

471-000-85 Explanation of Remittance Advice and Refund Requests Report

Use: The Remittance Advice and Refund Requests report contains information on Medicaid processed claims (paid or denied), adjusted claims and requested refunds. A report is sent weekly when there is reportable activity. While the report can contain both the Remittance Advice and Refund Requests, it is possible to receive only the Remittance Advice portion or the Refund Requests portion, both or neither, depending on the reportable activity that week. This report replaces the MC-7 Explanation of Medical Claims Activity report.

NOTE: The Remittance Advice mirrors the content of the national standard electronic Remittance Advice (ASC X12N 835). Only one version, either electronic or paper, will be produced for each provider number, not both. Additionally, when the electronic 835 Remittance Advice is chosen, the Refund Requests report will also only be electronic. For instructions regarding the electronic 835 Remittance Advice, consult the Nebraska Medicaid 835 Remittance Advice Companion Guide at <http://dhhs.ne.gov/Pages/Electronic-Data-Interchange-Submission-Requirements.aspx>.

Following is an example of the report with descriptions of key fields:

**REMITTANCE ADVICE HEADING SECTION EXAMPLE:**

```

MCPWKL7B MCP248                                STATE OF NEBRASKA                                REPORT PAGE  1,046
MCP248                                           HEALTH AND HUMAN SERVICES FINANCE AND SUPPORT
04:37 PM 06/07/2004
                                           REMITTANCE ADVICE                                PROV PAGE    001
                                           (1)
STATE OF NEBRASKA CONTACT INFORMATION: MEDICAID INQUIRY LINE
                                           (402) 471-9128
                                           (877) 255-3092
FOR PROVIDER NPI: 1234567899                    EFTN: 999999999
                                           (2)
                                           (3)
FAMILY PRACTICE, INC.
123 MAIN STREET
P O BOX 54321
LINCOLN NE 68509
WARRANT NBR: 990001234    PAYMENT AMOUNT:      164.00    PAYMENT DATE: 06/07/2004
EFT NBR: 999999999      PAYMENT AMOUNT: 999,999,999.99    PAYMENT DATE: WA/RR/DATE
*****

```

**KEY FIELDS DESCRIPTION:**

1. Remittance Advice – Report title for this portion of the report.
2. Provider NPI Number and Pay-To Name and Address
3. Warrant Number, payment amount and payment date or EFT (Electronic Fund Transfer) number, payment amount and payment date. Providers will receive either a paper warrant or EFT if there is a payment associated with this report. If the Remittance Advice is produced, but no payment is being made, "WARRANT NBR: NO PAYMENT" will be printed.
4. Payment Date – starts the 90-day time limit for requesting adjustments or appeal hearing. (See Medicaid policy 471 NAC 2-003.02 and 3-002.07.)



**REMITTANCE ADVICE END OF REPORT EXAMPLE:**

```

*****
*****END OF REMITTANCE ADVICE*****
*****
*****
REFUND REQUESTS CONTINUED ON NEXT PAGE...

```

**KEY FIELD DESCRIPTIONS:**

1. Banner to indicate the end of the Remittance Advice portion of the report.
2. If refunds are requested, the Refund Request Report begins on the next page.

**REFUND REQUESTS HEADING SECTION EXAMPLE:**

```

MCPWKL7B MCP248                STATE OF NEBRASKA
MCP248                          HEALTH AND HUMAN SERVICES FINANCE AND SUPPORT
04:37 PM 06/07/2004

                                REFUND REQUESTS                PROV PAGE    XXX

STATE OF NEBRASKA CONTACT INFORMATION: MEDICAID INQUIRY LINE
                                (402)471-9128
                                (877)255-3092

FOR PROVIDER NPI: 9999999999          FTIN: 9999999999
PROVIDER NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
ADDRESS: 1234567891123456789212345678931234567894123456789512345
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
CITYNAMEHEREXXXXXXXXXXXXXXXXXXXXX ST ZIPCD

```

**KEY FIELD DESCRIPTIONS:**

1. Refund Requests – Title of the Refund Requests portion of the report. This portion is produced when refunds are requested.
2. Provider NPI Number and Pay-To Name and Address

**REFUND REQUESTS PENDING REFUNDS SECTION EXAMPLE:**

```

*****PENDING*****
***** THE FOLLOWING MEDICAL CLAIMS WERE NOT COLLECTED THIS WEEK. YOUR WARRANT MAY BE REDUCED *****
***** THE NEXT TIME YOU ARE TO RECEIVE PAYMENT FOR MEDICAL CLAIMS. *****
*****
RECIPIENT NAME                RECIPIENT#  RECEIVED  CS  FT  PACCT #          CLAIM#
LN#  SVC FROM    SVC TO    PROCEDURE  MOD    UNITS    REV
      SUB AMT      CAS AMT   RSN  QTY    CAS AMT   RSN  QTY    NET AMT
SMITH PAT                    508XXXXXX02 03/10/2004  22  1  PTACCT00000000000001  711XXXXXX
  02/07/2004 02/18/2004
001 02/07/2004                99213                1                N1
      -67.00                -32.17  42                -34.83
002 02/18/2004                99213                1                N1
      -67.00                -32.17  42                -34.83
-----
      -134.00                CLAIM TOTALS                -69.66
ORIGINAL REQUEST DATE: 04/01/2004    REFUND DUE:    69.66
*****
    
```

**KEY FIELD DESCRIPTIONS:**

1. Claim information will appear with same heading and claim information as on the Remittance Advice.
2. Original Request Date starts the 30-day time frame for refunding the requested amount or to appeal the refund request. (See 471 NAC 2-003.02 and 3-002.08.)
3. Claim refund amount requested.

