



Electronic remittance advice

A toolkit to make the ERA work for you



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Visit www.ama-assn.org/go/era to access related materials



Getting started with electronic remittance advice

Introduction

Automating the revenue cycle process with standard electronic transactions can save your practice both time and money. Your practice may already submit electronic eligibility requests or claims to health plans. If so, you've already experienced the many benefits of moving from paper to electronic processes.

Electing to receive remittance advice electronically instead of by mail offers another opportunity for your practice to leverage the power of electronic health care transactions. By adopting electronic remittance advice (ERA), you can replace stacks of paper remittance statements with a streamlined, efficient payment reconciliation process. Read on to find out everything you need to know to implement ERA in your practice.

ERA basics

An ERA is an electronic version of a paper explanation of payment or explanation of benefits (EOB). Like a paper EOB, an ERA provides details about claims payments from health plans. For each claim that your practice submits, the ERA will detail the amount billed, the amount being paid by the health plan and the reasons for any differences between the billed and paid amounts. The ERA can also detail recoupments related to claim readjudication or adjustments unrelated to a particular claim, such as interest or capitation payments.

The Health Insurance Portability and Accountability Act (HIPAA) mandated the Accredited Standards Committee (ASC) X12N Health Care Claim Payment/Advice (835) transaction as the standard electronic transaction to be used by health plans in communicating claims payment information to providers. All health plans are required to offer ERA using the 835 standard transaction upon provider request.

Advantages to ERA

Physician practices that take advantage of the ERA mandate can benefit in a variety of ways:

- *Increased practice automation:* Practice management software systems (PMSs) offer uniform ERA processing that posts payments and all standard adjustment reason codes to the patient's account. This reduces the administrative burden associated with manual payment posting.
- *Reduced manual tasks:* The ERA eliminates the need to handle paper, open mail and file papers, as well as the risk of misplaced EOBs.

- *Easier coordination of benefits (COB) processing:* ERA adoption and implementation facilitates standardized and automated secondary claims reporting. The HIPAA standard electronic claim (837) transaction allows for reporting of the previous payer's payment and adjustments in a standard fashion from the ERA, omitting the need for additional administrative tasks such as manually scanning, copying or attaching a paper EOB with the paper secondary claim.
- *Faster payment:* Overall, payers reimburse more quickly when physicians use the ERA to facilitate their claims revenue process.
- *Opportunity for higher-value work:* Automated posting frees up staff time to handle higher-value and more impactful claims revenue cycle functions such as denial management or appeals.
- *Increased standardization:* Health plans are required to use standardized code sets in the HIPAA-standard ERA instead of proprietary payer remittance codes. This improved consistency in payment information facilitates a standardized denial management process, comparisons between payers and identification of practice claim submission issues.
- *Synergy with electronic payment:* Implementing both the ERA and HIPAA-standard electronic funds transfer (EFT) allows even greater savings and practice efficiency. For more information about using ERA and EFT together, see "Maximizing practice automation with electronic remittance and payment" in the AMA's [ERA processing tips](#).

All of these efficiencies translate into cost savings for a physician practice. More importantly, fewer manual processes free up staff time for patient care and support.

ERA anatomy

The manner in which ERA information is presented to the user is determined by a practice's PMS vendor. Every vendor's ERA display will have a different look and feel, but all share the same basic underlying structure and data elements. Some vendors also supply a view of the ERA using the Medicare paper EOB format, although this is not a requirement.

ERA levels and segments

Just like a paper form, the ERA is divided into various sections. ERAs contain three levels of data: the header, the detail and the trailer. Each ERA level contains data records known as segments, which in turn house the detailed ERA data elements. The following table outlines the overall organizational structure of an ERA.

