Chapter 13: Understanding the Remittance Advice

General Information

A Remittance Advice (RA) is sent with each claim payment. Providers are responsible for reviewing and reconciling their accounts receivable to all remittance advices accompanying payments. Each RA will contain an action code that describes in more detail the results of the claim determination.

The Health Choice Insurance Co. (Health Choice) Remittance Advice provides information about claims adjudicated by Health Choice, including claims paid or voided and claims which were denied. The RA is generated with each payment cycle. A Paper Remittance Advice is mailed to the billing provider. All claims adjudicated during the processing cycle are listed on the RA, along with the payment status or reason for denial (see Exhibit 12.0 – Action Cod list). The provider should use the RA to identify action reasons to determine whether to resubmit the claim or take alternative action.

If the billing provider has submitted claims for multiple service providers, the Remittance Advice will contain a section for each. This chapter primarily addresses the Paper Remittance Advice only.

Remittance Advice

Each Remittance Advice contains the following information:

- Paid claims
- Adjusted claims
- Denied claims

The last page provides an alphabetical listing of action codes and pricing explanation codes.

- Each is listed only once even if it applies to multiple claims.

Claim Disputes

- This page informs providers of their claim dispute rights (See Chapter 15, Claim Disputes and Member Appeals).

Information reported on the Remittance Advice (RA) page includes:

- Billing Provider ID number
- Check date
- Invoice Number which links payments to the services that generated the payment
- Service Code
- Quantity billed
- Amount billed
- Excluded and non-allowed amounts
- Allowed amount
- Amount of other payer's payment
- Member Co-pay/deductible/coinsurance
- Contractual write off amount

- Amount paid
- Adjustment/Denial code

Working the Remittance Advice (RA)

Here are some suggestions for working the Health Choice Remittance Advice to reconcile claims billed to the Health Choice Administration and the status of those claims:

- Review the RA to determine which claims have been paid and if the claims are paid correctly. Any errors, such as claims that have not paid the correct number of units, should be marked for resubmission, noting associated CRNs. (See Chapter 7, General Billing Rules, for information on resubmitting a paid claim.)
- Review the RA to determine if any claims submitted by the provider as adjustments are adjusted correctly. If problems still exist with a claim, it may be submitted again. The RA will also report any claims that were adjusted as a result of an audit or review.
- Review the RA for any claims submitted by the provider as void transactions. There are many reasons a claim may be voided. These may be claims that have been paid by other insurance and now need to be voided so that Health Choice can recoup its payment. The RA will also report any claims that were voided by Health Choice as a result of an audit or medical review recoupment. Providers who believe that a claim was voided in error should contact the Health Choice Claims Customer Service Unit.
- Review the RA for denied services. Review each denial reason and determine the action necessary to correct the claim. (See Chapter 7, General Billing Rules, for information on resubmitting a denied claim.)

Providers who have questions about the Remittance Advice or about resubmitting, adjusting, or voiding a claim should contact the Health Choice Claims Resolution Services Unit at 1-855-452-4242.