CLAIMS SUBMISSION AND PROCESSING PAYMENTS

CLAIM SUBMISSION

This section describes the following:

1. Claim submission requirements, including expression of drug quantities;
2. Overrides;
3. Time limits for claim submission; and
4. Methods of claim submission.

National Drug Code

Drugs are identified on Medicaid claims and the Medicaid computer system drug file by the National Drug Code (NDC). The NDC is an 11-digit number. The first five (5) digits identify the manufacturer or supplier, the next four (4) digits identify the product and the last two digits identify the package size.

Use of NDCs

The provider must enter the entire 11-digit NDC for the actual product dispensed on the claim. Billing an NDC number, other than the one for the product dispensed, is a false claim and a violation of Medicaid policy.

NDC Not on the Drug File

Medicaid can only reimburse drugs whose NDCs are on the Medicaid computer system drug file. If the NDC is not on the Medicaid drug file, the provider may contact the Pharmacy Benefits Management (PBM) Help Desk and request that the drug be added. Drugs may be added in accordance with program policy and/or manufacturer participation in the federal drug rebate program. (See Section 37.5.4 for contact information).

Drug Quantities and Unit of Measurement

Billing Unit Standard

Medicaid has adopted the National Council for Prescription Drug Programs (NCPDP) unit of measurement for the billing unit standard.

The NCPDP standard uses only three billing units to describe all drug products:

1. Each;
2. Milliliter (ml); or
3. Gram (gm).

The use of "tablet," "patch," "kit," etc. is not appropriate since these are dosage forms or package descriptions.

Dosage Forms Expressed as "Each"

The dosage forms that are expressed as "each" are, as follows:

1. Solid oral medications such as tablets, capsules, etc., even when presented in dose packs or cycles;
2. Suppositories;
3. Transdermal patches;
4. Powder packets;
5. Disposable syringes; and
6. Powder-filled vials, ampules and syringes for injection; irrigation; or inhalation (the quantity is the total number of vials dispensed, not the mls or gms of the final product).

Dosage Forms Expressed as "ml"

Dosage Forms that are expressed as "ml" are, as follows:

1. Liquid oral medications;
2. Ophthalmic and optic drops and suspensions;
3. Reconstitutable oral products (the quantity is the number of milliliters in the bottle after reconstitution);
4. Topical lotions or solutions;
5. Liquid-filled vials, ampules or syringes for injection, irrigation or inhalation (the quantity is the total number of milliliters dispensed); and
6. Inhalers and aerosols that are specified in milliliters by the manufacturer on the labeling.

Dosage Forms Expressed as "gm"

Dosage forms that are expressed as "gm" are, as follows:

1. Topical or ophthalmic ointments and creams; and
2. Inhalers and aerosols that are specified in grams by the manufacturer on the labeling.

Exceptions to the NCPDP Standard

The following are examples of exceptions to the NCPDP billing unit standard:

1. Antihemophilic products must be expressed as the number of antihemophilic units dispensed, which will vary from vial to vial;
2. Cordran® Tape and EpiPen® must be expressed as "each";
3. One Imitrex® or Diastat® kit with two syringes must be expressed as one "each";

4. One tube of Emla® cream with Tegaderm® patches must be expressed as one "each";

5. One heparin flush kit containing one syringe of heparin and two syringes of saline packaged in the same bag must be expressed as one "each"; and

6. Helidac® combination therapy must be expressed as 56 dosing units.

Metric Decimal Quantities

Metric decimal quantity is used to express quantity dispensed. Providers must bill for drug quantities using decimal numbers. Whole drug numbers are no longer required. The provider must ensure that his/her software enters the correct quantity in the metric decimal field (i.e., 0.030 does not equal 30.000). Rounding is not allowed (i.e., 3.500 cannot be billed as 4.000).

Billing Questions

Billing questions regarding the correct unit type should be directed to the fiscal intermediary (FI) from 8:00am to 5:00pm, Monday through Friday. (See Section 37.5.4 for contact information).

