Section 3
The Remittance Advice (RA)

The RAs, both **current and aged**, are available through the MHD web portal at www.emomed.com . Some providers utilize an electronic HIPAA 835 transaction to retrieve their RA.
Using www.emomed.com , under File Management providers can:

- Retrieve a remittance advice the Monday following the weekend Financial Cycle run
- View and print the RA from your desktop
- Download the RA into your computer system for future reference
- Request Aged RA's

When a claim is adjudicated, it is included as a line item on the next RA. Along with listing the claim, the RA lists an "**Adjustment Reason Code**" to explain a payment, denial, corrected claim, voided claim or other action. The Adjustment Reason Code is from a national administrative code set that identifies the reasons for any differences, or adjustments, between the original provider charge for a claim and the payer's reimbursement for it.

The RA may also list a "**Remittance Remark Code,"** which is from the same national administrative code set that indicates either a claim-level or service-level message that cannot be expressed with a claim Adjustment Reason Code. The Adjustment Reason Codes and Remittance Remark Codes may be found on the MO HealthNet Division Web site, https://dss.mo.gov/mhd/providers/fee-for-service-providers.htm , and clicking on the link "Remittance Advice Remark Codes and Claim Adjustment Reason Codes" . Or access the HIPPA related codes lists through the internet at: http://www.wpc-edi.com/reference/

The date on the RA is the date the final processing cycle runs. Reimbursement will be made through direct bank deposit approximately two weeks after the cycle run date. (Refer to the Claims Processing Schedule https://manuals.momed.com/ClaimsProcessingSchedule.htm)

The RA is grouped first by paid claims and followed by denied claims. Claims in each category are listed alphabetically by the patient's last name. If the patient's name and/or Departmental Client Number (DCN) are **not** on file, only the first two letters of the last name and first letter of the first name appear.

Each claim entered into the claims processing system is assigned a **13-digit Internal Control Number (ICN)** assigned for identification purposes. The **first two digits** of an ICN indicate the type of claim.

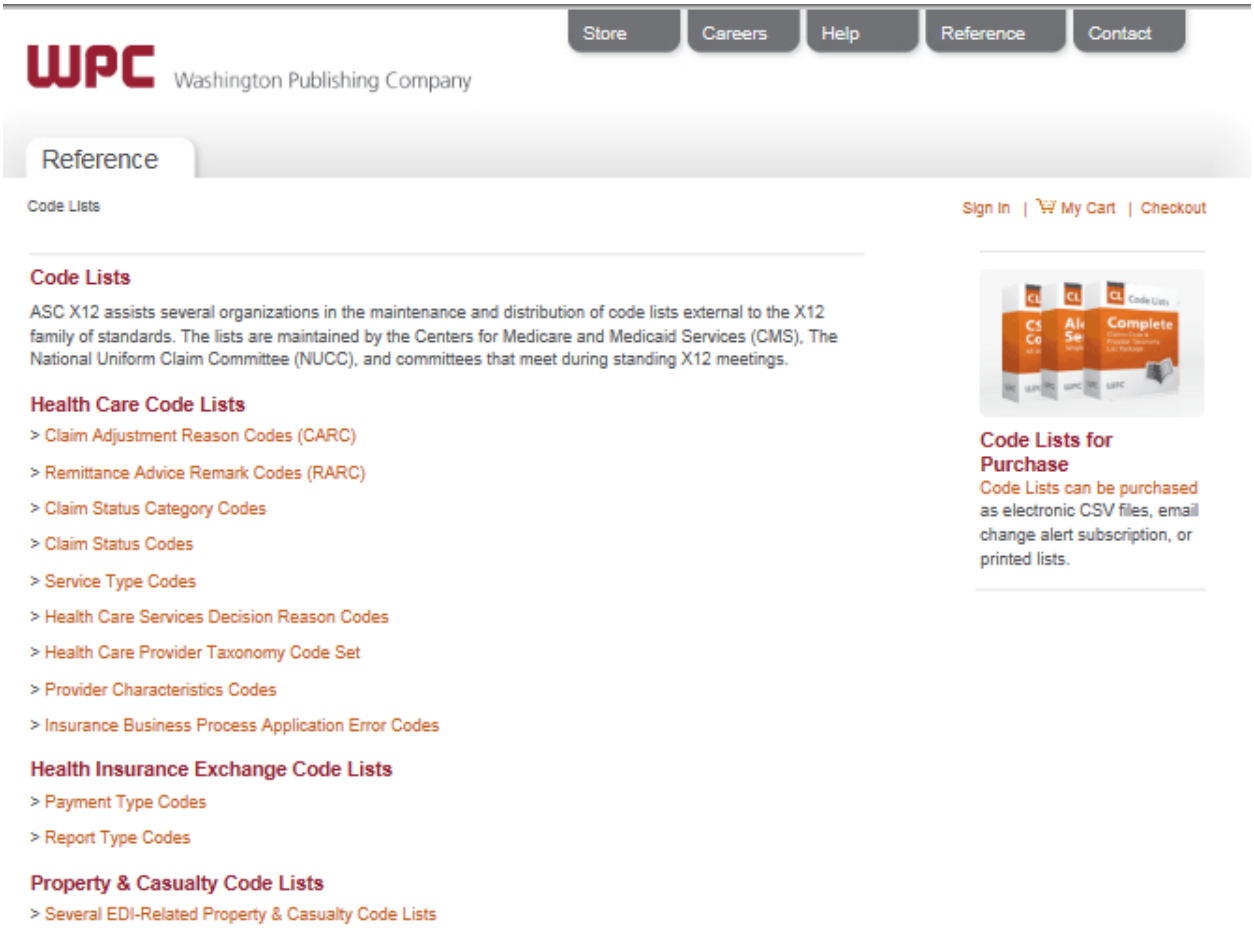
15 – CMS 1500 paper claim
49 – Internet claim