Table: ERA organization

Level	Segment	Date Elements
Header	TRN	<ul style="list-style-type: none"> Trace number (check or EFT number) Payer Tax ID (for match with a 1099 form)
	BPR	<ul style="list-style-type: none"> Total payment amount Payment method Payment date EFT bank account information
	N1	<ul style="list-style-type: none"> Payer Name Payer ID Provider/Payee Name Provider/Payee ID (National Provider Identifier [NPI])
	REF	<ul style="list-style-type: none"> Payee Tax ID
	PER	<ul style="list-style-type: none"> Payer health care policy website
Detail	CLP	<ul style="list-style-type: none"> Claim/account number Status of the claim Submitted charge Claim payment Total patient responsibility amount
	NM1	<ul style="list-style-type: none"> Patient Name and ID Subscriber Name and ID Rendering Provider Name and ID (NPI) Corrected Priority Payer Name and ID Crossover Payer Name and ID (when the claim was sent to another payer by this payer)
	SVC	<ul style="list-style-type: none"> Adjudicated and submitted procedure codes Paid and submitted units of service Service paid amount
	CAS	<ul style="list-style-type: none"> Reduction and denial reasons (CARCs; see <i>ERA Codes</i> on next page) and amounts
	LX	<ul style="list-style-type: none"> Support information (RARCs; see <i>ERA Codes</i> on next page)
	AMT	<ul style="list-style-type: none"> Allowed amount
Trailer	PLB	<ul style="list-style-type: none"> Capitation payments IRS levy Overpayment recovery Forwarding balance

ERA codes

Overview

The ERA uses standardized codes to express everything from the status of a claim to messages about reductions or increases in payment. This allows practice staff to review an ERA from any payer and understand the message without needing to look up the meaning of each payer's proprietary codes. It also enables a vendor to program the PMS to automate ERA processing across payers.

ERA codes provide critical information about a claim's adjudication that the practice staff needs to understand when making decisions and performing follow-up. Critical codes for the ERA include:

- **Claim adjustment group codes (CAGCs)** – Codes that identify the responsibility for a reduction or increased amount and suggest what action should be taken by the practice, in the opinion of the health plan. For example, the CAGC identifies when an amount is the patient's responsibility or when it is a contractual obligation that should be written off by the practice.
- **Claim adjustment reason codes (CARCs)** – Codes that identify the reason for a reduction or increase in payment from the original submitted charges.
- **Remittance advice remark codes (RARCs)** – Codes that provide additional details about a reduction or increase to enhance information from CARCs. For instance, when a claim is denied as requiring additional information through a CARC, a RARC will identify what information is needed to further consider the claim or service. RARCs can also supply miscellaneous information or unrelated messages about the claim or service (e.g., appeal rights).

ERA code references and resources

Most PMS vendors include CARC and RARC descriptions in their ERA displays. If your vendor does not offer this capability, or if the codes are not regularly updated, the code lists can be accessed on the [Washington Publishing Company website](#).

Another helpful resource in interpreting CARCs and RARCs and managing claims denials is the AMA's [Claims Workflow Assistant](#). This tool provides look-up capabilities for CAGCs, CARCs and RARCs, as well as offers recommended workflows for different denial messages.

ERA code standardization

HIPAA mandates the use of standard codes to provide claims adjudication information to physician practices. Health plans are responsible for converting their internal proprietary codes into the standard codes in a way that continues to convey the original meaning.

Operating rules created by the Center for the Advancement of Quality Health Care Committee on Operating Rules for Information Exchange (CAQH CORE) support additional ERA standardization. The [Phase III CORE 360 Uniform Use of Claim Adjustment Reason Codes and Remittance Advice Remark Codes \(835\) Rule](#) standardizes the usage for CAGCs, CARCs and RARCs. Specifically, the rule establishes claim reduction or denial business scenarios and lists the codes payers must use to report denials or adjustments within each scenario. There are currently four business scenarios:

- **Scenario #1: Additional Information Required – Missing/Invalid/Incomplete Documentation** – Refers to situations where additional documentation is needed from the billing provider or an ERA from a prior payer.
- **Scenario #2: Missing/Invalid/Incomplete Data from Submitted Claim** – Refers to situations where additional data are needed from the billing provider for missing or invalid data on the submitted claim.
- **Scenario #3: Billed Service Not Covered by Health Plan** – Refers to situations where the billed service is not covered by the health plan, such as when the patient's benefits do not cover the billed service or when the payer believes that another payer should be billed first.
- **Scenario #4: Benefit for Billed Service Not Separately Payable** – Refers to situations where the billed service or benefit is not separately payable by the health plan or was paid as part of the payment for another service.

When an adjudicated claim falls within one of those scenarios, payers are required to use codes in the combinations specified by CAQH CORE. CAQH CORE updates the [list of allowable code combinations](#) several times per year. The mandated code combinations bring further uniformity to ERA reporting and facilitate providers' understanding of ERA messages.

