Fundamentals for success
billing Arkansas Medicaid
Fundamentals for success…Professional series

Agenda

- Working with PCPs
- Verifying eligibility
- Learning the aid categories
- Billing methods and tips
PRIMARY CARE PHYSICIANS
PRIMARY CARE PHYSICIAN (PCP)

Beneficiaries

– Arkansas Medicaid operates as a Primary Care Case Management Program. Most beneficiaries are required to have a PCP, and most services require PCP referral.

– Beneficiaries that are not required to enroll with a PCP include:
  - Beneficiaries with Medicare coverage
  - Residents of an Intermediate Care Facility for the Mentally Retarded
  - Residents of Long Term Care facilities
  - Beneficiaries on spend down aid categories
  - Retroactive eligible beneficiaries
PRIMARY CARE PHYSICIAN (PCP)

Main responsibilities

- Provide health education
- Assess medical conditions, initiating and recommending treatment or therapy
- Refer to specialty physicians, hospital care, and other medically necessary services
- Locate needed medical services
- Coordinate prescribed medical and rehabilitation services with other professionals
- Monitor the enrollees’ prescribed medical and rehabilitation services
BENEFICIARIES
Main responsibilities

- Select a PCP (most beneficiaries)
- Report changes in income or circumstances
- Report TPL
VERIFY ELIGIBILITY
VERIFYING ELIGIBILITY
Provider's responsibility

– Although you may search eligibility for past dates, AR Medicaid will only accept proof of verifying eligibility if it was checked on the date of service.

– Scenario:

  • Recipient comes in office at 8:00 a.m. Your office verifies eligibility at time of visit, and eligibility shows active.
  • At 3:00 p.m DHS terminates the coverage
  • If you file your claim after 3:00 p.m it will deny for no coverage.
  • AR Medicaid will process your claim only if you can provide proof of checking eligibility on the date of service. If you checked eligibility the day before/or after, it will not be accepted as proof of verifying eligibility.
VERIFY ELIGIBILITY USING THE PORTAL

Welcome to Arkansas Medicaid - Windows Internet Explorer provided by HP - Arkansas Title XIX
https://www.medicaid.state.ar.us/InternetSolution/Provider/myInformation.aspx

Home | General | Provider | Consumer | Research | Site map | Provider training

My information
My information is a collection of tools tailored to meet your needs. Navigate this section using the links on the left.

Welcome back
NEW PCP NOT REQUIRED

Call HP Enterprise Services provider support
(800) 457-4454 In-state toll-free
(501) 376-2211 Local and out-of-state
(855) 661-7830 (BreastCare)

Contact your representative

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VERIFY ELIGIBILITY

270 Eligibility request on Internet

By logging into the Provider Portal, providers can check eligibility on the Internet.

Who is submitting the request
VERIFY ELIGIBILITY

270 Eligibility request on the Internet

**Beneficiary ID or SSN and DOB, Name and DOB, or Name and SSN is required**

**Verification dates**
ELIGIBILITY RESPONSE

Health Care Eligibility Benefit Inquiry

Menu Items
- Dental
- Institutional
- Professional
- Claim Status Request

Supplemental eligibility information

Interchange Control Header

Transaction Set Header
- Submitter Transaction Identifier: Internet Web Site
- Date: 20100728
- Time: 103144

Information Source Name
- Last Or Organization Name: Arkansas Medicaid
- Identification Code: 716007869

Information Receiver Name
- Last Or Organization Name: DRS OFFICE
- NPI: #####010
# ELIGIBILITY RESPONSE

