




DELAWARE HEALTH AND SOCIAL SERVICES

DIVISION OF MEDICAID & MEDICAL ASSISTANCE

DELAWARE MEDICAL ASSISTANCE PROGRAM

GENERAL BILLING INSTRUCTIONS

 <p>DELAWARE HEALTH AND SOCIAL SERVICES</p> <p>DIVISION OF MEDICAID & MEDICAL ASSISTANCE</p> <p><i>Delaware Medical Assistance Program</i></p>	<h2>General Billing Manual</h2> <h3>Revision Table</h3>
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Revision Date	Sections Revised	Description
7/1/02	All	Complete manual revision to reflect changes related to the MMIS and HIPAA compliance.
1/23/04	2.5	Clarification of timely filing policy for adjustments
5/14/07	1.3	Adding additional information regarding requests for copies of remittance advices and checks.
3/26/10	2.7	Made Adjustment Request Form a fillable form.
4/2/13	1.3	Effective July 1, 2013 the cost for reprinting a remittance advice is \$25.00.
4/2/13	1.4	Added information about electronic remittance advices and electronic funds transfer payments.
4/2/13	5.0	Updated the information on obtaining forms.
4/2/13	6.0	Updated the requirements for electronic billing
7/15/14	2.5	Clarification in reference to the General Policy Manual for information regarding the MCBR report.
1/15/15	1.3	Updated the information on reprinting costs.
10/28/2022	All	Updated HP Enterprise Services to Gainwell Technologies.
10/28/2022	3.0, 5.0	Removed Section 3.0 Written Inquiry and 5.0 Ordering Forms.
10/28/2022	2.1, 2.4, 2.6, 6.0	Updated electronic claims submissions information.
07/01/2023	1.0, 2.0, 6.0	Updated sections to reflect the removal of paper claims information in compliance with DMES and electronic claims filing requirements.

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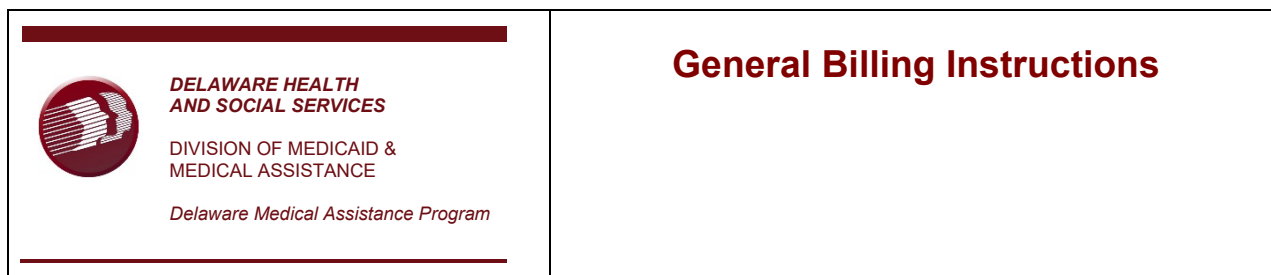


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1.0 Claims Processing

This section is dedicated to discussing how claims are processed by the fiscal agent for the Delaware Medical Assistance Program (DMAP). This section covers the following areas related to claims processing.

- Processing of Claims - Discusses how each claim is processed and as a result of processing, details the categories that claims fall into: paid, denied, in process.
- Payment Cycle - After each payment cycle, providers who had claims processed in that cycle will receive at least one of the following electronically: Remittance Advice, Electronic Funds Transfer (EFT) or a check.

1.1 Processing of Claims

Claims are analyzed and the status or disposition is determined. One of the following dispositions is assigned to a claim.

- Paid - Payment to the provider is approved in accordance with program criteria; or
- Denied - Payment cannot be made because the information supplied indicates the claim does not meet program criteria unless additional information can be provided that would allow payment; or
- Pending - The claim is put on 'hold' so an analyst can manually review it.

1.2 Payment Cycle

After each weekly payment cycle, providers who had claims processed in that cycle will receive at least one of the following electronically from the fiscal agent:

- Remittance Advice - A computer-generated document that advises the provider as to the status/disposition of each claim processed in the last payment cycle.
- EFT- The mechanism to pay the amount due to the provider.
- There is a \$25.00 charge for an additional hard copy of a remittance advice or a check that has been cashed by the provider.