Prescriber Numbers

Prescription claims must indicate a valid individual Louisiana Medicaid prescriber number or National Provider Identifier (NPI) until only the NPI is required. Group practice numbers, hospital numbers and clinic numbers are not acceptable.

NOTE: See Section 37.5.6 Prescribers of this manual chapter for detailed prescriber policy.

Diagnosis Codes

Some pharmacy claims require diagnosis codes as a condition for program coverage and override of monthly prescription limits.

NOTE: See Section 37.1 Covered Services, Limitations and Exclusions of this manual chapter for specific program policy involving diagnosis codes.

Overrides

Listed below are the detailed policies regarding overrides. Refer to Section 37.5.1 for the link to access point of sale (POS) User Guide for details regarding claims submission requiring overrides.

Federal Upper Limits /Louisiana Maximum Allowable Cost Limitations

A prescriber may certify that a specified brand is medically necessary for a particular beneficiary. The Federal upper limit (FUL) or Louisiana Maximum Allowable Cost (LMAC) limitations for that medication will not apply.

The certification must be written either directly on, or must be a signed attachment (which may be faxed) to, the prescription. The certification must be continued in the prescriber's handwriting. The only acceptable phrases are "brand necessary" or "brand medically necessary".

NOTE: See "Multiple Source Drugs" in Section 37.3 Reimbursement for Services of this manual chapter for detailed information.

Prescriptions Limit

The Medicaid Program has a four prescription monthly limit. The prescription monthly limit can be overridden when the prescribing practitioner authorizes the medical necessity of the drug and communicates to the pharmacist the following information in his own handwriting or by telephone or other telecommunications device noted on, or attached to, the hard copy prescription:

1. "Medically Necessary Override"; and

2. A valid numeric diagnosis code that directly relates to each drug prescribed that is over the four prescription limit. (A literal description is not acceptable in lieu of a diagnosis code).

Early Refills

If the beneficiary has requested the same medication at the same pharmacy five or more days early for a 30-day supply, or prior to 85 percent of medication being utilized, a claim is denied for early refill. Narcotic analgesics will deny for an early refill edit when less than 90 percent of the medication has been utilized. This translates into a two-day window based on a 30-day supply.

In some cases, the pharmacist may have knowledge of dosage changes which would warrant a beneficiary's request for medication earlier than previously reported in the estimated days' supply. With those requests, pharmacists may override this edit by documenting the circumstances on the prescription hard copy and reference the POS User Guide for detailed claims filing instructions.

Ingredient Duplication

A claim denial will occur as the beneficiary attempts to obtain the same drug from a different pharmacy sooner than is anticipated based on the estimated days' supply.

After consultation with a physician, beneficiary, and/or the POS Help Desk, the provider must determine whether there are extenuating circumstances which substantiate the dispensing of a duplicate claim. If extenuating circumstances exist, the provider must use procedures to initiate an override of the denial for the duplicate ingredient.

The provider must document on the prescription hard copy the circumstances for the override and reference the POS User Guide for detailed filing instructions.

Duration of Therapy

The Pharmacy Program has duration of therapy modules for the H2 antagonists, proton pump inhibitors (PPIs), sucralfate, and Hepatitis C medications.

NOTE: See Section 37.1 Covered Services, Limitations and Exclusions and Section 37.5.1 for the link to access the POS User Guide of this manual chapter for detailed information.

