

## 7.4 Paid/Denied Claims

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The following section is designed to help you understand the Paid/ Denied section of the RA.

### Understanding Paid/Denied Claims

**Paid claims** are line items passing adjudication that are acceptable for payment. They may be paid as submitted or at reduced amounts according to Medicaid program's reimbursement methodology. Reductions in payments such as fee reduction or patient responsibility will be noted in the claim header information and the line item information.

**Denied claims** represent services which have been through adjudication that are unacceptable for payment. Claim denial may occur if the fiscal agent cannot validate claim information, if the billed service is not a program benefit, or if a line item fails the edit/ audit process. **Denied claims may be reconsidered for payment if the provider submits corrected or additional claim information to the fiscal agent for further processing.** A service may be reconsidered for payment if errors were made in submitting or processing the original claim.

Field	Field Name	RA Field Description
<b>Claim Header Information for Paid/Denied Claims</b>		
1	<b>Beneficiary Name</b>	Patient name
2	<b>Medicaid ID</b>	Medicaid beneficiary's ID for this patient
3	<b>Transaction Control Number</b>	(TCN) This number uniquely identifies the claim.
4	<b>Patient Account Number</b>	Patient Account Number
5	<b>Medical Record Number</b>	The number assigned by a health care provider to a beneficiary or a claim for reference purposes. This number is printed on the RA to assist providers in identifying the patient for whom the service was rendered.
6	<b>Dates of Service</b>	First and last dates of service for this claim
7	<b>Type of Bill</b>	Depending on the type of claim submitted, the code will either be the Facility Type Code or Place of Service Code.
8	<b>Servicing Provider</b>	The Medicaid ID number of the healthcare provider who rendered the service
9	<b>Servicing Provider Name</b>	Name of the healthcare provider who rendered the service
10	<b>Submitted Amount</b>	Total charges submitted for this TCN
11	<b>Fee Reduction Amount</b>	The difference between the submitted amount and the paid amount
12	<b>Patient Responsible Amount</b>	Amount payable by the patient
13	<b>Total Paid Amount</b>	Total amount paid on this TCN. (For balancing purposes, this amount should equal submitted charges minus adjustments.)

Field	Field Name	RA Field Description
<b>Claim Header Information for Paid/Denied Claims</b>		
14	<b>Claim Status</b>	Claim Status (Paid – Denied – Suspended)
<b>Claim Line Item Information for Paid/Denied Claims</b>		
15	<b>Item Number</b>	The line item number on the claim
16	<b>Procedure Code</b>	The line item procedure code, if applicable
17	<b>Type/Description</b>	The type of code listed in the procedure code field
18	<b>M1, M2, M3, M4</b>	The procedure code modifiers
19	<b>Revenue Code</b>	The line item revenue code, if applicable
20	<b>Tooth Code</b>	Tooth number or quadrant (applies to dental providers only)
21	<b>Servicing Provider ID</b>	The line item servicing provider ID
22	<b>Provider Control Number</b>	The line item control number submitted in the 837, which is utilized by the provider for tracking purposes.
23	<b>Dates of Service</b>	First and last dates of service for this line item
24	<b>Units</b>	Number of units
25	<b>Submitted Amount</b>	Submitted amount for this line item

Field	Field Name	RA Field Description
<b>Claim Header Information for Paid/Denied Claims</b>		
26	<b>Fee Reduction Amount</b>	The difference between the submitted amount and the paid amount
27	<b>Paid Amount</b>	Amount paid for this line item
28	<b>Status</b>	The line item status
29	<b>Exception Codes</b>	The line item exception codes
30	<b>DRG Code</b>	(Not currently used)
31	<b>DRG Weight</b>	(Not currently used)