1.3 Remittance Advice

The Remittance Advice (RA) is a computer-generated document showing the status and payment breakdown of all claims submitted to DMAP for processing. The Remittance Advice plays an important communications role between the provider, DMAP and the DMAP fiscal agent. It tells the provider whether the claims submitted for payment were paid, denied, rejected, or in process. It is designed to simplify your accounting by allowing accurate reconciliation of claims submission.

Once a week, all claims completed in a daily cycle are processed through the financial cycle. During the financial cycle, the RA is created from the payment file for any paid claims for the provider. As of September 1, 2011, DMAP no longer mails paper RAs or paper checks to providers. Providers receive payment through an Electronic Funds Transfer (EFT) which is deposited directly to the provider's bank account. A PDF version of the provider's RA is uploaded to the [DMAP Provider Portal](#). The Remittance Advice is produced explaining each provider's payment on a claim-by-claim basis. Only providers who have finalized claims in process (received and keyed into the system), financial transactions, or adjusted claims will receive an RA.

Aside from providing a record of transactions, the Remittance Advice is intended to assist providers in reconciling their DMAP accounts. The RA should be the first source of reference if there are questions regarding a particular claim. Refer to the Telephone Inquiry and Written Inquiry sections of the Billing Instructions for more information regarding questions on a particular claim.

The RA is available on the DMAP web site for four weeks. It is the provider's responsibility to retain the RA information in their files. Also, this is the provider's only record of paid and denied claims.

The RA is also a status report that inventories the current status of active claims. Should a submitted claim not appear on the RA within four to six weeks after submission, resubmit an original claim form.

The Remittance Advice contains one or more of the following sections, depending on the claim(s) filed and the actions(s) taken on those claims:

- Banner Page
- Paid Claims
- Denied Claims
- Pending Claims
- Adjusted Claims
- Remaining Balance on Previous Adjustments
- Financial Items
- Earnings Data

The following sections describe each page of the Remittance Advice. Each page is described and a sample of that page follows each description. Each field on the RA page is numbered and can be matched to the numbered fields on the RA sample.

All pages of the RA contain the headings on the first page of the Remittance Sample on the following page. The first page of the RA is the Banner Page.

1.4 Banner Page

The Banner Page is the first page of the Remittance Advice and it presents a written message or messages to the provider. This message contains very important information related to DMAP changes or processing procedures.

1.5 RA Banner Page Example

PROV 0000123456
TAXONOMY: 261QA1903N
SEQ NO: 1

DELAWARE MEDICAID REMITTANCE ADVICE
BANNER PAGE
RA DATE 07/01/2023

SAMPLEPRACTICE
RA #: 4378564854
PAGE: 1

THIS PAGE DISPLAYS IMPORTANT MESSAGES SUCH AS RECENT POLICY UPDATES, BILLING
CHANGES AND HOLIDAY SCHEDULES FOR DHSS & GAINWELL TECHNOLOGIES. PLEASE READ THIS INFORMATION
AND RETAIN FOR FUTURE REFERENCE. THIS INFORMATION MAY BE DISPLAYED FOR ALL
PROVIDERS OR FOR A SPECIFIC PROVIDER TYPE.

SAMPLE PRACTICE
1 SAMPLE DRIVE
WILMINGTON DE 19809-0000

1.6 Claim Status

The Claim Status section includes the Paid Claims, Denied Claims, Pending Claims, and Adjusted Claims sections. The Claim Status prints in the left corner of the report section of the RA. This denotes where the section begins. (For example, Paid Claims in the upper left corner of the report section denotes where the Paid Claims section begins.) All of these sections have the same format unless noted otherwise in the description. The sample Paid Claims page that follows describes the elements found in the Paid Claims section of the RA. Use this page as a reference for the other three sections. A description of the elements unique to the Denied Claims, Adjusted Claims, and Claims In-Process sections is also provided following the Paid Claims section.