**Subscriber Trace Number**
- Authorization Number: 102094075122

**Subscriber Name**
- Last Name: DOE
- First Name: JOHN
- Middle Name: 
- Medicaid Recipient Identification Number: 292

**Subscriber City/State/Zip Code**
- County/Parish: 501 (Nevada)

**Subscriber Demographic Information**
- Birth Date: 19980803
- Gender Code: Male

**Subscriber Eligibility or Benefit Information**
- Eligibility or Benefit Information: 1 (Active Coverage)
- Coverage Level Code: IND (Individual)
- Service Type Code: 30 (Health Benefit Plan Coverage)
- Insurance Type Code: MC (Medicaid)
- Plan Coverage Description: 56 (U-18-EC)
- Date Time Period: 19950101-20100728

- Eligibility or Benefit Information: L (Primary Care Provider)
- Coverage Level Code: IND (Individual)
- Service Type Code: 30 (Health Benefit Plan Coverage)
- Insurance Type Code: MC (Medicaid)
- Date Time Period: 20010106-20100723
- Last Or Organization Name: DOE
- First Name: JANE
- Name Suffix: MD
- Communication Number: 5012345678
## ELIGIBILITY RESPONSE

<table>
<thead>
<tr>
<th>Eligibility or Benefit Information</th>
<th>Coverage Level Code</th>
<th>Service Type Code</th>
<th>Insurance Type Code</th>
<th>Monetary Amount Used</th>
<th>Lab benefits used</th>
<th>$500 annual benefit limit</th>
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</thead>
<tbody>
<tr>
<td>D (Benefit Description)</td>
<td>IND (Individual)</td>
<td>5 (Diagnostic Lab)</td>
<td>MC (Medicaid)</td>
<td>$0.00</td>
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<table>
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<th>Eligibility or Benefit Information</th>
<th>Coverage Level Code</th>
<th>Service Type Code</th>
<th>Insurance Type Code</th>
<th>Quantity Used</th>
<th>Prescription drug benefits used</th>
<th>Limit 3 prescriptions per month</th>
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<tr>
<td>D (Benefit Description)</td>
<td>IND (Individual)</td>
<td>88 (Pharmacy)</td>
<td>MC (Medicaid)</td>
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<th>Eligibility or Benefit Information</th>
<th>Coverage Level Code</th>
<th>Service Type Code</th>
<th>Insurance Type Code</th>
<th>Quantity Used</th>
<th>Physician Outpatient visit benefit limits</th>
<th>Limit of 12 per SFY</th>
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<tbody>
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<td>D (Benefit Description)</td>
<td>IND (Individual)</td>
<td>A0 (Professional (Physician) Visit - Outpatient)</td>
<td>MC (Medicaid)</td>
<td>00</td>
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<td></td>
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</table>

<table>
<thead>
<tr>
<th>Eligibility or Benefit Information</th>
<th>Coverage Level Code</th>
<th>Service Type Code</th>
<th>Insurance Type Code</th>
<th>Quantity Used</th>
<th>Physician Office visits benefit limit</th>
<th>Limit of 12 per SFY</th>
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<tbody>
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<td>IND (Individual)</td>
<td>98 (Professional (Physician) Visit - Office)</td>
<td>MC (Medicaid)</td>
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<td>Eligibility or Benefit Information</td>
<td>Coverage Level Code</td>
<td>Service Type Code</td>
<td>Insurance Type Code</td>
<td>Days</td>
<td>Visits</td>
<td>Limitation</td>
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<td>IND (Individual)</td>
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<td>Inpatient hospital benefits</td>
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<td>IND (Individual)</td>
<td>3 (Consultation)</td>
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<td>Limit 24 days per SFY</td>
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<td>D (Benefit Description)</td>
<td>IND (Individual)</td>
<td>34 (Chiropractic Office Visits)</td>
<td>MC (Medicaid)</td>
<td>00</td>
<td></td>
<td>Limit 2 per SFY, one perphysician</td>
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<td>IND (Individual)</td>
<td>AL (Vision)</td>
<td>MC (Medicaid)</td>
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<tr>
<td>D (Benefit Description)</td>
<td>IND (Individual)</td>
<td>AO (Lenses)</td>
<td>MC (Medicaid)</td>
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<td>Vision exam benefits</td>
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<tr>
<td>D (Benefit Description)</td>
<td>IND (Individual)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Vision equipment benefits</td>
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<tr>
<td>Date Time Period</td>
<td>000000000</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Last used date – once per 12 months</td>
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<tr>
<td>Date Time Period</td>
<td>000000000</td>
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<td></td>
<td></td>
<td></td>
<td>Last exam date – once per 12 months</td>
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<tr>
<td>Eligibility or Benefit Information</td>
<td>Coverage Level Code</td>
<td>Service Type Code</td>
<td>Plan Coverage Description</td>
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<td>F (Limitations)</td>
<td>IND (Individual)</td>
<td>30 (Health Benefit Plan Coverage)</td>
<td>W1 (Alternative Community Service)</td>
<td>20030401-20100728</td>
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<td>Eligibility or Benefit Information</td>
<td>Coverage Level Code</td>
<td>Service Type Code</td>
<td>Insurance Type Code</td>
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<td>D (Benefit Description)</td>
<td>IND (Individual)</td>
<td>35 (Dental Care (Adult Dental))</td>
<td>MC (Medicaid)</td>
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<tr>
<td>Limit $500 per SFY, excluding extractions</td>
<td></td>
<td></td>
<td></td>
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**ACS benefits**

