Remittance and Status (R&S) Reports for LTC Providers

A Quick Reference Guide

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Providers should always refer to the TMHP website for current and authoritative information.

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General Information

Remittance and Status (R&S) Reports list all claims that were submitted and processed in a reporting period. R&S Reports are generated twice weekly and are available every Saturday and Wednesday. R&S Reports generated on Saturday cover claims submitted the previous week between Tuesday (after close of business) and close of business on Friday. R&S Reports generated on Wednesday cover claims submitted between the previous Friday (after close of business) and close of business on Tuesday of the current week. In addition to the new claims that are submitted during the R&S reporting period, other claims that are finalized during the reporting period or that are still pending from the past period are also reported. Any system adjustments and recoupment claims are also included in the R&S Report.

Accessing and Viewing Your R&S Report

There are three different ways to access the R&S Report:

- **PDF** – Portable Document Format (PDF) is the most commonly used method to download R&S Reports. Multiple users from the same provider account can access the report through TexMedConnect on tmhp.com. Information is divided into three sections: Non-Pending Claims, Pending Claims, and Financial Summary. Reports remain available for 90 days after posting. After 90 days, reports are automatically removed from the website and are no longer available to the user.
- **ANSI 835 Format** – The Electronic Data Interchange (EDI) 835 is a Health Insurance Portability and Accountability Act (HIPAA)-compliant Electronic Remittance and Status (ER&S) Report that can be accessed by providers who submit claims electronically, often through third-party software. This report format shows only non-pending and finalized claims. Providers can download the 835 report from the FTP server up to 30 days after the report is posted. After a provider downloads the 835 report, it is no longer available for other users. Previously downloaded reports can be recovered by calling the TMHP EDI Help Desk at 888-863-3638, option 4**.** Providers can also contact the EDI Help Desk to get credentials to access the FTP server.
- **Claims Data Export** – Claims Data Export is a customized user search that allows providers to request up to three months of claims data (at one time) for the previous three years. Results are returned to the provider in a user-friendly Microsoft® Excel file. The data results are similar to the data in the PDF R&S Report format. The Claims Data Export format is primarily used to provide specific claims data for a National Provider Identifier (NPI), Atypical Provider Identifiers (API), or Provider Number. Only a TexMedConnect account administrator who has a submitter ID and password can access this option.

R&S Report Components

- **Title Page** – The title page contains provider information such as name and address, R&S Report number, report sequence number, report period dates, NPI, API and Provider numbers.
- **Non-Pending Claims** – These are the finalized claims for the reporting cycle. Claim statuses include:

- ***Paid (P)*** – Paid claims are those in which a pay warrant has been issued and financial reconciliation at TMHP has occurred.
- ***Denied (D)*** – Claims that have been denied due to one or more business edits and will not pay.
- ***Paid Transferred (PT)*** – Transferred claims that have been paid are updated to the status ***Paid Transferred*** by the Health and Human Services Commission (HHSC). Only PT claims with **balanced** warrants will be reported under the Non-Pending Claims section of the R&S Report.
  - Transferred (T) claims for positive amounts are paid through the Comptroller's miscellaneous claims process. When payment is issued, HHSC updates the warrant information in the Claims Management System, and the claims are marked as ***PT***.
  - Transferred claims for negative amounts represent recoupments owed to HHSC. Negative Transferred claims may be resolved by deducting funds from a provider's payment or by receiving a check from the provider. After negative Transferred claims are paid, HHSC updates the warrant information in the Claims Management System, and the claims are marked as ***PT***.
- ***Paid Force Transfer (PF)*** – After a Force Transfer (FT) claim is paid by check or deduction, or is offset by a corrected claim, the claim is marked as ***PF.*** Only PF claims with **balanced** warrants will be reported under the Non-Pending Claims section of the R&S Report.
- ***Paid Zero (PZ)*** – If the net payment to the provider for a given reporting period is $0, all claims for that payment are marked as ***PZ***. This can happen when money is being recouped from a provider through a deduction.