50 – Individual Adjustment Request
55 – Mass Adjustment
75 – Reversal of a Mass Adjusted Claim
70 – Adjudicated or Voided Claim

The **third and fourth digits** indicate the year the claim was received. **The fifth, sixth, and seventh digits** indicate the Julian date the claim was entered into the system. In the Julian system, the days are numbered consecutively from "001" (January 01) to "365" or "366" in a leap year (December 31). The **last digits** of an ICN are for internal processing.

The ICN 1518001000000 is read as a CMS-1500 paper medical claim entered in the processing system on January 1, 2018.

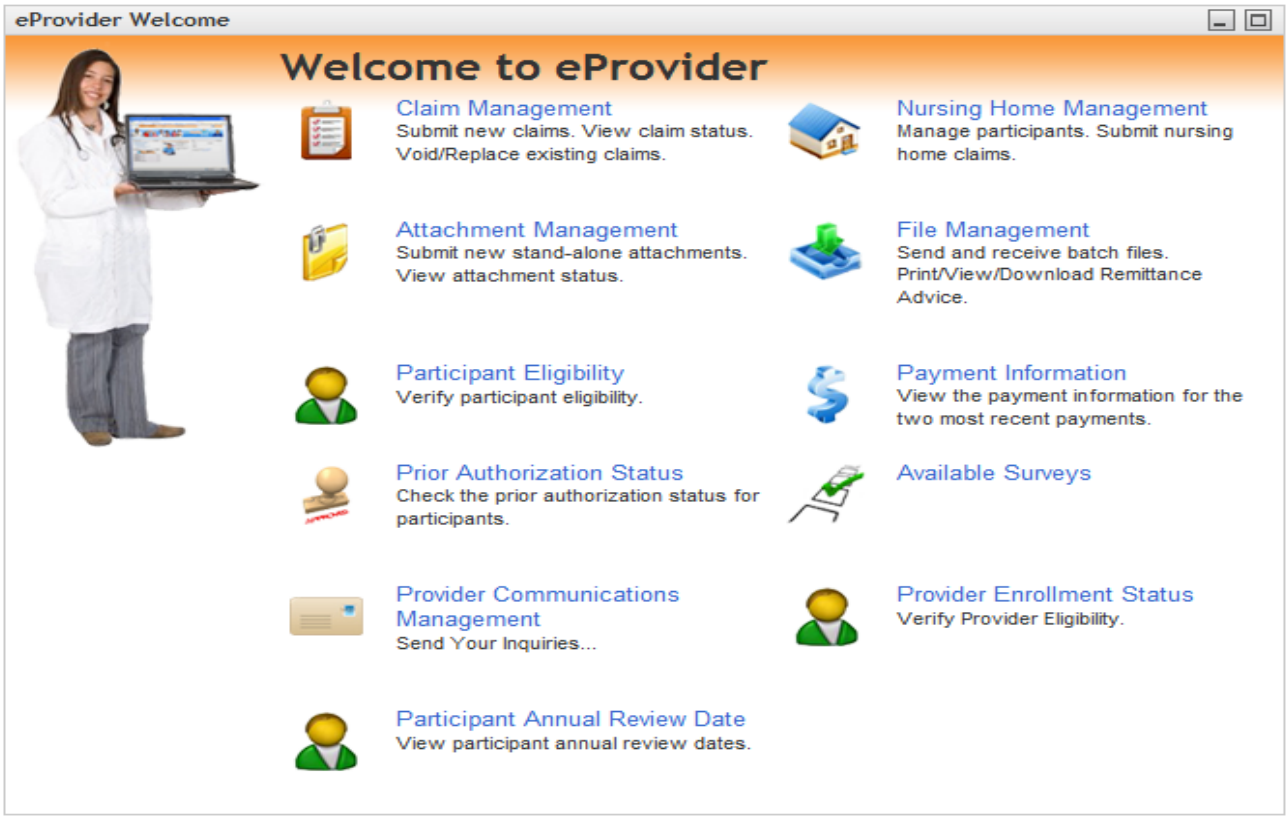
When a claim denies for other insurance, the commercial carrier information can be retrieved when participant's eligibility is checked.