Field Descriptions

Field	Description
PROV	This field indicates the unique number of the provider who is receiving the RA. The provider number consists of 10 unique digits.
RA NUM	This field indicates the number of the RA for the provider for the current financial cycle.
RA TITLE	This field indicates the type of RA generated (i.e. Institutional/UB92).
TAXONOMY	The taxonomy codifies provider type and provider area of specialization for all medical related providers.
SEQ NO	This field indicates the RA sequence number for the provider. This field increases by one each time a provider receives a RA. The sequence number is reset at the beginning of each calendar year.
RA DATE	This field indicates the date the RA was generated. This date is typically the Monday following the financial cycle and is equal to the check issue date.
PAGE NUM	The sequence number of this page of the report when compared to the total number of pages for this report.
CLAIM TYPE	This field indicates the claim type description for claims located in this section of the RA (inpatient, etc.).
CLIENT NAME	This group of two fields indicates the first five characters of the client's last name and the first three characters of the client's first name.
MID	This field indicates the client's unique Medicaid Identification (MID) number as it appears on the claim.
ICN	This field indicates the unique Internal Control Number (ICN) assigned to the claim.
VER	The version number corresponds to the ICN and indicates the version of the claim. The original header has a version number of 00. Subsequent version numbers are the result of adjustments.
PT ACCT/RX #	This field indicates the client account or medical record number that appears on the claim. This field may also contain the prescription number if the provider bills pharmacy claims under the same provider number.
BILLED AMT	This field indicates the amount billed by the provider for service.
NON ALLOWED AMT	This field indicates the non-allowed amount for the claim. It is equal to the billed amount minus the allowed amount.
ALLOWED AMT	This field indicates the Medicaid allowed payment for the claim.

Field	Description
OI	This field indicates the amount paid by another insurance carrier for this claim.
COPAY AMT	This field indicates the portion of the billed amount for which client is responsible, if a co-payment is applicable to the client and/or the service.
PAID AMT	This field indicates the dollar amount included in the payment for the claim. The value is calculated as: ALLOWED AMOUNT - COPAY AMOUNT - LIABILITY AMOUNT - <u>INSURANCE AMOUNT</u> PAID AMOUNT
HEADER EOB MESSAGES	These 10 fields relate to the message codes printed under the header information. These numbers are EOB codes and indicate the reasons for payment or denial of the claim. The definitions of these codes are listed on the last page of the RA.
LIAB AMT	This field indicates the dollar amount for which the client is responsible. It is based on claim details.
DTL#	The detail number corresponds to the ICN and indicates the detail of the claim.
FDOS	This field indicates the first date the service was rendered as it appears listed on the claim.
TDOS	This field indicates the last date the service was rendered as it appears listed on the claim.
PROC	This field indicates the procedure code.
MOD	This optional field indicates the HCPCS code modifier as it appears on the claim.
UNIT SVC	This field indicates the units of service.
DETAIL EOB MESSAGES	These 10 fields relate to the message codes printed under the detail information. These numbers are the Explanation Of Benefit codes and indicate the reasons for payment or denial of the claim on the detail level (lower portion of the claim). The narrative descriptions for the Explanation of Benefit codes can be found in earnings data section of the RA.
CLAIM TOTAL	This field indicates the total of all claims for that claim type.
PAID CLAIMS TOTALS	This field indicates the total number of claims appearing in the paid claims section of the provider's RA. This value is equal to the sum of the claim type subtotals in the paid claims section of the RA.

1.7 Paid Claims

The Professional Paid Claims section contains paid claim information for professional claims. Up to ten EOB codes are listed for each claim header and detail. The paid claims in this section are grouped together by provider taxonomy. Each provider taxonomy has a separate section. With provider taxonomy, the claims are grouped by claim type and sorted by client last name. Subtotals are calculated for each claim type and a grand total is calculated for all claim types.

1.8 Professional Paid Claims RA Example

PROV: 0000123456		DELAWARE MEDICAID MANAGEMENT INFORMATION SYSTEM						SAMPLE PRACTICE			
TAXONOMY: 261QA1903N		PROFESSIONAL						RA #: 8875455978			
RA SEQ NO: 1		RA DATE 07/01/2023						PAGE: 2			
CLIENT NAME	MID	ICN	VER	PT ACCT/RX #	BLD AMT	NON ALLOWED AMT	ALLOWED AMT	OI AMT	COPAY AMT	PAID AMT	
HEADER EOB									LIAB AMT		
DTL#	FDOS	TDOS	PROC	MOD MOD2	MOD UNIT	SVC					
DETAIL MESSAGES											
P A I D C L A I M S :											