ERA sample displays

The appearance of ERAs varies depending on a practice's PMS. Each PMS vendor uses their own proprietary screens to display ERA information to physicians and their staff. Ideally, the PMS processes the ERA, and most of the information is automatically posted to the practice's accounts. Practice staff will generally not need to review raw ERA data, as the ERA is designed for computer-to-computer processing. In addition to ERA screen displays, some vendors will provide a printable version of the ERA in a format similar to the Medicare paper remittance advice.

The next pages include sample ERA-related screenshots supplied by vendors, with some common ERA information identified. The examples show the same ERA data in both a proprietary screen display and a printable version in the Medicare format. The AMA thanks Encoda, LLC, and Practice Admin for sharing these examples and supporting ERA education.

Practice Admin: Sample ERA screen display

Batch ID: 5150034 Started: 09/10/2012 Released: Batch By: CRSPMTS Posted: \$12,732.63 Batch Proof: \$12,732.63

Payment Amount: \$12,732.63 Check/Ref #: 885126029

Check/EFT Trace #

status: hold

Total Payment Amount: \$12,732.63 Date Received: 09/08/2012 Accounting Date: Deposit Date:

Total ERA Amount: \$12,732.63 Remittance #: 005120029 Check/Ref #: 885126029 Deposit ID:

Claim Status

Pat Name: ABERNATHY, EDNA, G Pat Acnt#: R14785 Pat HIC: 16326491803
 Payer ICD: 0909237525270 Claim Status: Processed as Primary, Forwarded to Additional Payer(s) ClaimID: 2554981

Service paid amount

DOS From	DOS To	CPT	Remark	Charges	Allowed	Deduct	Coins	Pt. Resp.	Adj. Code	Adj. Amt	Payments	Other Pmts	Other Adj	New Bal
08/20/2012	08/20/2012	99214		\$191.00	\$95.29		\$19.06	\$0.00	CO 45	\$95.71	\$76.23	\$0.00	\$0.00	\$19.06
08/20/2012	08/20/2012	G8447	N365	\$0.10	\$0.00		\$0.00	\$0.00	CO 96	\$0.10	\$0.00	\$0.00	\$0.00	\$0.00
Total Pt. Resp.				\$19.06	Claim Totals	\$95.29	\$0.00	\$19.06		\$95.81	\$76.23			

Service allowed amount

CAGCs

CARCs

Pat Name: ADAMS, JOHN, C Pat Acnt#: R24944 Pat HIC: 192143243A
 Payer ICD: 1009236147170 Claim Status: Processed as Primary, Forwarded to Additional Payer(s) ClaimID: 2558277

Pat Name: ASAFAYLO, BRENDA, C Pat Acnt#: R428900 Pat HIC: 16326491803
 Payer ICD: 0909237525270 Claim Status: Processed as Primary, Forwarded to Additional Payer(s) ClaimID: 2561309

Debtor: 2- FL AMERICAN PIONEER (MG) (21714) PENSACOLA, FL 32

Transaction: Medicare Crossover Service NA Amount: \$0.00

Remarks:

Adjustments: \$17,775.69 Refunds: \$0.00 Payments: -\$12,732.63

Print file view:

Batch ID: 5150034 Started: 09/10/2012 Released: Batch By: CRSPMTS Posted: \$12,732.63 Batch Proof: \$12,732.63

Payment Amount: \$12,732.63 Check/Ref #: 885126029

ERA Detail

FL MEDICARE Explanation of benefits 09/09/2012

INSTANT PRIMARY CARE

7115 37TH PLACE, 3ND FLOOR

BARNS CITY, IA 50027

Payee ID: 1023192507

Provider Number:

of Claims: 177 User: Payment Poster, CRS Batch: 5150034 (not released)

Check/EFT Trace #

Check # 885126029

Payments \$12,732.63

Claim Status

Service RARC

Pat Name: ABERNATHY, EDNA, G Pat acnt#: R14785 Pat HIC: 16326491803
 Payer ICD: 0909237525270 Claim Status: Processed as Primary, Forwarded to Additional Payer(s) ClaimID: 2554981