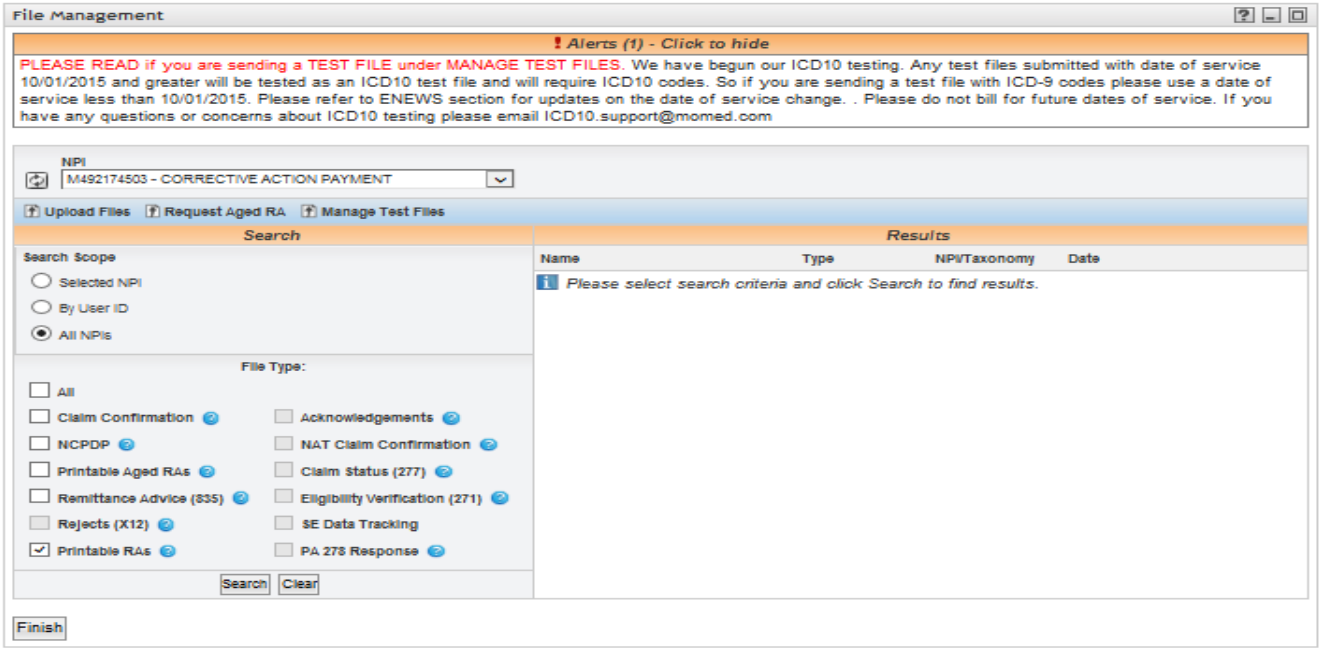
PRINTABLE REMITTANCE ADVICE

The Printable Internet Remittance Advice is accessed at www.emomed.com . A provider must be enrolled with emomed to access the web portal and the printable RA. To apply online go to the MO HealthNet web portal www.emomed.com and select Provider Sign up for **Electronic Remittance Advice (ERA).**