Therapeutic Duplication

The Medicaid Program denies pharmacy claims for drugs in the following classes if the beneficiary has an active paid claim on file for another drug in the same therapeutic class. Antipsychotic agents require two active prescriptions on file to deny for therapeutic duplication:

1. First and second generation antihistamines and first and second generation antihistamine combination agents;

2. Angiotensin Converting Enzyme (ACE) Inhibitors and ACE Inhibitor/Diuretic Combinations, ACE Inhibitors/Calcium Channel Blocker Combinations;

3. Angiotensin Receptor Antagonists (ARB) and ARB/Diuretic Combinations;

4. ARB/Calcium Channel Blocker Combinations;

5. Beta Adrenergic Blocking Agents and Beta-adrenergic Blocking Agent/Diuretic Combinations;

6. Calcium Channel Blockers;

7. Calcium Channel Blocker/Antihyperlipidemia Agent Combination;

8. Potassium Replacement Agents;

9. Tricyclic Antidepressants;

10. Selective Serotonin Reuptake Inhibitors;

11. Antipsychotic Agents (typical and atypical);

12. Antipsychotic/Selective Serotonin Reuptake Inhibitor Combinations;

13. Anti-anxiety Agents;

14. Sedative Hypnotic Agents;

15. Attention Deficit Disorder Agents;

16. Non-steroidal Anti-inflammatory Agents (inclusive of COX-2 selective agent);

17. Short Acting Opiate Agents;

18. Long Acting Opiate Agents; and

19. Proton Pump Inhibitors.

Override provisions will be allowed after contacting the prescriber. If an override is determined to be appropriate, additional hard-copy documentation on the new prescription is necessary. The

reason for service code, professional service code and result of service code are required for audit purposes. Diagnosis codes may be required in some instances.

NOTE: See Section 37.1 Covered Services, Limitations and Exclusions and Section 37.5.1 for the link to access the POS User Guide of this manual chapter for detailed claims filing instructions.

Unnecessary Drug Therapy

The Pharmacy Program has an unnecessary drug therapy module for the use of celecoxib (Celebrex®), armodafinil (Nuvigil®), and modafinil (Provigil®).

A valid diagnosis code is required, as well as a valid condition, warranting the COX-2 selective agent, celecoxib (Celebrex®), and armodafinil (Nuvigil®, and modafinil (Provigil®). Should the beneficiary not have a valid condition, and the prescriber determines that the drug therapy is necessary, the pharmacy provider must supply the reason for service code, professional service code and result of service code with the POS submission. This information must be documented on the hard copy prescription.

NOTE: See "Prospective Drug Utilization Policies/Limits/Edits" in Section 37.1 Covered Services, Limitations and Exclusions of this manual chapter for detailed information.

Drug/Drug Interaction

A valid diagnosis code is required for all Sildenafil (Revatio®) and Tadalafil (Adcirca®) prescriptions.

Override provisions for the drug to drug interaction between Sildenafil or Tadalafil and nitrates will be allowed after contacting the prescriber. The pharmacist must document the reason the prescriber required both drugs. Additionally, documentation of the reason for service code, professional service code and result of service code is required on the hard copy prescription and for submission of the POS claim.

Coordination of Benefits

Certain circumstances allow for the override of edits, which allows Medicaid to be the primary payor.

NOTE: See "Override Capabilities and Codes" in Section 37.3 Reimbursement/Third Party Liability/Coordination of Benefits of this manual chapter for detailed information on these overrides.

Pregnancy Co-Payment

Services furnished to pregnant women, if such services are related to the pregnancy or any other medical conditions that complicate the pregnancy, are exempt from co-payments.

When a prescribing provider issues a prescription to a pregnant woman, he or she shall indicate on the prescription that the beneficiary is pregnant. In the case of a telephoned prescription, the information that the beneficiary is pregnant shall be communicated to the pharmacist and the pharmacist must document on the prescription that the beneficiary is pregnant.

When the prescribing provider authorizes a prescription for a pregnant beneficiary, the pharmacist shall maintain the proper documentation on the prescription, for audit purposes, indicating that the individual is pregnant.

NOTE: See Section 37.5.1 for the link to access POS User Guide of this manual chapter for detailed claims filing instructions.

Age and Gender Overrides

Some drugs have age and/or sex restrictions.

Pharmacy providers should contact the Pharmacy Program to address questions regarding age or sex restrictions. (See Section 37.5.4 for contact information).

