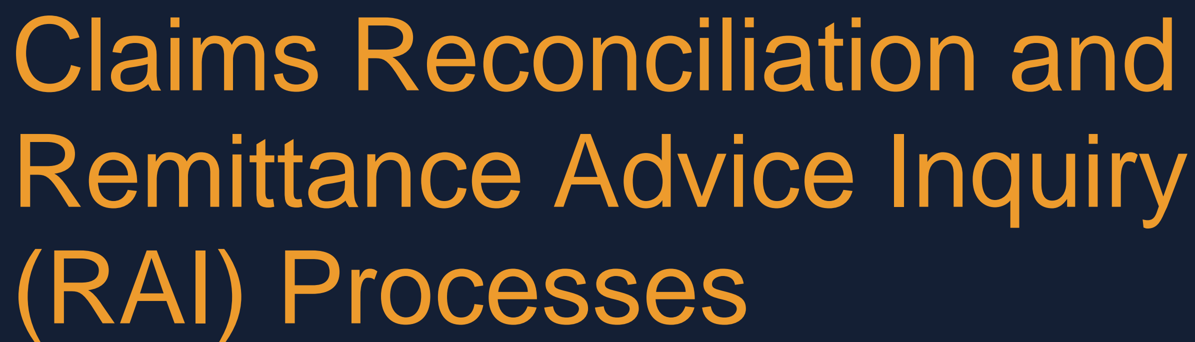

Claims Reconciliation and Remittance Advice Inquiry (RAI) Processes

Quick Reference Guide

Economics, Policy & Research

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ONTARIO MEDICAL ASSOCIATION

Claims Reconciliation and Remittance Advice Inquiry (RAI) Processes
Quick Reference Guide[1]

The purpose of this reference guide is to provide a general overview on the claims reconciliation and remittance advice inquiry processes. By understanding these processes, steps can be taken to avoid errors leading to claims being rejected and/or avoid delays in processing claims that ultimately results in delays in payment.

Remember, even if you assign a staff person or have a billing agent submit claims on your behalf, you are ultimately responsible for the claims submitted to ensure appropriate and timely payment of OHIP claims.

The guide contains the following sections:

- (A) OHIP Claims Submission Reports;
- (B) Claims Requiring Documentation; and
- (C) Remittance Advice Inquiry (RAI) Process
- (D) eSubmit
- (E) Resources

A: OHIP Claims Submission Reports

The ministry operates on a monthly processing cycle. Submissions received by the 18th of the month will typically be processed for approval the following month. When the 18th falls on a weekend or holiday, the deadline will be extended to the next business day. To ensure prompt and correct payment, it is imperative to review the following OHIP claim submission reports once available:

1. Claims Batch Edit Report
2. Error Report (ER)
3. Remittance Advice (RA)

These reports provide insight on the status of your claims and, where a claim was not paid as submitted, the reason it was not paid and the appropriate course of action to reconcile the claim.

Claims data may be subject to rejection by the Ministry at three levels:

- Rejection of entire file submission
- Rejection of batch within a file
- Rejection of a claim within a batch

(1) Claims Batch Edit Reports

If a file is accepted, a Claims Batch Edit Report is sent to acknowledge receipt of each batch submitted. This report is sent to the user ID and notes whether the batch is accepted or rejected.

[1] **Disclaimer**: Every effort has been made to ensure that the contents of this Guide are accurate. Members should, however, be aware that the laws, regulations and other agreements may change over time. The Ontario Medical Association assumes no responsibility for any discrepancies or differences of interpretation of applicable Regulations with the Government of Ontario including but not limited to the Ministry of Health (MOH), and the College of Physicians and Surgeons of Ontario (CPSO). Members are advised that the ultimate authority in matters of interpretation and payment of insured services (as well as determination of what constitutes an uninsured service) are in the purview of the government. Members are advised to request updated billing information and interpretations – in writing – by contacting their regional OHIP office.

An entire batch or file may be rejected; consequently, it is recommended that batches be maintained at a manageable size (e.g., batches should not exceed 500 claims and file size should not exceed 10MB). The originator will be advised by receipt of a Claim Batch Edit Report via the Medical Claims Electronic Data Transfer (MC EDT[2]) that the rejected files or batches must be resubmitted. A claim file rejection message is sent with the reason(s) for rejections and once corrected the rejected files or batches must be resubmitted.

(2) Error Report (ER)

Rejected individual claims/items to be corrected by the health care provider will appear on an Error Report with the appropriate error code(s), 3-character alpha/numeric codes. The Claims Error Report is sent to the MC EDT user ID specified by the provider at the time of application. This report lists rejected claims, with the appropriate error codes, for correction. These claims are rejected from the Ministry's system and must be corrected and resubmitted in order to be considered for payment. Please refer to Error Codes or Error Report Message[3] for further detailed explanations.