**Eligible dates**

**Adult dental benefits**

**Orthodontic benefits**

**Orthodontics date**
SUPPLEMENTAL ELIGIBILITY RESPONSE

- Up to four beneficiary eligibility segments with matching beneficiary IDs
- EPSDT screening information
- Medicare A and B effective dates
SUPPLEMENTAL ELIGIBILITY RESPONSE
SUPPLEMENTAL ELIGIBILITY RESPONSE

<table>
<thead>
<tr>
<th>Medicare Buyin</th>
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<tr>
<td>Part A:</td>
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<tr>
<td>Part B:</td>
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<table>
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<tr>
<th>ARKIDS B Screenings</th>
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<tr>
<td>Medical:</td>
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<tr>
<td>Dental:</td>
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<table>
<thead>
<tr>
<th>Dental</th>
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</thead>
<tbody>
<tr>
<td>Panoramic/Full mouth X-ray:</td>
<td>00/00/0000</td>
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<tr>
<td>BiteWings:</td>
<td>00/00/0000</td>
</tr>
<tr>
<td>Prophylaxix/Flouride:</td>
<td>00/00/0000</td>
</tr>
<tr>
<td>Sealant - Tooth 2:</td>
<td>00/00/0000</td>
</tr>
<tr>
<td>Sealant - Tooth 3:</td>
<td>00/00/0000</td>
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<tr>
<td>Sealant - Tooth 14:</td>
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<td>Sealant - Tooth 15:</td>
<td>00/00/0000</td>
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<tr>
<td>Sealant - Tooth 18:</td>
<td>00/00/0000</td>
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<tr>
<td>Sealant - Tooth 19:</td>
<td>00/00/0000</td>
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<tr>
<td>Sealant - Tooth 30:</td>
<td>00/00/0000</td>
</tr>
<tr>
<td>Sealant - Tooth 31:</td>
<td>00/00/0000</td>
</tr>
</tbody>
</table>
VOICE RESPONSE

Providers can verify a beneficiary’s eligibility by calling the automated Voice Response System (VRS). By dialing the Provider Assistance Center line and selecting option 3, the VRS will retrieve recipient Medicaid eligibility, PCP and other information based on the beneficiary ID or date of birth and SSN and dates of service requested.

Toll-free in Arkansas: 800.457.4454
Local or out of state: 501.376.2211
RESTRICTED AID CATEGORIES
PLAN DESCRIPTIONS

Overview

All Medicaid beneficiaries are assigned to a plan description with corresponding levels of coverage. These are listed in Section I of the Arkansas Medicaid provider manuals.