NOTE: See "Drugs with Special Payment Criteria/Limitations" in Section 37.1 Covered Services, Limitations and Exclusions for other criteria and Section 37.5.1 to access the link to the POS User Guide for detailed billing information.

Maximum Dosage

Selected medications have maximum dosage limits. Prescriptions for atypical antipsychotic agents, agents containing tramadol and tapentadol (Nucynta®) will deny when the maximum recommended doses are exceeded.

Due to the potential of hepatotoxicity, claims billed with a dosage of acetaminophen that exceeds four grams per day will deny. Claims for products containing aspirin will deny payment when the maximum daily dosage billed exceeds six grams a day.

The prescriber must be consulted and the reason and override codes must be documented on the hard copy prescription. The pharmacy must supply the reason for service code, professional service code and result of service code with the POS submission.

Quantity Exceeds Program Maximum

Pharmacy claims for selected medications used in the management of pain are subject to maximum quantities. Quantity limits are cumulative, based on a rolling days' supply and apply to all strengths of an agent. Selected medications may be eligible for an override with prescriber authorization and documentation. If the prescriber chooses to exceed the limit, he/she must provide the reason why the quantity limit needs to be exceeded. After consulting with the prescriber, the pharmacist must document the prescriber's reason and DUR override codes on the hardcopy prescription or in the pharmacy's electronic recordkeeping system. The pharmacist should reference the POS User Guide for detailed claims filing instructions.

Most prescriptions for beneficiaries who have confirmed diagnosis of cancer are exempt from quantity limits for pain medications. All prescriptions for Schedule II narcotic agents require a diagnosis code documented on the hardcopy prescription. When a diagnosis code is not on the prescription and the prescriber cannot be reached, the pharmacist can then determine if the beneficiary cannot wait to receive the medication and override the edit.

Prior Authorization (PA) Emergency

This emergency procedure may be used when the PA Unit is closed (Sundays and Monday-Saturday before 8am and after 6pm) or when the PA system is unavailable. The pharmacist should also use professional judgment in situations that would necessitate an emergency supply.

Prescriptions indicating emergency situations shall be dispensed in a minimum quantity of a 72-hour or a three-day supply. **Refills for the dispensing of the non-preferred products in these emergency situations are not permitted.**

The prescribing practitioner must indicate that the prescription is an emergency prescription (Rx) on the face of the prescription if hard copy or if the prescription is called in to the pharmacy, the

emergency status of the prescription must be communicated to the pharmacist who must indicate "Emergency by Pharmacist" on the hard copy prescription.

Hospital Discharge Prescriptions for Atypical Antipsychotic Agents

When a beneficiary is discharged from a hospital with a prescription for an atypical antipsychotic prescription, the prescribing practitioner must indicate on the face of the prescription, if the prescription is hard copy, that the prescription is a "Hospital Discharge." If the prescription is called in to the pharmacy, the "Hospital Discharge" status of the prescription must be communicated to the pharmacist who must indicate "Hospital Discharge" on the hard copy of the prescription.

In situations where the prescribing practitioner is unavailable and the pharmacist determines the prescription is a "Hospital Discharge" prescription, the pharmacist must indicate "Hospital Discharge" on the hard copy prescription.

Claims for "Hospital Discharge" prescriptions needing prior authorization will be submitted using the same process used for an emergency override.

Prescriptions for "Hospital Discharge" products shall be dispensed in a minimum quantity of a three-day supply and refills for the dispensing of the non-preferred products are not permitted. The beneficiary's practitioner must contact the PA Unit to request authorization to continue the medication past the "Hospital Discharge" supply, and a new prescription must be issued.

Lock-In Emergency

This override is provided because the Louisiana Department of Health (LDH) recognizes that there may be unusual circumstances when it is necessary for a pharmacy or physician provider to grant services for a Lock-In beneficiary when the provider is not the Lock-In provider. Payment will be made to any pharmacist enrolled in the Medicaid Program who grants services to a Lock-In beneficiary in emergency situations or when life sustaining medicines are required. Prescriptions written as a result of an emergency visit or as a discharge prescription following a hospital admission are applicable for payment if the correct emergency procedure is followed.