CLAIM TYPE: PHYSICIAN											

MEMBER SAMPLE 06575480000 111997160050010 00 05545878											
365	01	06/06/23	06/06/23	99381	1	59.00	6.57	52.43	28.60	0.00	23.83
	365									0.00	
	02	06/06/23	06/06/23	0100J	3	15.00	6.00	9.00	0.00	0.00	9.00
										0.00	
CLAIM TOTALS:						74.00	12.57	61.43	28.60	0.00	32.83
										0.00	
PREVIOUS BALANCE DUE: -0000			ADJUSTED AMOUNT THIS CYCLE: 0000				REMAINING BALANCE DUE: -000				
TOTAL REMIANING BALANCE DUE: -00000											

1.9 Pended Claims

This section lists those claims that have been entered into the system but have not reached final disposition. Please do not rebill a claim shown in this section as it is already in our system and will result in a denial as a duplicate claim. These claims will appear on subsequent RA's in this section until they are paid, denied or rejected.

The format of this section differs from the standard RA page as follows. The only valid amount field is the billed amount field. The Paid Amount, Total Allowed, Total Medicare Allowed Amount, Total Medicare Paid Amount, Total Deductible, Total TPL Amount, and the Total Status Amount fields are not included in this section as they are not relevant to pending claims.

The pended claims in this section are grouped together by provider taxonomy. Each provider taxonomy has a separate section. Within provider taxonomy, the claims are grouped by claim type and sorted by client last name. Subtotals are calculated for each claim type and a grand total is calculated for all claim types.

1.10 Pending Claims RA Example

PROV #:	0000123456	DELAWARE MEDICAID REMITTANCE ADVICE	SAMPLE PRACTICE
TAXONOMY:	261QA1903N	PROFESSIONAL	RA #: :2215935645
RA SEQ NO:	1	RA DATE 07/01/2023	PAGE: 4

CLIENT NAME	MID	ICN	VER	PT ACCT/RX #	LD AMT	NON ALLOWED	ALLOWED AMT	OI AMT	COPAY AMT	PAID AMT
HEADER EOB				AMT					CLIENT	CONT AMT
DTL #	FDOS	TDOS	PROC	MOD MOD2 MOD3	UNIT	SVC				
	DETAIL	EOB								

P E N D I N G C L A I M S D O N O T R E B I L L

CLAIM TYPE: CMS-1500

MEMBER SAMPLE 0555786000 401997174248011 00

01 06/15/2023 06/15/2023 0542P 31.68

CLAIM TOTALS: 31.68

TOTALS FOR CLAIM TYPE: CMS-1500: 1 CLAIM(S) 31.68

PENDING CLAIMS TOTALS: 1 CLAIM(S) 31.68

1.11 Adjusted Claims

The Professional Adjusted Claim section contains adjusted claim information for professional adjusted claims. Up to ten EOB codes are listed for each claim header and detail. For each adjusted claim, the RA displays the original claim payment information along with the adjusted claim payment information. The original paid amount, refunds from provider amount, net adjustment amount, and a description of the adjustment reason code are included after each adjusted claim.

The adjusted claims in this section are grouped together by provider taxonomy. Each provider taxonomy has a separate section. Within provider taxonomy, the adjusted claims are sorted by client last name. Grand totals are calculated for adjustment claim totals and total net adjustment amounts are calculated to reflect the net effect of all adjustments.

1.12 Professional Adjusted Claims RA Example

PROV #: 0000123456 DELAWARE MEDICAID REMITTANCE ADVICE SAMPLE PRACTICE
 TAXONOMY: 261QA1903N PROFESSIONAL RA #: 3335458216
 RA SEQ NO: 1 RA DATE 07/01/2023 PAGE: 5

CLIENT NAME	MID	ICN	VER	PT ACCT/RX #	BLD AMT	NON ALLOWED AMT	ALLOWED AMT	OI AMT	COPAY AMT	PAID AMT
HEADER EOB										
DTL #	FDOS	TDOS	PROC	MOD MOD2 MOD3 UNIT SVC					CLIENT CONT	AMT
DETAIL EOB										