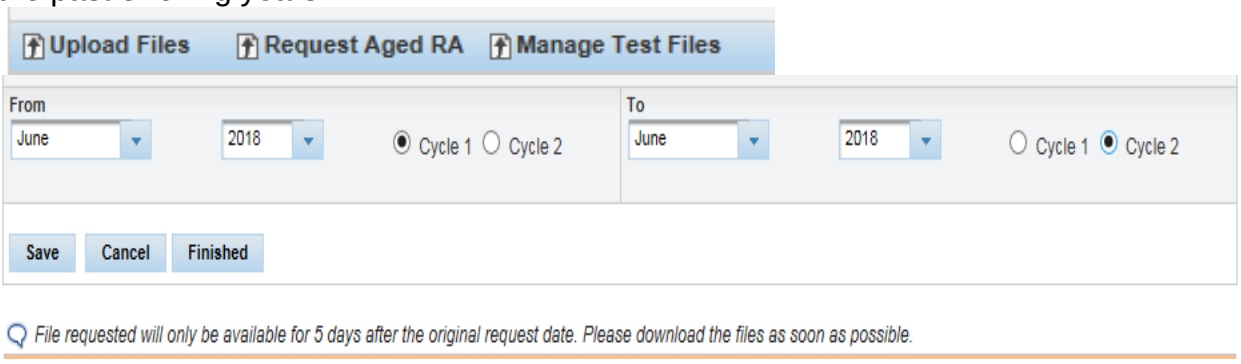
On the **Welcome to eProvider** page, select **File Management**, then select **Printable RAs** and the date to view; print or upload files to your system. The RA is in the PDF file format. The browser will open the file directly, if you have Adobe Acrobat Reader installed on your computer. If you do not have this program, go to http://www.adobe.com/products/acrobat/readstep2.htm to download it to your computer.