The notation **"**Emergency Prescription" or "Discharge Prescription" should be written on the hardcopy prescription by either the prescribing physician or the dispensing pharmacist. Please ensure that the notation is included on the hard copy claim for audit purposes.

NOTE: See Section 37.5.13 Lock-In Program of this manual chapter for detailed information.

Types of Pharmacy Claims

Types of Claim Submissions

Providers can submit prescribed drug claims through the POS system, an electronic batch system upon testing and approval, or on paper claim forms. The paper claim form for Medicaid prescribed drug services is the NCPDP Universal Claim Form.

POS Claim Submission

Medicaid pharmacy providers can submit Medicaid claims through a LDH authorized electronic switch vendor using on-line, real time, POS processing. The transaction is processed through the claims processing cycle, and the disposition of the claim is returned to the pharmacy within seconds of submission.

POS processing is available through authorized telecommunication vendors that are connected to virtually every pharmacy in the United States.

Features of POS

The POS system is designed to work under the general framework of standards and protocols established by the NCPDP. It uses methods of communication that are in place for other pharmacy POS processing. POS uses the Health Insurance Portability and Accountability Act (HIPAA) approved telecommunication standard, NCPDP D.0.

The POS system is available 24 hours per day, seven days per week, except for scheduled downtime for system maintenance.

Authorization to Use POS

To obtain authorization to submit Medicaid claims through POS, the provider must submit the POS authorization agreements to the Medicaid fiscal agent.

NOTE: See "POS Enrollment" in Section 37.2 Provider Requirements and Participation Guidelines in this manual chapter for information on provider enrollment.

Electronic Claim Submission (BATCH)

Providers interested in using the NCPDP 1.2 Batch version must contact the POS Help Desk. Testing and approval are required. (See Section 37.5.4 for contact information).

Hard Copy Submission

When it is necessary to paper bill the Medicaid Program for services, pharmacy providers must use the NCPDP Universal Claim Form (UCF) regardless of date of service. No photocopied versions are acceptable.

Ordering the Claim Forms

NCPDP Universal Claim Forms may be purchased from Communi Form, LLC. (See Section 37.5.4 for contact information).

Claim Submission

All information, whether handwritten or computer generated, must be legible and completely contained in the designated area of the claim form. Claims submitted on the UCF claim form to the FI.

Retroactive Eligibility Claim Submission

When filing prescription claims for beneficiaries with retroactive Medicaid, with a date of service greater than one year, providers must file these claims hard copy for special handling.

Claims less than one year may be submitted on-line, with some exceptions. Claims over one year for beneficiaries with retroactive coverage, e.g., spend-down medically needy beneficiaries, should be sent to Medicaid Management Information Systems within LDH with a note of explanation or a copy of the beneficiary's Medicaid identification card as soon as possible. These claims must be sent to the Bureau of Health Services Financing. (See Section 37.5.4 for contact information).

Billing Instructions

All fields of the Universal Claim Form are not numbered; however, all fields are denoted as "Required", "Not Required", or "Leave Blank" as appropriate.

"Required" information must be entered to ensure processing of the claim. "Not required" information is optional, based on entry of a previous field. "Leave Blank" is a field unrelated to pharmacy claims.

NOTE: See Section 37.5.1 of this manual chapter for an example of the Universal Claim Form and billing instructions.

Claim Adjustments

From time to time some claims submitted and paid require adjustments. This can be done through the POS claim reversal process, which involves reversing the incorrect claim and resubmitting a new, corrected claim via POS. Claims requiring adjustments may be reversed within the timely filing period by using the pharmacy provider NPI, date of service and prescription number. Upon reversal, the claim may be resubmitted with the corrected information.

In some instances, it is necessary to submit a hard copy adjustment claim form.

NOTE: See Section 37.5.1 to access the link to the POS User Guide of this manual chapter for instructions for both types of claim adjustments.