**ADDITIONAL INFORMATION:**

This section contains refund requests that have not yet been received by the Department. After 30 days of no response or appeal, the amounts will be recouped/withheld from future payments. Refunds that cannot be recouped due to lack of available money show up in this section. Once enough money is available, these amounts will be recouped.

**REFUND DISPUTES SECTION EXAMPLE:**

```

*****DISPUTES*****
**** THE FOLLOWING MEDICAL CLAIMS ADJUSTMENTS ARE IN DISPUTE. ****
*****
RECIPIENT NAME          RECIPIENT# RECEIVED  CS  FT  PACCT #          CLAIM#
LN# SVC FROM    SVC TO    PROCEDURE  MOD  UNITS  REV
SUB AMT          CAS AMT  RSN  QTY  CAS AMT  RSN  QTY  NET AMT

JONES PAT          508XXXXXX02 03/10/2004 22  1 PTACCT00000000000001  711XXXXXX
  02/07/2004 02/18/2004
001 02/07/2004          99213          1          N1          -34.83
    -67.00          -32.17  42
002 02/18/2004          99213          1          N1          -34.83
    -67.00          -32.17  42
-----
    -134.00          CLAIM TOTALS          -69.66
    ORIGINAL REQUEST DATE: 06/05/2004          REFUND DUE:          69.66
*****
    
```

**KEY FIELD DESCRIPTIONS:**

1. Claim information will appear with same heading and claim information as on the Remittance Advice.
2. Original Request Date starts the 30-day time frame for refunding the requested amount or to appeal the refund request. (See 471 NAC 2-003.02 and 3-002.08.)
3. Claim refund amount requested.

**ADDITIONAL INFORMATION:**

This section contains refunds that are under review by the Department as additional information has been received from the Provider.

**REFUND REQUESTS SECTION EXAMPLE:**

```

*****REQUESTS*****
**** REFUNDS ARE DUE ON THE FOLLOWING CLAIMS. ****
*****
RECIPIENT NAME          RECIPIENT# RECEIVED  CS FT  PACCT #          CLAIM#
LN# SVC FROM    SVC TO    PROCEDURE  MOD   UNITS   CS FT  PACCT #          CLAIM#
  SUB AMT        CAS AMT   RSN  QTY   CAS AMT  RSN  QTY          NET AMT

JONES PAT                508XXXXXX02 03/10/2004 22  1 PTACCT00000000000001  711XXXXXX
  02/07/2004 02/18/2004
001 02/07/2004                99213          1          N1
      -67.00          -32.17  42          -34.83
-----
      -67.00          CLAIM TOTALS          -34.83
ORIGINAL REQUEST DATE: 06/05/2004          REFUND DUE:          34.83
TOTAL REFUND DUE:          34.83
*****
    
```

**KEY FIELD DESCRIPTIONS:**

1. Claim information will appear with same heading and claim information as on the Remittance Advice.
2. Original Request Date starts the 30-day time frame for refunding the requested amount or to appeal the refund request. (See 471 NAC 2-003.02 and 3-002.08.)
3. Claim refund amount requested.
4. TOTAL refund amount requested.

**ADDITIONAL INFORMATION:**

Refund Requests will appear in this Section. This part contains claims for which a refund has been requested but has not been received by the Department.

```

*****
*****END OF REFUND REQUESTS*****
*****
*****
**** EEEEEEE NN NN DDDDDD OOOO FFFFFFF RRRRRR EEEEEEE PPPPPP TTTTTTTT *****
**** EE NNNN NN DD DD OO OO FFFF RR RR EE PP PP TT *****
**** EEEEEE NN NN NN DD DD OO OO FFFF RRRRRR EEEEEE PPPPPP TT *****
**** EE NN NNNN DD DD OO OO FF RR RR EE PP TT *****
**** EEEEEEE NN NN DDDDDD OOOO FF RR RR EEEEEEE PP TT *****
*****
    
```

**KEY FIELD DESCRIPTIONS:**

1. End of Refund Requests banner will run at the end of Refund Requests report.
2. End of Rept (report) banner will run on the last page of the report.

Additional information is available on the Medicaid Electronic Data Interchange (EDI) Customer Service web site at <http://dhhs.ne.gov/Pages/Electronic-Data-Interchange-Submission-Requirements.aspx> regarding electronic transactions.

If you have questions regarding the information on the Remittance Advice Refund Requests Report, please call the Medicaid Inquiry Line at 1-877-255-3092 (toll free) or 402-471-9128 (Lincoln).