See Section I manual – 124.000
PLAN DESCRIPTIONS
General classifications

- FR - Full benefits
- MNLB – Medically needy, limited benefits
- AC - Additional cost sharing
- LB - Limited benefits
PLAN DESCRIPTION 01
ARKids First B

- Beneficiaries may have limited services
- Beneficiaries may have co-payment requirements
- ARKids First B beneficiaries have a co-pay cap. Co-pay cap is 5%, based on the family’s total gross income
PLAN DESCRIPTION 03
Children’s Medical Services

- Services must be prior-authorized
- This is a non-Medicaid category
PLAN DESCRIPTION 04
Developmental Disability Services

- This is a non-Medicaid category
- DDS non-Medicaid beneficiary ID numbers begin with 8888
- DDS non-Medicaid provider ID numbers end with 86
- Only DDS non-Medicaid providers may bill for DDS non-Medicaid beneficiaries
PLAN DESCRIPTION *6
Medically Needy Exceptional

These beneficiaries are eligible for the full range of Medicaid services except:

- Nursing Facility
- Personal Care
PLAN DESCRIPTION *7

Spend down

- Beneficiaries must pay toward medical expenses when income and resources exceed the Medicaid financial guidelines.

- Exception: Plan Description 07 BCC (Breast and Cervical Cancer) has full benefits.
Beneficiary coverage includes drugs, physician services, outpatient services, rural health clinic encounters, Federally Qualified Health Center (FQHC), and clinic visits for TB related services only.
PLAN DESCRIPTION *8
Qualified Medicare Beneficiary

- For QMB beneficiaries, Medicaid pays Medicare premiums, coinsurance, and deductible.

- If the service provided is not a Medicare-covered service, then Medicaid will not pay for the service under the QMB policy.

- 8S – ARSeniors has full benefits.
PLAN DESCRIPTION 61
Pregnant Women Infants and children poverty level (PW-PL)

- Includes both pregnant women and children. Providers must use the last three (3) digits of the Medicaid ID number to determine benefits. When the last three digits are:
  - **100 series** (101, 102, etc.) the beneficiary is eligible as an adult for pregnancy-related services only;
  - **200 series** (201, 202, etc.) the beneficiary is eligible as a child and receives a full range of Medicaid services.

- A pregnant teen may be eligible either as a child or as an adult. The last three digits of her ID number determine the services for which she is eligible.

- If the plan description is “PW unborn ch-noster/FP cov” then there is no sterilization or family planning benefit.
PLAN DESCRIPTION 62
Pregnant Woman Presumptive eligibility (PW-PE)

This is a temporary plan description that pays ambulatory, prenatal care services only. Delivery and hospitalization are not covered in this category.
PLAN DESCRIPTION 69
Family planning waiver (FPW)

- Medicaid pays for family planning preventative services only, such as birth control, counseling, etc.

- A claim for a beneficiary in this category must contain both a family planning diagnosis code and a family planning procedure code.
PLAN DESCRIPTION 58, 78, 88

Specified low income Medicare beneficiary (SLIMB, SMB)

- Beneficiaries are not eligible for any Medicaid services.
- Medicaid pays only their Medicare premium.
SUBMITTING CLAIMS
WAYS TO SUBMIT CLAIMS

- Paper
- Direct Data Entry (Professional Claims only)
- Provider Electronic Solutions
- Vendor Software
CLAIM STATUS
CLAIM STATUS
Claims adjudication cycle

- Electronic claims are typically adjudicated on the next remittance advice.
- Paper claims that could have been sent electronically typically adjudicate 30-45 days after submission.
- Claims that must be sent on paper typically adjudicate 2-3 weeks after submission.
CLAIM STATUS
Five ways to check claim status

- Verify claims on the remittance advice
- PES software
- Arkansas Medicaid website
- VRS
- Provider Assistance Center 800.457.4454 or 501.376.2211
BILLING TIPS
BILLING TIPS

- Steps to get your “MC” number:
  
  Open PES software

  Select “Tools”

  Select “Options”

  Select “Batch” tab

  Print

- Claims denying/rejecting for the lack of “FP” modifier when it is a sterilization claim. The “FP” modifier is used for other AID categories other than 69. If you are using Diagnosis Code V25.2, use the “FP” modifier.