NOTE: See Section 37.5.1 of this manual chapter for Form 211 Drug Adjustment Form and instructions for completion.

Time Limit for Submission of Medicaid Claims

Timely Claim Submission

Medicaid providers should submit claims immediately after providing services so that any problems with a claim can be corrected and the claim resubmitted before the filing deadline.

Twelve Month Filing Limit

A claim for services rendered must be received by the Department or its fiscal intermediary no later than 12 months from the date of service.

Dates of Service Greater Than Two Years Old

Claims with dates of service over two years old are not to be submitted to the fiscal intermediary or to Medicaid for overriding of the timely filing edit unless one or more of the guidelines listed below is met:

1. The beneficiary was certified for retroactive Medicaid benefits;

2. The beneficiary won a Medicare or SSI appeal in which he was granted retroactive Medicaid benefits; and/or

3. The failure of the claim to pay was not the fault of the provider each time the claim was adjudicated.

Medicare/Third Party Payor Insurance Claims

Claims for beneficiaries who have Medicare or other insurance must be submitted to a third party payor prior to sending the claim to Medicaid.

A claim coordinated with a third party payor shall be submitted to the fiscal intermediary within 12 months of the date of service.

The time limit for filing Medicare crossover claims to the Medicaid Program is six (6) months from the date of the Medicare adjudication of the claim, providing the claim was filed timely with Medicare (12 months from the date of service).

Proof of Timely Filing

Medicaid claims received after the maximum timely filing date cannot be processed unless the provider is able to furnish proof of timely filing. Such proof may include the following:

1. A Remittance Advice indicating that the claim was processed earlier (within the specified timeframe); or

2. Proof of retroactive eligibility.

When resubmitting the claim and documentation, providers must be certain that the claim is legible to ensure accurate processing. Documentation must reference the individual beneficiary and date of service.

Billing for Spend-Down Medically Needy Beneficiaries

Any provider who has medical bills from the exact date of the beneficiary's spend-down will receive a Spend-down Medically Needy Notice (Form 110-MNP) from the local Medicaid office. This form will notify the provider of the co-payment amount due by the beneficiary and the amount to be billed to Medicaid. *The provider must attach this form to the claim and submit the claim manually to the fiscal intermediary for processing.* The provider cannot bill the beneficiary for any amount over the amount specified on the Form 110-MNP under beneficiary liability. If service(s) were provided on the date of spend-down but does not appear on the 110-MNP form, the provider should contact the local Medicaid office that issued the form to get a corrected form.

CLAIMS PROCESSING and PAYMENTS

Claims for Medicaid reimbursement are processed by the Medicaid fiscal intermediary (FI). This section describes claims processing and gives the provider information about the remittance advice as well as how to obtain help with claims processing problems.

Claims Processing

Claim Entry

POS claims enter the claims processing system directly through a telecommunications network and adjudicate in real time. Paper claims are keyed directly into the system for adjudication. Paper claims should be submitted to the FI. (See Section 37.5.4 for contact information).

Claim Adjudication

The system edits the claim information and determines the status or disposition of the claim. This process is known as claim adjudication.

Disposition of Claim

A claim disposition can be:

1. Paid - payment is approved in accordance with program criteria; or

2. Denied - payment cannot be made because the information supplied indicates the claim does not meet program criteria, or information necessary for payment was either erroneous or missing.

Processing Time Frames

POS claims submitted by the end of the day on Thursday typically appear as adjudicated/pended on the provider's remittance advice (RA) the following Tuesday. Payments are made to the provider based upon LDH payment guidelines. Paper claims are processed for adjudication within 10 to 30 days.

POS Claims

Pharmacy claims are processed through a LDH approved switch vendor through the POS system. The POS system is designed to work under the general framework of standards and protocols established by the National Council for Prescription Drug Programs (NCPDP). It uses methods of communication which are in place for other pharmacy POS processing.

NOTE: Refer to Section 37.5.1 for the link to access of the POS User Guide of this manual chapter for comprehensive information.