Remark Codes: MOA, MA01, MA19, MA18

DOS From	DOS To	CPT	Units	Remark	Charges	Allowed	Deduct	Coins	Pt. Resp.	Adj. Code	Adj. Amt	Payments
08/20/2012	08/20/2012	99214	1		\$191.00	\$95.29		\$19.06		CO 45	\$95.71	\$76.23
08/20/2012	08/20/2012	G8447	0	N365	\$0.10	\$0.00		\$0.00		CO 96	\$0.10	\$0.00
Total Pt. Resp.				19.06	Claim Totals	\$95.29	\$0.00	\$19.06			\$95.81	\$76.23

Service Allowed Amount

Claim RARCs

Pat Name: ADAMS, JOHN, C Pat acnt#: R24944 Pat HIC: 192143243A
 Payer ICD: 1009236147170 Claim Status: Processed as Primary, Forwarded to Additional Payer(s) ClaimID: 2558277

Remark Codes: MOA, MA01, MA16

DOS From	DOS To	CPT	Units	Remark	Charges	Allowed	Deduct	Coins	Pt. Resp.	Adj. Code	Adj. Amt	Payments
08/21/2012	08/21/2012	99214	25		\$191.00	\$95.29		\$19.06		CO 45	\$95.71	\$76.23
08/21/2012	08/21/2012	G6415	1		\$17.00	\$3.00		\$0.00		CO 45	\$14.00	\$3.00
08/21/2012	08/21/2012	G8447	0	N365	\$0.10	\$0.00		\$0.00		CO 96	\$0.10	\$0.00
Total Pt. Resp.				19.06	Claim Totals	\$200.10	\$98.29	\$19.06			\$109.81	\$79.23

Claim total patient responsibility

CARCs

Pat Name: ASAFAYLO, BRENDA, C Pat acnt#: R428900 Pat HIC: 16326491803
 Payer ICD: 0909237525270 Claim Status: Processed as Primary, Forwarded to Additional Payer(s) ClaimID: 2561309

Remark Codes: MOA, MA01, MA19, MA18

DOS From	DOS To	CPT	Units	Remark	Charges	Allowed	Deduct	Coins	Pt. Resp.	Adj. Code	Adj. Amt	Payments
08/24/2012	08/24/2012	99214	1		\$191.00	\$95.29		\$19.06		CO 45	\$95.71	\$76.23
08/24/2012	08/24/2012	G8447	0	N365	\$0.10	\$0.00		\$0.00		CO 96	\$0.10	\$0.00
Total Pt. Resp.				19.06	Claim Totals	\$191.10	\$95.29	\$19.06			\$95.81	\$76.23

Pat Name: ASAFAYLO, WANDA, L Pat acnt#: R105059 Pat HIC: 2614005170A
 Payer ICD: 0909237525270 Claim Status: Processed as Primary, Forwarded to Additional Payer(s) ClaimID: 2555107

Remark Codes: MOA, MA01, MA19, MA18

DOS From	DOS To	CPT	Units	Remark	Charges	Allowed	Deduct	Coins	Pt. Resp.	Adj. Code	Adj. Amt	Payments
08/20/2012	08/20/2012	99213	25		\$127.00	\$63.15		\$12.63		CO 45	\$63.85	\$50.52
08/20/2012	08/20/2012	G0610	1		\$160.00	\$78.60		\$18.12		CO 45	\$84.40	\$60.48
08/20/2012	08/20/2012	J3301	4		\$88.00	\$6.28		\$1.26		CO 45	\$81.72	\$5.02

Debtor: 2- FL AMERICAN PIONEER (MG) (21714) PENSACOLA, FL 32

Transaction: Medicare Crossover Service NA Amount: \$0.00

Remarks:

Adjustments: \$17,775.69 Refunds: \$0.00 Payments: -\$12,732.63

ERA enrollment

Now that you know the advantages of accepting ERAs in your practice and are armed with some basic information about the transaction, you are ready to start saving your practice time and money. The first step in implementing ERA is to request this functionality from each health plan with which you do business. In most cases, you will need to enroll separately with every health plan, although CAQH offers a multi-payer ERA/EFT enrollment tool called [EnrollHub™](#).

Health plans differ in how they manage ERA enrollment for multiple-physician practices. In some cases, a payer may require enrollment of the individual physicians, while other payers enroll a practice in a single enrollment. A payer's claim payment process determines which method will be used in physician ERA enrollment.

