Missouri Department of SOCIAL SERVICES

MoHealthNet

PROVIDER BULLETIN

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HIPAA X12 835 REMITTANCE ADVICE TRANSACTIONS

Applies to: All Providers

Effective date: December 18, 2022

- **HIPAA X12 835 REMITTANCE ADVICE TRANSACTIONS**
- **APPLICABILITY**

HIPAA X12 835 REMITTANCE ADVICE TRANSACTIONS

Effective December 18, 2022 Electronic 835s and printable Remittance Advices will reflect changes in Claim Adjustment Amounts and associated Claim Adjustment Reason Codes (CARC) and/or Remittance Advice Remark Codes (RARC).

Currently the HIPAA X12 835 remittance advice transactions, sent by the MO HealthNet Division (MHD), report the claim adjustment amount associated with the OA (Other Adjustment) group code and adjustment reason code 23 (The impact of prior payer(s) adjudication including payments and/or adjustments) as the amount of the previous payer's payment that was applied to the claim or claim line. With this change this claim adjustment amount will begin reflecting the previous payer's payment impact which will be calculated as the total of the previous payer's payment amount as sent on the claim or claim line plus any adjustment amounts sent by the previous payer that are not associated with PR (patient responsibility) group code. Below is a before and after example of the calculations:

Prior to Changes			After changes		
Payer 1	BILLED CHARGES	$1,098.78	Payer 1	BILLED CHARGES	$1,098.78
	PAYMENT	$225.82		PAYMENT	$225.82
	CO 45	$810.71		CO 45	$810.71
	CO 253	$4.64		CO 253	$4.64
	PR 2	$57.61		PR 2	$57.61
MHD	BILLED CHARGES	$1,098.78	MHD	BILLED CHARGES	$1,098.78
	PAYMENT	$43.20		PAYMENT	$43.20
	OA 23	$810.71		OA 23	$1,041.17
	CO 45	$244.87		CO 45	$14.41

KEY	
OA 23	The impact of prior payer(s) adjudication including payments and/or adjustments (Use only with Group Code OA)
CO 45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Usage: This adjustment cannot equal the total service or claim charge amount; and must not duplicate provider adjustment amounts (payments and contractual reductions) that have resulted from prior payer(s) adjudication. (Use only with Group Codes PR or CO depending on liability)
CO 253	Sequestration - reduction in federal payment

Additionally, MHD is implementing a change to correct the use of group code CO (contractual obligation) with reason code 45 when the adjustment amount is equal to the billed amount. The appropriate reason code will now be reported in these cases, which will most often be either a CARC of 96 (Non-covered Charge(s)) or 97 (The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.).

Providers will be given a chance to test this change to the Electronic 835s and printable Remittance Advices. A selection of production claims submitted from 9/19/2022 through 10/7/2022 will be ran through a test cycle. Providers are also welcome to submit their own claims through the test system.

Billers who use Emomed can access the resulting test remittance advices by following the below steps:

1. Go to the eProvider tab
2. Select the “Manage Test Files” tab
3. Fill out the search criteria
4. Choose the file type “Remittance Advice (835)”

Billers who use clearinghouses can get their files from their clearinghouse. The clearinghouse can pick up the test files from the SFTP server by going to the outboxtest folder.

To report issues and identify concerns please contact the Wipro Help Desk at Help.Desk@momed.com or call 573-635-3559.

APPLICABILITY

The information in this bulletin applies to the MHD fee-for-service program and may apply to the MHD managed care program, as well. MHD’s fee-for-service policies set the basic

coverage policies for benefits and limitations in the managed care program. The managed care health plans have additional flexibilities in operating their respective programs, such as determining which services require prior authorization, and details required for claims submission. Certain services, such as pharmacy, are "carved out" of managed care and will be paid through the fee-for-service program. To ensure your understanding of this bulletin's applicability to each managed care health plan, please contact your health plan directly, or contact MHD.MCCommunications@dss.mo.gov.

Provider Bulletins are available on the MO HealthNet Division (MHD) website at http://dss.mo.gov/mhd/providers/pages/bulletins.htm. Bulletins will remain on the Provider Bulletins page only until incorporated into the provider manuals as appropriate, then moved to the Archived Bulletin page.

MO HealthNet News: Providers and other interested parties are urged to go to the MHD website at http://dss.mo.gov/mhd/ to subscribe to the electronic mailing list to receive automatic notifications of provider bulletins, provider manual updates, and other official MO HealthNet communications via E-mail.

The information contained in this bulletin applies to coverage for:

- MO HealthNet Fee-for-Service
- MO HealthNet Managed Care

Questions regarding MO HealthNet Managed Care benefits should be directed to the patient's MO HealthNet Managed Care health plan. Before delivering a service, please check the patient's eligibility status by swiping the MO HealthNet card or by calling the Provider Communications Interactive Voice Response (IVR) System at 573-751-2896 and using Option One for the MO HealthNet ID card.

Provider Communications Hotline
573-751-2896