS		ERRORS									
DOEJ85	DOE JOHN	0185133789	130902744A	100301	100901	0123456	X9874	99	7	26600			26600-	(DBADJ)
DIAG		PA	OTH INS		ERRORS									

A Pended Claim

In this example, it was determined that $1,178.00 was payable for this claim; however, payment is being withheld as a result of a sanction initiated by the Division's Program Review Recoveries Unit (PRRU). A sanction inhibits the release of current payments to a provider. This claim may be released for payment when a resolution is reached between the provider and the PRRU.

PATIENT ACCOUNT NUMBER	RECIPIENT NAME	RECIPIENT ID	TCN	FROM DATE	TO DATE	SERV-ICING PROV NO	PROC CODE/ MOD	PLACE OF SERV	UNITS	AMOUNT REQUEST	OTHER PAID AMOUNT	AMOUNT PAID BY MEDICAID	STATUS	REMARKS
DOEJ85	DOE JOHN	0123456789	130902744A	100101	103101	0123456	X9874	99	31	1178.00		1178.00	PAID	(PRR123)
DIAG		PA	OTH INS		ERRORS									

A Void

A void transaction is reported on a remittance advice to return incorrect payments, including, but not limited to, any one of the following situations:

- payment to wrong provider;
- payment for wrong member;
- payment for overstated services; and
- payment for services for which payment has been received from third-party payers.

A void transaction always results in a negative payment. These amounts are overpayments and are deducted from current and future payments made to the provider until collected in full. See the section on correcting claims for information on how to request a void to paid or pended claims.

PATIENT ACCOUNT NUMBER	RECIPIENT NAME	RECIPIENT ID	TCN	FROM DATE	TO DATE	SERV-ICING PROV NO	PROC CODE/ MOD	PLACE OF SERV	UNITS	AMOUNT REQUEST	OTHER PAID AMOUNT	AMOUNT PAID BY MEDICAID	STATUS	REMARKS
SMITHJ	SMITHJ	0123456789	132302744A	100101	103101	0123456	X9874	99	31	1178.00		1178.00-	ACCEPTED	(VOID)
DIAG		PA	OTH INS		ERRORS									

Examples of Claim Lines on the Remittance Advice

A Recoupment

When a claim adjustment, or a void, results in an amount due to the Division, a negative amount appears in the "Amount Paid by Medicaid" column on the remittance advice. These negative amounts are subtracted from the provider's current payment. If a negative balance is still outstanding, after the current pay cycle, the balance is carried forward as an outstanding recoupment account. In this example $1,178.00 is applied toward the outstanding balance.

PATIENT ACCOUNT NUMBER	RECIPIENT NAME	RECIPIENT ID	TCN	FROM DATE	TO DATE	SERV-ICING PROV NO	PROC CODE/ MOD	PLACE OF SERV	UNITS	AMOUNT REQUEST	OTHER PAID AMOUNT	AMOUNT PAID BY MEDICAID	STATUS	REMARKS
DOEJ85	DOE JOHN	0123456789	130902744A	100101	103101	0123456	X9874	99	31	1178.00		1178.00	1178.00	(RECOUP)
DIAG		PA	OTH INS		ERRORS									

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