Your business partners may be able to provide assistance with ERA enrollment. Many clearinghouses, billing services and other vendors can manage much of the ERA enrollment process for a practice. Consult you partners for details about the services that they offer.

For more information on what you need from health plans when enrolling in ERA, please see [Critical conversations with trading partners about ERA](#).



Critical conversations with trading partners about electronic remittance advice

Like any of the standard electronic transactions for health care, the electronic remittance advice (ERA) communicates information between different entities. In the case of the ERA, payment information is being transmitted between the health plan and the provider. As such, physician practices need to have a clear understanding of each plan's ERA processes to facilitate a smooth transition to an electronic remittance process. Because so much of the ERA's display and functionality is dependent upon practice management system (PMS) capabilities, it is also key for practices to closely engage with PMS vendors during ERA implementation. There may be other parties involved in handling the ERA transaction and information, such as clearinghouses and billing services, and these organizations should also be consulted by practices before adopting ERA. Engaging all of these key parties prior to launching the ERA process in your practice will ensure success.

ERA discussions with health plans

Before implementing ERA with a health plan, you will want to gather the following critical information.

- *How do I enroll in ERA with your plan?*

For each payer with which you wish to enroll in ERA, you will need to know the particular enrollment process—paper, Web portal, or other service—and where to access the related forms or Web page(s). In some cases, there may be pre-enrollment steps that are necessary, like establishing a trading partner relationship and/or communication connectivity.

A health plan may use another entity (clearinghouse or vendor) to administer its enrollment process, and you may be directed to that entity's website or help desk. For example, the Center for the Advancement of Quality Health Care (CAQH) offers a service called [EnrollHub™](#) that allows a practice to enroll in ERA and/or electronic funds transfer (EFT) with multiple health plans at one time. The EnrollHub service is free to providers.

Because ERA and EFT work synergistically to enhance practice automation and efficiency, your practice may choose to implement ERA and EFT at the same time. Understanding both the ERA and EFT enrollment processes is critical for practice staff, as they will need to know when and where to find the payment detail from both the bank and the ERA in order to reassociate the electronic payment and ERA. For more information about using ERA and EFT together, see "Maximizing practice automation with electronic remittance and payment" in the AMA's [ERA processing tips](#).

- *What can I expect when transitioning from paper remittance to ERA with your organization?*

Once enrollment has been completed, each health plan has different internal processes to review and approve the enrollment. Health plans differ in the amount of time needed to complete these processes, and your practice should ask for an estimate of how long it will take the health plan to begin sending ERAs. The practice should also be provided with appropriate notice once ERAs are available from the health plan.

Like any process change, conversion from a paper explanation of benefits (EOB) to the ERA can be challenging for practice staff. Many health plans continue to send their paper EOBs for a period of time after starting to send the ERA (60 or 90 days) to allow the practice to become familiar with the ERA and comfortable with the standard codes and before stopping the paper remittance. Other payers never stop sending a paper remittance advice. Some practices compare the paper to the ERA during the conversion to verify that the ERA's data are accurate before enabling automated posting and other functionalities within the PMS. Using automated posting is dependent upon staff confidence in the quality of the health plan's ERA contents.

- *Do you use the same adjustment reason codes on your paper, internet portal and ERAs?*

The ERA (835 transaction) must use the standard claims adjustment reason codes (CARCs) and remittance advice remark codes (RARCs), but these are not required on paper remittance. Web portals may show both the standard codes and the payer's internal proprietary codes. Different codes on paper and electronic remittances make following up with the health plan more difficult, since the codes will not be consistent.

Some payers provide a crosswalk from their proprietary codes to the standard CARCs and RARCs, which is a valuable tool to have when doing any denial follow-up. Some payers will provide the crosswalk on the paper remittance; otherwise, the practice must request the list from the payer. It is important for payers to keep this crosswalk updated, since the standard code lists are updated several times a year.

The crosswalk can be used to verify that the payer has accurately converted their internal messages to the standard codes. Inappropriate conversions, where the message in the ERA is different than that sent on paper, need to be addressed with the payer. The health plan must not only use the standard codes in the ERA, but it must use them correctly.

- *How do you notify me about overpayment recovery when I get an ERA?*

There are three mechanisms for documenting overpayment recovery within a standard ERA:

- 1) Letter notification with check from the practice or subsequent deduction from a remittance advice,
- 2) Accounting reversal and correction within the ERA with immediate recoupment or
- 3) Accounting reversal and correction within the ERA with delayed recoupment by check from the practice or subsequent deduction from a remittance advice.