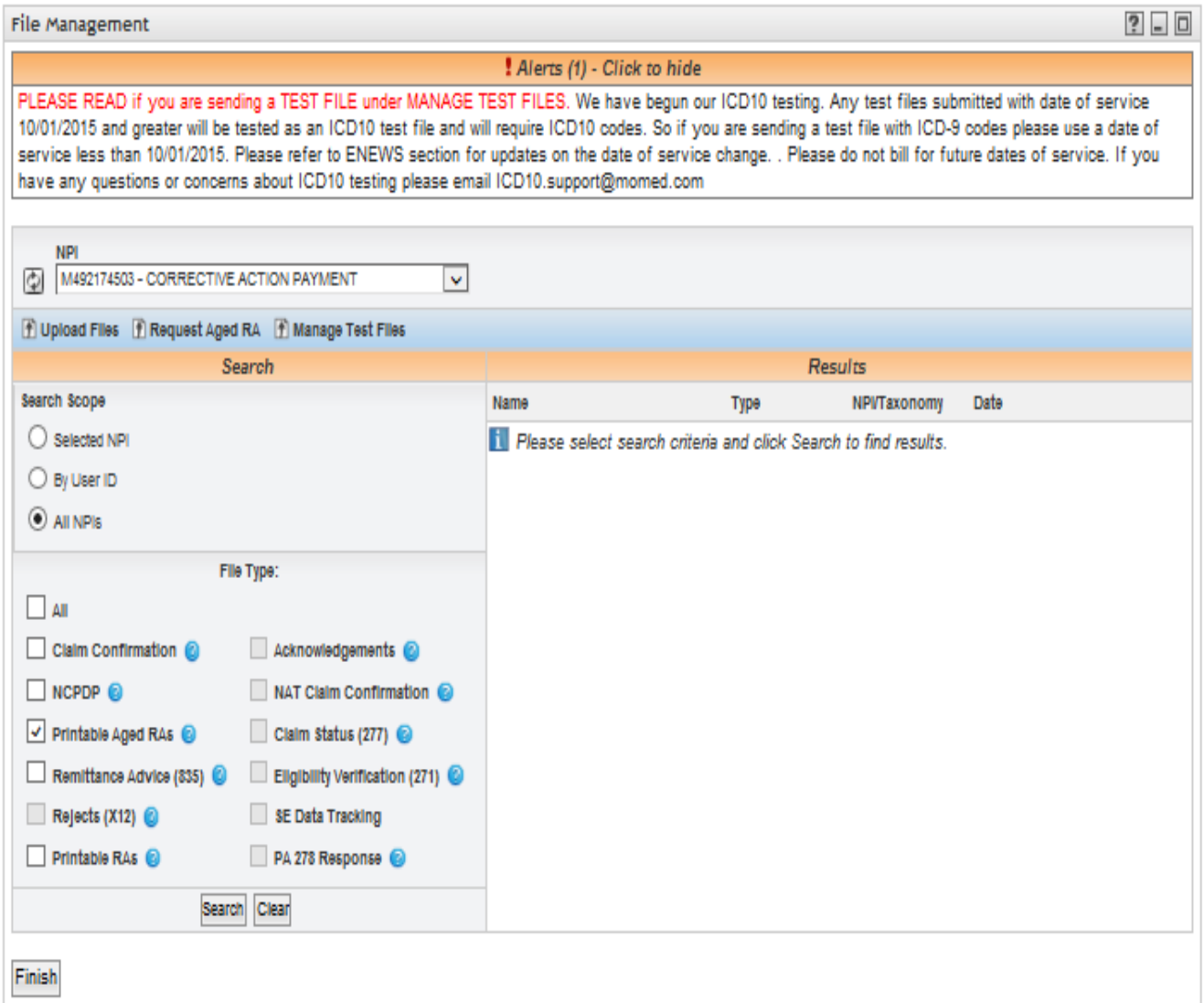


RAs are available automatically following each financial cycle. Each RA remains available for a total of 62 days. The oldest RA drops off as the newest RA becomes available. Therefore, providers are encouraged to save each RA to their computer system for future reference and use.
Note: When printing an RA, it is set to page break after 70 lines per page.



The provider can request the RA through the “Aged RA Request” by selecting the File Management option, for RA’s that are not available. Aged RA Request will take overnight to download and retrievable by selecting “Printable Aged RA’s”. Aged RA’s will be only available for 5 days. Requested RA’s can be prompted for retrieval within the past 3 rolling years.





In general, the Printable Remittance Advice is displayed as follows.

Field	Description
PARTICIPANT'S NAME	The participant's last name and first name. NOTE: If the participant's name and identification number are not on file, only the first two letters of the last name and first letter of the first name appear.
MO HealthNet ID	The participant's 8-digit MO HealthNet identification number.
ICN	The 13-digit number assigned to the claim for identification purposes.
SERVICE DATES **FROM**	The initial date of service in MMDDYY format for the claim.
SERVICE DATES **TO**	The final date of service in MMDDYY format for the claim.
PAT ACCT	The provider's own patient account name or number.
CLAIM: ST	This field reflects the status of the claim. Values are: 1 = Processed as Primary, 3 = Processed as Tertiary, 4 = Denied, 22 = Reversal of Previous Payment
TOT BILLED	The total claim amount submitted.
TOT PAID	The total amount MO HealthNet paid on the claim.
TOT OTHER	The combined totals for patient liability (surplus), recipient co-pay, and spenddown total withheld.
LN	The line number of the billed service.
SERVICE DATES	The date of service(s) for the specific detail line.
REV/PROC/NDC	The submitted procedure code, NDC, or revenue code for the specific detail line. Note: The revenue code will only appear in this field if a procedure code is not present.
MOD	The submitted modifier(s) for the specific detail line.
REV CODE	The submitted revenue code for the specific detail line. Note: The revenue code only appears in this field if a procedure code has also been submitted.
QTY	The units of service submitted.
BILLED AMOUNT	The submitted billed amount for the specific detail line.
ALLOWED AMOUNT	The MO HealthNet maximum allowed amount for the procedure.
PAID AMOUNT	The amount MO HealthNet paid on the claim.
PERF PROV	The National Provider Identifier (NPI) number for the performing provider submitted at the detail.

Field	Description
SUBMITTER LN ITM CNTL	The submitted line item control number.
GROUP CODE	The Claim **Adjustment Group Code** is a code identifying the general category of payment adjustment. Values are: CO = Contractual Obligation CR = Correction and Reversals OA = Other Adjustment PI = Payer Initiated Reductions PR = Patient Responsibility
RSN	The Claim **Adjustment Reason Code** is the code identifying the detailed reason the adjustment was made.
AMT	The dollar amount adjusted for the corresponding reason code.
QTY	The adjustment to the submitted units of service. This field will not be printed if the value is zero.
REMARK CODES	The **Code List Qualifier Code** and the Health Care Remark Code **(Remittance Advice Remark Codes).** The Code List Qualifier Code is a code identifying a specific industry code list. Values are: HE = Claim Payment Remark Code RX = National Council for Prescription Drug Programs Reject/Payment Codes. The Health Care Remark Codes (Remittance Advice Remark Codes) are codes used to convey information about remittance processing or to provide a supplemental explanation for an adjustment already described by a Claim Adjustment Reason Code.
CATEGORY TOTALS	Each category (i.e., paid crossover, paid medical, denied crossover, denied medical, drug, etc.) has separate totals for number of claims, billed amount, allowed amount, and paid amount.