



DIVISION OF MEDICAL SERVICES PROVIDER BULLETIN

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CLAIM INFORMATION

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CLAIM GROUP CODES/CLAIM ADJUSTMENT REASON CODES

With the implementation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Transaction and Code Sets standards, Missouri Medicaid lost the ability to report Medicaid-specific claim payment information to providers on the Health Care Claim Payment/Advice ASC X12N 835 transaction [Remittance Advice (RA)]. Missouri Medicaid no longer reports Medicaid-specific Explanation of Benefits (EOB) or Exception message codes on any type of RA. As required by the HIPAA national standards, administrative code sets Claim Adjustment Reason Codes, Remittance Advice Remark Codes and NCPDP Version 5.0 Reject Codes for Telecommunication Standard are now used to report claim payment information.

To aid providers in identifying the most common payment reductions or cutbacks by Missouri Medicaid, distinctive Claim Group Codes and Claim Adjustment Reason Codes were selected and are being reported to providers on all RA formats when the following claim payment reduction or cutback occurs:

Missouri Medicaid Claim Payment Reduction/Cutback	Claim Group Code	Description	Claim Adjustment Reason Code	Description
Payment reimbursed at the maximum allowed	CO	Contractual Obligation	42	Charges exceed our fee schedule or maximum allowable amount
Payment reduced by other insurance amount	OA	Other Adjustment	23	Payment adjusted because charges have been paid by another payer

Medicare Part A Repricing	OA	Other Adjustment	42	Charges exceed our fee schedule or maximum allowable amount
Payment cut back to federal percentage (IEP therapy services)	OA	Other Adjustment	B6	This payment is adjusted when performed/billed by this type of provider, by this type of provider in this facility, or by a provider of this specialty
Payment reduced by co-payment amount	PR	Patient Responsibility	3	Co-Payment Amount
Payment reduced by patient spenddown amount	PR	Patient Responsibility	30	Payment adjusted because the patient has not met required eligibility, spend down, waiting or residency requirement
Payment reduced by patient liability amount	PR	Patient Responsibility	142	Claim adjusted by monthly Medicaid patient liability amount

CLAIM ATTACHMENT STATUS

Missouri Medicaid providers may check the Claim Attachment status of six different claim attachments using the Real Time Queries function on-line at www.emomed.com. Claim attachment status queries are restricted to the provider who submitted the attachment. Providers may view the status for the following claim attachments on-line:

- Acknowledgement of Receipt of Hysterectomy Information
- Certificate of Medical Necessity (for Durable Medical Equipment only)
- Medical Referral Form of Restricted Recipient (PI-118)
- Oxygen and Respiratory Equipment Medical Justification Form (OREMJ)
- Second Surgical Opinion Form
- (Sterilization) Consent Form

Providers may use one or more of the following selection criteria to search for the status of a claim attachment on-line:

- Attachment Type
- Recipient ID
- Date of Service/Certification Date
- Procedure Code/Modifiers
- Attachment Status

Detailed Help Screens have been developed to assist providers searching for claim attachment status on-line. If technical assistance is required, providers are instructed to call the Infocrossing Healthcare Services Help Desk at 573/635-3559.

Provider Bulletins are available on the DMS Website at <http://www.dss.mo.gov/dms/pages/bulletins.htm>. Bulletins will remain on the Published Bulletin site only until incorporated into the [provider manuals](#) as appropriate, then moved to the Archived Bulletin site.

Missouri Medicaid News: Providers and other interested parties are urged to go to the DMS Website at <http://dss.missouri.gov/dms/subscribe/MedNewsSubscribe.htm> to subscribe to the list serve to receive automatic notifications of provider bulletins, provider manual updates, and other official Missouri Medicaid communications via e-mail.

MC+ Managed Care: The information contained in this bulletin applies to coverage for:

- MC+ Fee-for-Service
- Medicaid Fee-for-Service
- Services not included in MC+ Managed Care

Questions regarding MC+ Managed Care benefits should be directed to the patient's MC+ Managed Care health plan. Before delivering a service, please check the patient's eligibility status by swiping the red MC+ card or by calling the Interactive Voice Response (IVR) System at 1-800-392-0938 and using Option One.

**Provider Communications Hotline
800-392-0938 or 573-751-2896**

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