Which mechanism is used by any given health plan may be dependent upon state regulations or contractual provisions. The practice staff needs to know how each health plan notifies the practice about overpayment recoveries, how the money is handled and when the actual funds

are recovered in order to automate processes and eliminate unnecessary manual handling or phone calls.

- *What is the timing between ERA release and EFT payment?*

The payment date reported in the ERA must be the date the funds are available in your bank account if the payment is made by EFT. It is important for the ERA to be posted in the PMS on the same day of the EFT deposit, if possible. Historically, the ERA has been delivered many days prior to the payment deposit date (or many days after), making it challenging for practices to balance their general ledgers. The CAQH Committee on Operating Rules for Information Exchange (CORE) [Phase III 370 EFT & ERA Reassociation \(CCD+/835\) Rule](#) requires that health plans release the ERA and EFT within three business days of each other. Knowing the normal schedule used by each health plan helps a practice configure its PMS to know when to expect an EFT related to an ERA or an ERA related to an EFT. Your PMS would then only alert the practice staff in cases of abnormal delay or missing transactions.

- *Do your ERAs always balance?*

The ERA must balance at three levels: the service line, the claim and the check (also referred to as “transaction”) levels. If any of these levels fail to balance, the ERA is noncompliant. If a payer’s ERA does not completely balance, you need to know how the payer addresses the situation. Although payers should not use dummy codes to force balance the service, claim or check payment, some payers do use a specific CARC for this purpose. This results in bad information in the ERA that must be handled manually by the practice.

Alternatively, the health plan may hold the file until the specific problem can be fixed, or do nothing, which forces the practice to make adjustments when posting the details manually. While a health plan’s failure to address unbalanced ERAs means that you receive a noncompliant ERA, which is detrimental to your practice, being aware of this issue allows your practice to spot the problem and minimize the impact.

For more information on how to recognize and address compliance issues, access the [AMA’s Electronic Transaction Compliance and Enforcement resources](#).

- *How do you process multiple claim retroactive adjustments in the ERA?*

Some payers perform bulk adjustments of multiple claims months or years after the original payment. This usually occurs when incorrect fee schedule information was used for the original adjudication, but the error was not noticed in a timely fashion. How these changes are reported in the ERA is critical to automation, practice staff understanding and elimination of phone calls and confusion. The method used also impacts the options available for posting the information into the accounts receivable, general ledger or both.

ERA discussions with PMS vendors

While large practices may have staff on hand to create and maintain computer software for the automation of administrative tasks, many practices are dependent upon external PMS vendors for automation. PMS vendors therefore play a vital role in physician practice automation efforts and achieving the efficiency benefits possible from the ERA. The features and flexibility that vendors build into their PMS products determine the ease, scope and ultimately the success of automating the

internal ERA process. For detailed information on how to choose a PMS, visit the AMA's [Selecting a Practice Management System Toolkit](#).

Read on to learn the key questions you should ask a PMS vendor before implementing ERA in your practice.

- *Do you support auto-posting of the ERA?*

PMS support for pre-processing and auto-posting is the primary factor in minimizing staff time needed for manual ERA processes. The PMS vendor should be able to support customized, flexible configuration options for auto-posting based upon the adjustment details and specific payers.

There should be an option to auto-post specific CARCs along with the group code (which determines liability and patient responsibility) and remark codes. However, some ERA adjustments should **not** be automatically posted, so the PMS should allow the practice to determine which codes to post automatically, and which require staff intervention. For example, automatic posting of a noncovered denial that is reported as patient's responsibility could be automated, while a noncovered denial that is reported as the contractual write-off to the practice would receive staff attention.

The PMS should also support configuration by payer to allow for ERA-reporting idiosyncrasies from one payer to the next. A specific message from Medicare may get auto-posted, while the same message from a commercial payer may need staff attention or even an appeal. Appropriate auto-posting of ERAs allows your practice to focus on those cases that really require staff attention.

- *Do you allow staff to access the adjustment and remittance codes from the original ERA?*

The vendor should include the code descriptions on the same screens as the codes so that users are not required to open another screen or website to see the descriptions. Seeing the original codes and their descriptions together facilitates decision-making for situations that are not automated and require manual review before posting. The information is also helpful when assisting a patient in understanding the plan's explanation of benefits and the remaining balance.