- Claims denying/rejecting for the lack of a prior authorization code or someone had a CLIA code in the “PA” Box.
BILLING TIPS


- Check eligibility, including supplemental eligibility, and the DATE OF SERVICE. Not before or after....

- Assigning or changing a PCP - Connect Care 800.275.1131
  http://www.seeyourdoc.org/connect/search/select.php

- The State will not allow an HP associate to tell you what code to bill with; we are not licensed coders. Providers must get their procedure and diagnosis codes from the following: ICD-9, CPT code book, or the Arkansas Medicaid Manual.
BILLING TIPS

- A "True" ER does not need a PCP referral. However, if it is not a "True" ER and the PCP doesn’t give a referral, Medicaid will not pay for the visit. If the patient is told it is not a payable service by Medicaid, and it would be "self" paid visit, you can charge the patient if the patient elects to have the service preformed.

- Can you bill the patient for a co-pay? This is at the State for review. Continue to follow your office policy until further notice from the State.

- You should be at PES 2.11

- You can check claim status on PES.

- It’s easier and faster to check eligibility on the Medicaid website. Please print out the Eligibility and the supplemental eligibility.

- Extension of benefits- Section 220.000
# BILLING TIPS – MOST COMMON BILLING ERRORS

<table>
<thead>
<tr>
<th>EOB Code</th>
<th>Error</th>
<th>Method of correction</th>
</tr>
</thead>
<tbody>
<tr>
<td>254, 263 and 267</td>
<td>Recipient is partially or totally ineligible for the DOS.</td>
<td>Verify the recipient is eligible for all claim dates of service. Resubmit the claim/portion of the claim for the time of eligibility.</td>
</tr>
<tr>
<td>282 and 284</td>
<td>Recipient has Medicare coverage.</td>
<td>Bill Medicare first. Submit crossover claim to Medicaid after Medicare adjudication.</td>
</tr>
<tr>
<td>208</td>
<td>Recipient aid category 69 is limited to family planning services only.</td>
<td>Verify that the original claim has a family planning diagnosis, procedure code. Correct and resubmit the claim.</td>
</tr>
<tr>
<td>252</td>
<td>Medicaid ID number submitted does not match patient’s name on Medicaid ID card.</td>
<td>Verify eligibility through Medicaid’s electronic eligibility system and resubmit the claim with correct information.</td>
</tr>
</tbody>
</table>
# BILLING TIPS

## Most common billing errors

<table>
<thead>
<tr>
<th>EOB Code</th>
<th>Error</th>
<th>Method of correction</th>
</tr>
</thead>
<tbody>
<tr>
<td>792 or 900</td>
<td>Ten days post-op care is included in the payment for the surgical procedure. Pricing of this procedure includes services. A related service has been paid preventing payment of this code.</td>
<td>Post-op care claims filed after surgery will deny correctly with EOB 792. No additional payment is made. An adjustment must be filed to bill the surgery if post-op care is paid before the procedure is billed.</td>
</tr>
<tr>
<td>900 venipuncture</td>
<td>Pricing of this procedure includes related services. A related service has been paid preventing payment of this code.</td>
<td>Venipuncture is included in lab work when performed on the same DOS by the same provider. An adjustment must be filed to bill for lab work if venipuncture has been paid.</td>
</tr>
<tr>
<td>469 or 470</td>
<td>Duplicate billing. Claim is identical to another claim for DOS, performing provider, procedure, TOS, and price.</td>
<td>Verify that the service is not a duplicate bill. Resubmit the corrected claim</td>
</tr>
</tbody>
</table>
## BILLING TIPS