A D J U S T E D C L A I M S

MEMBER SAMPLE 0000000 0000997036222049 00 000111222 111
 01 02/03/2023 02/04/2023 0541P 64 173.44 0.00 173.44 0.00 0.00 173.44
 ORIGINAL CLAIM TOTALS: 173.44 0.00 173.44 0.00 0.00 173.44
 ORIGINAL CLAIM -PAID DATE: 02/10/1997

MEMBER SAMPLE0000000 001997148231050 01 000111222 111
 01 02/03/2023 02/04/2023 0541P 40 108.40 0.00 108.40 0.00 0.00 108.40
 ADJUSTED CLAIM TOTALS: 108.40 0.00 108.40 0.00 0.00 108.40

ADJUSTMENT DESCRIPTION: WRONG UNITS OF SERVICE
 ORIGINAL PAID AMT: 173.44 ADJUSTED PAID AMT: 108.40 REFUND FROM PROV: 64.04 NET ADJUSTMENT AMT: 0.00

ADJUSTMENT CLAIM TOTALS: 1 CLAIM(S) 108.40 0.00 108.40 0.00 0.00 108.40
 TOTAL NET ADJUSTMENT AMOUNT: 0.00

1.13 Remaining Balance on Previous Adjustments

The Professional Remaining Balance on Previous Adjustments section contains adjusted claim information for previously adjusted, professional claims with outstanding balances. Up to ten EOB codes are listed for each claim header and detail. This section shows unsatisfied adjustments that were carried over from previous cycles that have had monies applied to them in the current cycle. For each previously adjusted claim, the RA displays only the adjusted claim payment information along with the previous balance, any money applied to the balance, and the remaining balance.

The previously adjusted claims in this section are grouped together by provider taxonomy. Each provider taxonomy has a separate section. With provider taxonomy, the adjusted claims are sorted by client last name. A total remaining balance due is calculated to reflect the remaining balance of all previous adjustments.

1.14 Remaining Balance on Previous Adjustments RA Example

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PROV:          0000123456          DELAWARE MEDICAID MANAGEMENT INFORMATION SYSTEM          SAMPLE PRACTICE
TAXONOMY:     261QA1903N          PROFESSIONAL          RA #: 5545876215
RA SEQ NO:    1          RA DATE 07/01/2023          PAGE: 6

CLIENT NAME      MID      ICN      VER  PT ACCT/RX #  BILLED AMT  NON ALLOWED  ALLOWED AMT  OI AMT  COPAY AMT  PAID AMT
HEADER EOB
DTL#             FDOS      TDOS      PROC  MOD  MOD2  MOD3      UNIT SVC      AMT          LIAB AMT
DETAIL MESSAGES

R E M A I N I N G   B A L A N C E   O N   P R E V I O U S   A D J U S T M E N T S
-----
MEMBER SAMPLE 0000060000 2000997139238460 99 854562JAU
368
01      01/06/23      01/06/23      33870          1          3,800.00      392.10      3,407.90      0.00      0.00      3,407.90
                                0.00
                CLAIM TOTALS:          3,800.00      392.10      3,407.90      0.00      0.00      3,407.90
                                0.00
PREVIOUS BALANCE DUE:      -2,228.60      ADJUSTED AMOUNT THIS CYCLE:      1,100.00      REMAINING BALANCE DUE:      -1,128..60