The adjustment and remittance codes (CARCs and RARCs) currently undergo maintenance three times per year. Ensuring that you are seeing the correct codes and descriptions is critical to acting on the actual message. The description of a code needs to reflect the current definition at the time of receipt.

- *Do you track provider summary adjustments for reconciliation in subsequent ERAs for situations such as overpayment recovery and balance-forward processing?*

The ERA can include multiple types of reductions that are not specific to a claim reported in that ERA, or even reductions and payments not related to claims at all. Since the ERA is intended for computer processing, it is important that the PMS track these adjustments back to the original claims, when appropriate, for automation and basic validation.

Some examples of provider-level adjustments include:

- Recovery of overpayments (see the AMA's [Overpayment Recovery Toolkit](#))
- Balance forward (when recovery of overpayments exceeds payments in a specific ERA)
- IRS withholding
- Capitation payments
- Performance bonuses
- Interest payments
- Recovery check acknowledgment

- *Does your system support tracking of overpayment recovery letters and check-writing?*

Some plans send overpayment recovery information via letter due to state regulations or contractual requirements, and sometimes physicians return overpayments by check. In these cases, the PMS needs to store the related information within the system in order to reconcile recoupments and check acknowledgments when they are reported in the ERA. Without this support, the reconciliation process becomes manual. In addition, storing the information within the PMS allows for reports to be generated identifying the balance due in multiple reporting formats. This gives a clearer picture of the practice's financial health.

- *Do you automatically validate allowed amounts against the payer's fee schedule?*

If payers provide their contracted fee schedules in a machine-readable format, a PMS can validate the payments received against those fee schedules. The ERA supports identification of the contract related to each claim payment, as well as the allowed amount for each service. With this information, it is easy to:

- Identify when services were paid at an incorrect allowed amount, permitting follow-up with the payer by your staff,
 - Automate posting of remittance information with confidence that the information is accurate and
 - Report on the actual value of the outstanding accounts receivable based upon the fee schedule and contract information for each patient and service
- *What additional features and client support does your company offer related to ERA?*

Many PMS vendors offer additional ERA functionalities and practice support. For example, in situations that do not allow ERA auto-posting, PMS tools to assist in denial management can streamline the process and facilitate staff efficiency. Work lists by payer and by denial reason (CARC) allow for greater focus and efficiency than researching denials using the telephone or a payer's Internet portal.

You will also want to find out what training and support the PMS vendor offers for ERA implementation. Vendor screenshots or demonstrations can help a practice assess how easy it will be to navigate the vendor's ERA display and transition from reading paper EOBs to interpreting ERA displays. You should also find out if the system allows the user to sort, search, print and/or save ERAs.

ERA discussions with clearinghouses and billing services

While some health plans support direct submission and retrieval of Health Insurance Portability and Accountability Act (HIPAA)-mandated electronic transactions, many others require access through a clearinghouse. In addition, physician practices frequently choose to use a clearinghouse in order to simplify their transaction communications with all health plans. When a clearinghouse is involved, how that clearinghouse interfaces with the PMS for receiving the ERA is crucial. Manual retrieval of the ERA files means staff time, versus automatic retrieval that happens behind the scenes. In addition, a clearinghouse may offer value-added services, like matching the ERA with the related EFT, relieving staff of related administrative tasks. Physician practices may also use billing services to assist with ERA receipt and processing. The following questions capture the information you need from a clearinghouse and/or billing service before implementing ERA.

- *Do you validate health plan ERAs for overall compliance before delivering to my practice?*

The clearinghouse or billing service should validate the payer's process and file integrity when obtaining the ERA. In most cases, the clearinghouse or billing service will already be processing ERAs for the payer and know of any current issues. If the payer is new to the clearinghouse or billing service, then a compliance validation must be done.

The clearinghouse or billing service should have a built-in editor to check an ERA's compliance with HIPAA rules. This check should both evaluate transactional compliance and ensure proper balancing. You will need to know how the practice is going to be notified if there are any issues with an ERA. In addition, both your practice and PMS vendor need to know what compliance checking has already been done by the clearinghouse or billing service in order to avoid duplicate work.