Claims within a batch will be rejected to the Claims Error Report for any of the following reasons:

- V — Validity Error (applies to HCP/WCB/RMB payment programs)
- A — Assessment Error (applies to HCP/WCB/RMB payment programs)
- E — Eligibility Error (applies to HCP/WCB/RMB payment programs)
- R — Reciprocal Medical Billing (RMB) Specific Errors
- T — Telemedicine Error (applies to HCP payment programs)

Note: HCP is Health Care Payment claims, WCB is Workplace Safety and Insurance Board claims and RMB is Reciprocal Medical Billing claims.

Claims submitted three months after the service date will be rejected to the Claims Error Report with error condition '**VJ7 - Stale dated claim'**. Claims that are stale dated will not be accepted for payment unless there are extenuating circumstances, or the claim has been previously rejected to the Claims Error Report within 3 months of the date of service.

The ministry's process for reviewing stale-dated claims has been updated to allow claims submitted within three months of the date of service that reject to an error report to be corrected and resubmitted after the three-month claims submission timeframe[4]. This process only applies to claims for services rendered on or after April 1, 2023.

In such cases, the provider must submit supporting documentation, including a copy of their error report and claim identifying data, to demonstrate that the original claim was submitted within 3 months.

(3) Remittance Advice (RA)

A Remittance Advice is a monthly statement of approved claims and is issued on or about the 5th working day of the month, prior to receipt of payment. The Remittance Advice file contains accounting details of claims approved during the Ministry's previous claims processing cycle. It will also contain explanatory codes, 2-character alpha/numeric code[5], to clarify payment exceptions.

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[2] MCEDT(https://www.ontario.ca/page/medical-claims-electronic-data-transfer-mcedt)

[3] Error Codes & Error Report Messages (https://www.ontario.ca/document/resources-for-physicians/claims-submission#section-8)

[4] Bulletin 231001 — Update: Three-month submission timeframe for in-province claims (https://www.ontario.ca/document/ohip-infobulletins-2023/bulletin-231001-update-three-month-submission-timeframe-province)

[5] Remittance Advice Explanatory Codes/Messages (https://files.ontario.ca/moh-remittance-advice-explanatory-codes-en-2023-09-01.pdf)

The Remittance Advice may also contain general communication or messages from the Ministry.

Upon review of the RA, should there be any inquiries regarding an overpayment, underpayment or a claim submission that was modified by the Ministry, the inquiry should be submitted to your Ministry claims processing office on a Remittance Advice Inquiry (RAI) (form #0918-84) or via eSubmit. Please refer to the **eSubmit** section for an overview of the application and "***Remittance Advice Inquiry (RAI) Process***" section of this document for additional information.

B: Claims Requiring Documentation

In cases where you are required to submit supporting documentation and/or know you are submitting a complex claim that will likely require supporting documentation (e.g., claim submission involving several fee codes), use your billing software to flag the claim with a manual review indicator or eSubmit. This will notify your OHIP Claims processing office that the claim submission requires special attention.

If you are uncertain whether or not to flag a claim, phone your Claims Services Branch office for assistance, please refer to (E)Resource section for contact information.

If an operative report is necessary the Ministry will make the request on the Error Report using an explanatory code. The claim must be resubmitted.

When faxing documents to the Ministry, ensure that you are faxing it to the appropriate claims processing office and ensure that your billing number is clearly identified on each of the documents. Ideally, supporting documentation should be faxed the same day as the MC EDT submission since it is needed to coordinate with the claim processing. Alternatively, you may use eSubmit or your own EMR's manual review function.

C: Remittance Advice Inquiry (RAI) Process

Inquiries regarding overpayments, underpayments or claim submissions that were modified by the Ministry must be made within **7 months** of the date of the remittance advice (RA) on which the payment appears for any adjustments to payments to occur. Inquiries should be submitted to your Ministry claims processing office on a Remittance Advice Inquiry (RAI)[6] (form #0918-84) to 1-905-434-4186 or via eSubmit. **Do not resubmit the claim, as it will simply get rejected and remain unresolved.**

Claim submissions that were modified by the Ministry will have an associated explanatory code that provides information on why the claim submission payment was modified. If you feel that the claim was not paid appropriately and/or would like additional clarification on the payment, submit a RAI form with additional information and/or request for clarification. Ministry staff will review the inquiry and provide an explanation back on the RAI form by indicating Paid Correctly (P.C.), Adjustment Required (A.R.) or Final Decision (F.D.). If a more detailed Ministry response is required, a letter will be sent to the physician.

