Claims Reconciliation and Remittance Advice Inquiry (RAI) Processes

Quick Reference Guide

Economics, Policy & Research

OMA
ONTARIO MEDICAL ASSOCIATION

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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

A: OHIP Claims Submission Reports

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.

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

[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.

Data Transfer (MC EDT) 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). 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.**

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

- Missing/invalid data as per the field description specified by error code(s) prefixed with "V"
- Ineligible patient/health care provider data (specified by error code(s) prefixed with "E")
- Missing/invalid data as specified in the Schedules of Benefits (specified by error code(s) prefixed with "A")

NOTE: For an exhaustive list of rejects, please refer to the Physicians Resource Manual. Once corrected, these claims may be resubmitted for payment on a subsequent file. Corrected claims must be **resubmitted within six months from the date of service**.

(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 to clarify payment exceptions.

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). Please refer to the "***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. This will notify your OHIP Claims processing office that the claim submission requires special attention.

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.

C: Remittance Advice Inquiry (RAI) Process

Inquiries regarding overpayments, underpayments or claim submissions that were modified by the Ministry must be made within **four 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) (form #0918-84). **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.

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 **four months** 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 Physician Payment Review Board (PPRB). At any point in the payment inquiry process, the Ministry can deem its payment decision as final at which point the physician has 20 business days from the date of receipt of the notification of a final payment decision to submit their appeal to the PPRB.

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

- Resource Manual for Physicians, Sections 3 and 4. (http://www.health.gov.on.ca/english/providers/pub/ohip/physmanual/physmanual_mn.html) Note that the changes to the manual are in process.
- INFOBulletin #4658, *Timelines for Inquiry and Dispute of a Claims Payment Decision*, October 5, 2015 (http://www.health.gov.on.ca/en/pro/programs/ohip/bulletins/4000/bul4658.pdf)
- EPC Interpretive Bulletin, Vol. 6. *No. 3, The Revised Medical Audit Process* (https://www.oma.org/wp-content/uploa ds/0603epc_bulletin.pdf)
- INFOBulletin #4511, *The Physician Payment Review Board becomes Functional*, April 30, 2010 (http://www.health.gov.on.ca/en/pro/programs/ohip/bulletins/4000/bul4511.pdf)
- OMR December 2012 article[2] "*Physician Payment Review Board: mandate, structure, and appeals process*" (https://www.oma.org/sections/member-benefits/practising-physician/ontario-medical-review-omr/)
- PPRB website: www.pprb.on.ca

[2] Available in the OMR online archives

If you require assistance or have questions, please contact the Ministry's Service Support Contact Centre at 1-800-262-6524 or SSContactCentre.MOH@ontario.ca.

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.
- Retain all Error Reports until claims are paid.

Document compiled by the OMA's Economics, Policy & Research department
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