- **Pending Claims** – These claims are still in the system and have not been finalized. Claims will be in one of the following statuses:
  - ***Approved to Pay (A)*** – The claims have passed all system edits and are approved for payment, but a pay warrant has not yet been issued.
  - ***Force Transfer (FT)*** – HHSC staff have the ability to force transfer negative A claims. This prevents the negative A claims from counting against new provider billing. HHSC may use this process to apply a provider check (if received for a negative A status balance) or correct errors such as an inaccurate rate change.
  - ***Paid Force Transfer (PF)*** – After a FT claim is paid by check or deduction, or offset by a corrected claim, the claim is marked as PF. PF claims with **unbalanced** warrants will be reported under the Pending Claims section of the R&S Report.
  - ***Transferred (T)*** – Also known as miscellaneous claims, these claims have service dates that precede the two fiscal years before the current state fiscal year and are not processed through the standard claims payment process. Contact HHSC Provider Recoupments and Holds at 512-438-2200, option 3, to make payment arrangements for T claim balances.
    - T claims **that add up to an overall positive amount** are paid through the Comptroller's miscellaneous claims process. Amounts over $50,000 or for services more than eight years old require state legislative approval for payment. These claims can remain in ***Pending*** status for several months before moving to a final status.

    - T claims for negative amounts represent recoupments owed to HHSC. T claims **that add up to an overall negative amount** may be resolved by deducting funds from a provider's payment or by receiving a check from the provider.
  - ***Paid Transferred (PT)*** – Transferred claims which have been paid are updated to the status ***Paid Transferred*** by HHSC. PT claims with **unbalanced** warrants will be reported under the Pending Claims section of the R&S Report.
  - ***Suspended (S)*** – These claims have had processing suspended. The most common reason that a claim is suspended is a vendor hold. After HHSC releases the vendor hold, the claims will process.
  - ***In Process (I)*** – An I claim has been submitted, but has not yet passed all system edits. This is a transitional status only; and it is rare to see a claim in this status.
- **Financial Summary** – This section provides warrant information and amounts for the reporting period. The warrant number reported on claims that are in the Non-Pending Claims section allows the provider to reconcile claims submitted against payments received. If the warrant amount on the Financial Summary page is less than the total amount of the ***P*** status claims on the Non-Pending R&S Report, or if a warrant amount was not received but there are claims on the Non-Pending R&S Report in the status ***PZ***, a deduction may have been applied by HHSC. Check for correspondence concerning the deduction from HHSC Provider Recoupments and Holds, or call them at 512-438-2200, option 3.
- **Explanation of Benefits (EOB) Codes and Descriptions** – The EOB code and description is a numerical codes and a brief description of the reason or reasons a claim has not been paid.

More Information

Providers can find additional details about R&S Reports by accessing these resources:

- TMHP Learning Management System (LMS): Registered LMS users can access the computer-based training (CBT) **TexMedConnect for Long-Term Care Providers** and *The Long-Term Care (LTC) User Guide for TexMedConnect* on learn.tmhp.com.
- TMHP Contact Center: Call 800-626-4117, option 1, for assistance with your R&S Report.
- HHSC Provider Recoupments and Holds: Call 512-438-2200, option 3 for assistance on adjusted claims and to obtain the current outstanding balance, or to facilitate payment by provider check or deduction from an associated contract.

Important: Stay Current and Reconcile

After a claim has been finalized, the claim is reported only once in the Non-Pending section of the R&S Report, so we recommend that providers download and reconcile their R&S Reports on a weekly basis. Making this process a part of your regular routine will allow you to know the status of your claims at any given time.

The R&S Report is a valuable tool for tracking billing activities. Providers that do not reconcile their R&S Reports may be billing incorrectly, which can result in audits and penalties. It is the provider's responsibility to ensure that all billing is accurate, and that any problems or issues associated with the claim are resolved within the 12-month filing limitation. Providers are responsible for reviewing their R&S Reports, resolving negative ***Transferred*** claim balances, and monitoring negative ***Approved to Pay*** claims to ensure they are offset by future billing. Negative ***Transferred*** and ***Approved To Pay*** claim balances represent funds owed to HHSC, and providers have a responsibility to make arrangements to resolve these balances.