[6] INFOBulletin #4658, *Timelines for Inquiry and Dispute of a Claims Payment Decision*, October 5, 2015 (https://collections.ola.org/ser/168629/2015/2015no4658.pdf)

In situations where a physician disagrees with the resulting RAI adjudication of the claim submission, (e.g., disagreement with reasons for not paying and/or adjustment of a claim submission), a subsequent request for reconsideration with new information provided to the Ministry) is reviewed by an Internal Review Committee (IRC); this request must be made within **20 days** of receiving the Ministry's RAI response.

In the situation where a resolution cannot be had through the payment inquiry process, the physician may request a review by the Health Services Appeal and Review Board (HSARB)[7]. The HSARB is an independent quasi-judicial adjudicative tribunal with jurisdiction to decide billing audit disputes between the OHIP GM and physicians. The HSARB and its processes have replaced the Physician Payment Review Board[8] and its processes. At any point in the payment inquiry process, the Ministry can deem its payment decision as final at which point the physician has **30 business days** from receiving OHIP's decision to submit their appeal to the HSARB.

The Board's contact information is:
The Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4
hsarb@ontario.ca
Attention: Registrar

D: eSubmit[9]

eSubmit is a secure electronic channel for submitting documents containing personal health information to the Ministry of Health. Supporting Documentation and Remittance Advice Inquiries can be uploaded to eSubmit through MCEDT.

Use eSubmit to:

- Submit Medical Claims Supporting Documentation (manual review)
- Submit Remittance Advice Inquiries and Responses to Additional Information Requests
- View responses to Additional Information Requests
- View the status of an eSubmit ticket by selecting My Ticket Status on the main menu

Requests for Additional Information and responses to Remittance Advice Inquiries are sent to your MCEDT Communications Download page. This is the same place as you receive Remittance Advices and Error Reports.

[7] HSARB website (https://www.hsarb.on.ca/)
[8] INFOBulletin #4511, *The Physician Payment Review Board becomes Functional*, April 30, 2010 (https://collections.ola.org/ser/168629/2010/2010no4511.pdf)
[9] eSubmit (https://www.ontario.ca/page/esubmit-ready-set-go-secure)

E: Resources

For additional details on the payment inquiry process and the HSARB appeals process please see:

- Resource Manual for Physicians (https://www.ontario.ca/document/resources-for-physicians)
- Claim Submissions (https://www.ontario.ca/document/resources-for-physicians/claims-submission)
- EPC Interpretive Bulletin, Vol. 6. *No. 3, The Revised Medical Audit Process*
- The physician fee-for-service post-payment audit process (https://files.ontario.ca/moh/moh-resources-physicians-physician-ffs-post-pay-audit-process-en-2023-05-12.pdf)

For assistance or have questions, please contact your Claims Services Branch office or the main Service Support Contact Centre:

- Oshawa: 1-855-250-3696 or 905-576-2870
- Toronto: 1-855-645-1282 or 416-314-7770
- Hamilton: 1-888-630-8066 or 905-521-7547
- Service Support Contact Centre: 1-800-262-6524
  - Email: SSContactCentre.MOH@ontario.ca

eSubmit Resources:

- Welcome to eSubmit (https://sway.cloud.microsoft/KZG0u38cbMOi44we)
- eSubmit Technical Specifications for RAI and Supporting Documentation Electronic Submissions (https://www.ontario.ca/files/2024-07/moh-ohip-esubmit-tech-specs-rai-electronic-submissions-en-2024-07-10.pdf)

Summary Points

- Review both your monthly Remittance Advice and Error Reports; some physicians only review their Remittance Advice report and miss important information contained in their Error Report.
- Diligently follow up on all underpaid/overpaid claims; error and explanatory codes help determine the appropriate course of action.
- Send supporting documentation the same day as your claim (MC EDT) submission – this makes it easier for MOH staff to collate all applicable documents.
- If the claim was rejected to the claims error report, or it was not processed by the OHIP medical claims payment system (e.g., due to a submission error), make the appropriate correction(s) to the claim and resubmit.
- If you feel that the claim was not paid appropriately on your RA, submit a Remittance Advice Inquiry (RAI) form with additional information and/or request for clarification. Do not resubmit the claim, it will simply get rejected and remain unresolved.
- Keep copies of your Remittance Advice, if you would like to correct any claims, you have 7 months from the date of the RA to submit an RAI.
- Retain all Error Reports until claims are paid, you have an unlimited amount of time to correct the claims, please use the appropriate submission process.

Document compiled by the OMA's Economics, Policy & Research department
Please forward questions to economics@oma.org