Paper Claims

Paper claims are screened for completion. If information is missing, the claim will not be entered into the system and will be returned to the provider. The provider needs to correct the error, attach any missing documentation and return the claim for processing.

Pharmacy providers should verify payment or denial of paper claims on their weekly RA. Paper claims should be resubmitted if the services meet the criteria for payment.

Remittance Advice

The RA plays an important communication role between the provider, the Medicaid Program, and the FI. Aside from providing a record of transactions, the RA assists providers in resolving and correcting possible errors and reconciling paid claims. The RA also serves as a bulletin board for messages from the Medicaid Program.

The RA is the control document which informs the provider of the current status of submitted claims. It is sent out each week when the provider has an adjudicated claim.

On the line immediately below each claim, a code will be printed representing denial reasons and payment reduction reasons. Messages explaining all codes found on the RA will be found on a separate page following the status listing of all claims. The only type of claim status which will not have a code is one which is paid as billed.

If the provider uses a medical record number (which may consist of up to 16 alpha and/or numeric characters), it will appear on the line immediately following the beneficiary's number.

Internal Control Number

At the end of each claim line is the 13-digit internal control number (ICN) assigned to that claim line. Each separate claim line is assigned a unique ICN for tracking and audit purposes. Following is a breakdown of the 13-digits of the ICN and what they represent:

Position 1:	Last Digit of Current Year
Positions 2-4:	Julian Date - ordinal day of 365-day year
Position 5:	Media Code - 0 = paper claim with no attachments 1 = Electronic batched claim 3 = System adjustment 4 = System void 5 = Paper claim with attachments 6 = Resubmission 7 = Pharmacy POS electronic claim
Positions 6-8:	Batch Number - for FI internal purposes
Positions 9-11:	Sequence Number - for FI internal purposes

Positions 12-13: Number of Lines within Claim

00 = First line
01 = Second line
02 = Third line, etc.

Copies of the five most current weeks' RAs are available on the Louisiana Medicaid website's password-protected section, "Weekly Remittance Advices".

Electronic Remittance Advice

The Electronic Media Claims (EMC) Department offers Electronic Remittance Advices (ERA) in the ANSI X12 835 format. The 835 would be in addition to the NCPDP response. This allows providers to have their RAs transmitted from the FI and posted to accounts electronically. Further information may be obtained by calling the FI. (See Section 37.5.4 for contact information).

Remittance Advice Breakdown

Claims presented on the RA can appear under one of several headings: Approved Original Claims (paid claims); Denied Claims; Claims in Process; Adjustment Claims; Previously Paid Claims; and Voided Claims. When reviewing the RA, providers should look carefully at the heading under which the claims appear to assist with the reconciliation process.

Claims appearing under the heading, "Claims in Process", indicate claims that have been received by the FI, and should not be worked until they appear as either "Approved Original Claims" or "Denied Claims."

Remittance Summary

"Approved Original Claims" may appear with zero (0 dollar) payments. These claims are still considered paid claims. Claims pay a zero amount legitimately, based on other insurance payments, maximum allowable payments, etc.

When providers choose to return checks to adjust or void a claim rather than completing an adjustment/void form, the checks will initially appear as a financial transaction on the front of the RA to acknowledge receipt of that check. The provider's check number and amount will be indicated, as well as an internal control number (ICN) which is assigned to the check. If claims associated with the check are processed immediately, they will appear on the same RA as the check financial transaction, under the heading of "adjustment or void" as appropriate, as well as the corresponding "previously paid claim." The amount of the check posted to the RA should offset

the amount recouped from the RA as a result of the adjustment/void, and other payments should not be affected. However, if the adjustments/voids cannot be processed on the same RA, the check will be posted and appear on the financial page of the RA under "Suspense Balance Brought Forward" where it will be carried forward on forthcoming RA's until all adjustments/voids are processed. As the adjustments/voids are processed, they will appear on the RA and the amount of money being recouped will be deducted from the "Suspense Balance Brought Forward" until all claims payments returned are processed.