TOTAL REMAINING BALANCE DUE:      -1,128.60
    
```

1.15 Earnings Data

The Remittance Advice - Earnings Data section contains a summary of provider earnings, both current and year to date. This information is calculated and shown at the provider level. The earnings section is separated by program and includes the month-to-date totals.

1.16 Earnings Data RA Example

PROV: 0000123456		DELAWARE MEDICAID REMITTANCE ADVICE		SAMPLE PRACTICE	
TAXONOMY: 261QA1903N		RA DATE 07/01/2023		RA NUM: 0544255455	
RA SEQ NO: 1				PAGE # 6	
		CURRENT		YEAR-TO-DATE	
NUM OF PAID CLAIMS		426		8,111	
NUM OF DENIED CLAIMS		21		44	
NUM OF PENDED CLAIMS		8			
NUM OF ADJUSTED CLAIMS		10		17	
NUM OF VOIDED CLAIMS		0		0	
NUM OF CASE MAINTENANCE FEE CLAIMS		0		1,200	
** WARRANT DATA **					
CLAIMS PAID AMOUNT		28,443.70		405,550.66	
INCREASE DUE TO CLAIM ADJUSTMENTS		12.60		12.60	
NON-CLAIM PAYOUT AMOUNT		0.00		0.00	
RECOUPMENT AMOUNT WITHHELD		-88.25		-88.25	
AMOUNT WITHHELD DUE TO CLAIM ADJUSTMENTS		-374.11		-866.35	
LEIN, PENALTY, AND INTEREST WITHHELD		0.00		0.00	
*TOTAL WARRANT PAYMENT AMOUNT		27,993.94		408,808.66	
** EARNINGS DATA **					
NET EARNINGS (INCLUDES LEIN, PENALTY, AND INTEREST WITHHELD AMT)		28,443.70		409,750.66	
REFUNDS / RETURNED WARRANTS		0.00		0.00	
OTHER ADJUSTMENTS		-449.76		-942.00	
TOTAL EARNINGS		27,993.94		408,808.66	
. . .					
** MESSAGE CODES **					
365 FEE ADJUSTED TO MAXIMUM ALLOWABLE					
399 PROCEDURE REQUIRES PRIOR AUTHORIZATION					

2.0 Adjustments

2.1 Adjusting a Paid Claim

It is the provider's responsibility to adjust a claim in the following situations:

- When a provider receives an incorrect payment
- Inaccurate claim information was submitted with the original claim.
- The provider has received payment from a third party source after Medicaid has made payment.

2.2 Remittance Advice

An adjustment request is processed through the claims system. It may result in an increase or a decrease in payment. Disposition of the processed request appears in the Adjusted Claims section on the Remittance Advice. Refer to the Remittance Advice section of the Billing Instructions in your manual for detailed information about the Adjusted Claims section of your Remittance Advice.

2.3 Adjustment of Inaccurate Medicare/Medicaid Payments

To appeal the amount paid for services provided to Medicare/Medicaid clients, notify the appropriate Medicare Fiscal Intermediary of your appeal.

If payment has been made to an incorrect provider or if an overpayment has been made, return the erroneous check(s) or issue refunds to Medicare and to Medicaid for their respective shares.

2.4 Overpayment/Refund Adjustments

If an overpayment is made on a claim, it is the provider's responsibility to refund the overpayment amount by adjusting the claim electronically.

2.5 Adjustment Filing Limitation

A claim that has been paid may be adjusted up to two years from the date of service.

3.0 Section Removed

4.0 Telephone Inquiry

4.1 Provider Telephone Inquiry

The DMAP fiscal agent has a Provider Services Unit available to answer telephone inquiries. Provider service representatives are available Monday through Friday, 8:00 am until 4:30 pm (Eastern Time). The following telephone number can be used to contact the Provider Services staff at:

Toll-free - 1-800-999-3371

When calling the Provider Services Unit, it is important to have such information as provider number, Member ID number and dates of service readily available. If your inquiry cannot be answered at the time of your phone call, all necessary information will be taken and a return call made to you as soon as possible.

5.0 Section Removed

6.0 Electronic Claims Submission

6.1 General Information

Provider Electronic Claim Submission is required effective 7/1/2023. ECS has many benefits including:

- Payment of claims can be quicker
- Reduction of clerical effort in your office
- Significant improvement in your cash flow
- No manual intervention
- Costs to the provider should decrease

6.2 How to Submit Claims Electronically

There are three methods of how claims can be submitted electronically. They are:

- Clearinghouse - A clearinghouse collects claims at a central office from many providers and sends claims electronically to our clearinghouse – Electronic Commerce Management System (ECMS).
- Vendor - A vendor who has created a Medicaid electronic billing software package installs this in the provider's computer. The provider would transmit the claim to our clearinghouse – Electronic Commerce Management System (ECMS).
- Provider Portal - Use the Delaware Medical Assistance Portal for Providers or X12 EDI for your claims submission.

6.3 Contact Information

If you have any questions regarding submitting your claims electronically or would like more information, contact Provider Services at:

1-800-999-3371 or delawarepret@gainwelltechnologies.com