**Header Information for Paid/Denied Claims**

DATE: 01/14/08  
 PROVIDER NO: 00099999  
 REMITTANCE: 00000065  
 NPI NUMBER: 1234567890

MISSISSIPPI ENVISION MMIS  
 DIVISION OF MEDICAID  
 REMITTANCE ADVICE  
 PAID / DENIED

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 RPT PAGE: 000077770  
 REMIT SEQ: 00000996  
 VISION AND HEARING

(1) BENEFICIARY NAME	(2) MEDICAID ID	(3) TCN	(4) PAT ACCT NUM	(5) MED REC NO	(6) DATES OF SERVICE	(7) TOB	(8) SVC PVDR	(9) SERVICE PROVIDER NAME	(10) SUBMITTED AMT	(11) FEE REDUCTION AMT	(12) PAT RESP AMT	(13) TOT PAID AMT	(14) STATUS	
(15) LINE	(16) PROC	(17) TYPE/DESC	(18) M1 M2 M3 M4	(19) REVCD	(20) THCD	SVC PROV	(21)	(22) PROV CONTROL NO	(23) DATES OF SERVICE	(24) LINE UNITS	(25) LN SUBM AMOUNT	(26) LN FEE REDUCT AMT	(27) LN PAID AMOUNT	(28) LN STATUS
=====														
JOHN A BENEFICIARY 00000995588771 08000000360109867 59A92														
01/15/08-01/15/08 11 00011111 CHARLES Q PROVIDER 181.23 9.06 .00 172.17 PAID														
1	99204	HC/HCPCS/CPT CODE						00011111 0801111114700						
	01/15/08-01/15/08	1.00		114.09	5.70		108.39	PAID						
2	V2020	HC/HCPCS/CPT CODE						00011111 08011111114701						
	01/15/08-01/15/08	1.00		36.00	1.80		34.20	PAID						
3	V2100	HC/HCPCS/CPT CODE						00011111 08011111114702						
	01/15/08-01/15/08	1.00		19.49	.97		18.52	PAID						
4	92340	HC/HCPCS/CPT CODE						00011111 08011111114703						
JIM Q BENEFICIARY 00000994488775 0800000000920007 59J19														
01/16/08-01/16/08 11 00011111 CHARLES Q PROVIDER 161.28 11.74 3.00 149.54 PAID														
1	92014	HC/HCPCS/CPT CODE						00011111 08010007999991						
	01/16/08-01/16/08	1.00		76.28	6.81		69.47	PAID						
2	92015	HC/HCPCS/CPT CODE						00011111 08010007999992						
	01/16/08-01/16/08	1.00		25.00	1.25		23.75	PAID						
3	2021F	HC/HCPCS/CPT CODE						00011111 08010007999993						
	01/16/08-01/16/08	1.00		0.00	.00		.00	DENY						
(29) EXCEPTION CODES: 0132 0439														

Line Item Information  
 for  
 Paid/Denied Claims



Section: Remittance Advice

DATE: 01/07/08  
 PROVIDER NO:00099999  
 REMITTANCE: 04952126  
 NPI NUMBER: 1234567890

MISSISSIPPI ENVISION MMIS  
 DIVISION OF MEDICAID  
 REMITTANCE ADVICE  
 PAID / DENIED

INPATIENT

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 RPT PAGE: 000013542  
 REMIT SEQ: 00000480

BENEFICIARY NAME	MEDICAID ID	TCN	PAT ACCT NUM	MED REC NO	DATES OF SERVICE	TOB	SVC	PVDR	SERVICE PROVIDER NAME	SUBMITTED AMT	FEE REDUCTION AMT	PAT RESP AMT	TOT PAID AMT	STATUS
JANE A DOE	00000998877667	08001355000025107	3719JANEAC2000	3719JANEAC2000	12/21/07-12/23/07	111	00099999	ANYTOWN	MEDICAL CENT	6,964.77	4,555.11	.00	2,409.66	PAID
DRG CODE: <b>(30)</b>		DRG WEIGHT: 0.00000		<b>(31)</b>		EXCEPTION CODES: 0674								