It is the provider's responsibility to track these refund checks and corresponding claims until they are all processed.

When providers choose to submit adjustment/void forms for refunds, the claims are adjusted/voided on the RA, the monies recouped will appear on the RA appropriately as "Adjustment Claims" or "Voided Claims." A corresponding "Previously Paid Claim" will also be indicated. The system calculates the difference between what has been paid ("Previously Paid Claim") and the additional amount being paid or the amount being recouped through the adjustment/void. If additional money is being paid, it will be added to the provider's check and the payment should be posted to the appropriate beneficiary's account. If money is being recouped, it will be deducted from the provider's check amount. This process means that when recoupments appear on the RA, the paid claims must be posted as payments to the appropriate beneficiary accounts through the bookkeeping process, and the recoupments must be deducted from the accounts of the beneficiaries for which adjustment or voids appear. If the total voided exceeds the total original payment, a negative balance occurs, and money will be recouped out of future checks. This also includes state recoupments, Surveillance and Utilization Review Subsystem (SURS) recoupments and cost settlements.

Below are the summary headings which may appear on the financial summary page and an explanation of each:

1. **Suspense Balance Brought Forward** - A refund check or portion of a refund check carried forward from a previous RA because all associated claims have not been processed;

2. **Approved Original Claim -** Total of all approved (paid) claims appearing on this RA;

3. **Adjustment Claims -** Total of all claims being adjusted on this RA;

4. **Previously Paid Claim -** Total of all previously paid claims which correspond to an adjustment or void appearing on this RA;

5. **Void Claims -** Total of all claims being voided on this RA;

6. **Net Current Claims Transactions -** Total number of all claims related transactions appearing on this RA (approved, adjustments, previously paid, voided, denied, claims in process);

7. **Suspense Balance Brought Forward** - A refund check or portion of a refund check carried forward from a previous RA because all associated claims have not been processed;

8. **Approved Original Claim -** Total of all approved (paid) claims appearing on this RA;

9. **Adjustment Claims -** Total of all claims being adjusted on this RA;

10. **Previously Paid Claim -** Total of all previously paid claims which correspond to an adjustment or void appearing on this RA;

11. **Void Claims -** Total of all claims being voided on this RA;

12. **Net Current Claims Transactions -** Total number of all claims related transactions appearing on this RA (approved, adjustments, previously paid, voided, denied, claims in process);

13. **Net Current Financial Transactions -** Total number of all financial transactions appearing on the RA;

14. **Prior Negative Balance -** If a negative balance has been created through adjustments or voids processed, the negative balance is carried forward to the next RA. (This also includes state recoupments, SURS recoupments and cost settlements);

15. **Recoupment Bypassed by LDH**;

16. **Withheld for Future Recoveries -** Difference between provider checks posted on the RA and the deduction from those checks when associated claims are processed on the same RA as the posting of the check. (This is added to Suspense Balance Brought Forward on the next RA);

17. **Total Payments This RA -** Total of current check;

18. **Total Copayment Deducted This RA -** Total pharmacy co-payments deducted for this RA;

19. **Suspense Balance Carried Forward -** Total of Suspense Balance Brought Forward and withheld for future recoveries;

20. **Y-T-D Amount Paid -** Total amount paid for the calendar year;

21. **Denied Claims -** Total of all denied claims appearing on this RA; and

22. **Claims in Process -** Total of all pending claims appearing on this RA.

Messages

Important messages appear on the RA pertinent to the pharmacy program. Messages include, but are not limited to the following:

1. Updates to program policy;

2. Changes in participating manufacturers in the federal rebate program; and

3. Changes in the Federal Upper Limits (FULs) and Louisiana Maximum Allowable Costs (LMACs).

Help Desk

POS information is available to Pharmacy providers between 8:00 a.m. and 5:00 p.m. Monday through Friday by contacting the FI's POS Helpdesk. (See Section 37.5.4 for contact information).