Most common billing errors

<table>
<thead>
<tr>
<th>EOB Code</th>
<th>Error</th>
<th>Method of Correction</th>
</tr>
</thead>
<tbody>
<tr>
<td>103 and 009</td>
<td>Claim does not meet the timely filing requirements for Medicaid.</td>
<td>Claims must be received by HP Enterprise Services within 12 months from the “from” DOS. Claims received beyond this deadline will not be paid. Claims for global services (i.e. claims for prenatal, delivery, and antepartum care) must be received 12 months from the date of delivery.</td>
</tr>
<tr>
<td>952</td>
<td>Service requires Primary Care Physician referral.</td>
<td>Resubmit the claim with the corrected PCP information required for adjudication.</td>
</tr>
<tr>
<td>041 and 152</td>
<td>Procedure code, revenue code, modifier is invalid.</td>
<td>Verify the procedure code and/or modifier in section II of the appropriate provider manual and resubmit the claim.</td>
</tr>
</tbody>
</table>
BILLING TIPS

The adjustment claim form EDS-AR-004 is used to adjust or void claims that have been PAID to the provider.

When Medicare denies a claim for lack of medical necessity with denial codes CO-50 or PR-50, Medicaid will not make a payment. Details are found in Provider Enrollment Contract in Section G.
BILLING TIPS-TIMELY FILING

The Code of Federal Regulations (42 CFR), at 447.45 (d) (1), states “The Medicaid agency must require providers to submit all claims no later than 12 months from the date of service.” The 12-month filing deadline applies to all claims, including:

Claims for services provided to recipients with joint Medicare/Medicaid eligibility.

Adjustment requests and resubmissions of claims previously considered.

Claims for services provided to individuals who acquire Medicaid eligibility retroactively.

Section 302.000
BILLING TIPS AND TIMELY FILING

The exceptions to the 12 month timely filing rule are:

If the beneficiary has Medicare, the Medicare claim will establish timely filing for Medicaid, if the provider files with Medicare during the 12 months Medicaid filing deadline.

If Medicare pays after 12 month timely filing, federal regulations permit Medicaid to pay it’s portion of the claim within 6 months after the Medicaid “agency or the provider receives notice of the disposition of the Medicare claim”.

Sometimes a clean claim pays incorrectly or denies incorrectly. a provider files an adjustment request for such a claim, or re-files the claim after 12 months have passed from the beginning date of service, the submission is not necessarily a new claim. The adjustment or claim may be within the filing deadline. For Medicaid to consider that the submission is not a new claim and therefore within the filing deadline, the adjustment or claim must meet two requirements.
BILLING TIPS AND TIMELY FILING

Sometimes beneficiaries will come in with no Medicaid coverage, but is in the process of getting Medicaid. Medicaid timely filing is nearing and the recipient still does not have Medicaid. In this instance, providers are allowed to bill with a pseudo number (9999999999) on a clean claim. At the point when the beneficiary is eligible for Medicaid, the provider has 365 days after the authorization date to re-submit a clean claim after filing a pseudo claim.

This issue on timely filing is found in **Section 302.000** of your provider manual.
BILLING TIPS

Condition codes

*Inpatient paper claims must not use new condition codes 80, 81, or 82. Continue to use condition codes AB, AN, or AX.

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<thead>
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<th>Old/paper*</th>
<th>Electronic</th>
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<tbody>
<tr>
<td>80 (EPSDT)</td>
<td>A1</td>
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<tr>
<td>AB</td>
<td>80</td>
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<tr>
<td>AN</td>
<td>81</td>
</tr>
<tr>
<td>AX</td>
<td>82</td>
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<td>Emergency (101)</td>
<td>88</td>
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<tr>
<td>38</td>
<td>38</td>
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<tr>
<td>39</td>
<td>39</td>
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</tbody>
</table>
BILLING TIPS
Remittance and status report

Check your remittance and status report (RA) each week for:

- Paid claims
- Pending claims
- Denied claims
QUESTIONS?