Depending on the nature of the issue, it might be acceptable to receive ERA files with known problems. For example, the practice may decide that minor ERA balancing issues can be managed. However, the practice should also have the option to stop the ERA from processing or allow it to process with a report of what was wrong if there is a compliance issue. The practice must discuss and resolve how the clearinghouse or billing service will address compliance issues during the initial testing phase and prior to ERA implementation. Since compliance issues will ultimately need to be addressed with the health plan, it is important to determine who will bear this responsibility in order to avoid duplicate efforts. If the clearinghouse or billing service manages this process, the practice should receive regular status updates.

- *What support do you provide for tracking late or missing ERAs and/or EFTs/payments [billing services only]?*

The CAQH CORE [Phase III 370 EFT & ERA Reassociation \(CCD+/835\) Rule](#) requires that health plans release the ERA and EFT within three business days of each other. When payment is by check, there is no mandated requirement; however, posting of the ERA and depositing of the payment still need to happen together. While the payment can be deposited to the bank account when the ERA is missing, the practice must locate the ERA in order to appropriately account for the payment and avoid accounting issues for the practice.

Many payers establish a schedule for ERA delivery or availability, and the clearinghouse/billing service can easily identify when the schedule was missed. Your clearinghouse or billing service should track down missing ERAs in a timely manner and offer functionality (either via a website

or reports) to track receipt of all ERAs that can be accessed by the practice. Your staff needs to know how they will be notified regarding missing ERAs and any associated follow-up, including notice of ERA receipt.

In addition to tracking missing ERAs, billing services should also track missing EFTs and other payment types and manage ERA and EFT posting accordingly. The billing service should be responsible for obtaining EFTs/payments and hold ERA posting until payment is verified. The service should also offer functionality (via a website or reports) that allows the practice to track receipt of all ERAs and payments.

- *Do you post the ERA when received, wait for the associated payment or post on the payment date in the ERA? [billing services only]*

If the billing service is managing both the ERA and payment, then the ERA can be posted when the payment is received. If the billing service's system includes functionality to post the ERA automatically, there should be an option to post based on the payment date, method of payment and payer.

- *Do you post the ERA using an automated solution or view the information and post manually? [billing services only]*

The vendor should offer a solution to post the payment and adjustments automatically. This process should be payer-driven and allow options for posting the payment and adjustments. Efficiency gained through automation should be reflected in reduced costs in the billing service contract.

The billing service should provide summary reporting of the ERA activity. This should include the check amount, payment date, claims totals and provider-level adjustments. Depending on the arrangement with the billing service, this detail may be needed to balance the general ledger with accounts receivable.



Electronic remittance advice processing tips

Overview

Physician practices can achieve the greatest gains from the standard electronic transactions mandated under the Health Insurance Portability and Accountability Act (HIPAA), such as the electronic remittance advice (ERA), when they maximize opportunities to convert manual processes that require staff attention to tasks that can be performed by computers. The ERA is designed as a computer-to-computer transaction; it is not intended to be used directly by a person. While ERA management will never be 100% automated, due to difficult health care business issues, as much as 80% of ERA processing can and should be handled without human intervention. Ideally, your practice staff should only need to review ERAs that cannot be automatically processed by your practice management system (PMS). In other words, to get the most value from ERA implementation, your PMS must provide a high level of ERA support and automation. In addition, because processes and workflows differ across physician practices, your PMS must be flexible and allow for customized handling instructions depending on the specific payer or denial code.

General ERA processing flow

Although your practice's ERA processing flow may differ between payers, some high-level principles apply across most payment situations. The processes outlined below provide general guidance on how your practice can efficiently process ERAs.

1. *Paid claims*

- a) If there is a contractual reduction to the allowed amount, is the amount consistent with the related fee schedule? **Yes** – Continue; **No** – Send to staff.
- b) Post any contractual reduction to the patient's account.
- c) Does the patient responsibility amount account for the difference between the payment and the allowed amount? **Yes** – Continue; **No** – Send to staff.
- d) Post the payment to the patient's account and record the patient responsibility details (deductible amounts, co-pay, co-insurance, etc.).
- e) Is there a remaining balance? **Yes** – Bill secondary/tertiary health plan or the patient; **No** – Account is settled.

2. *Claim rejected for missing or incomplete information*
 - Send to staff to identify the necessary information and resubmit to the payer for reconsideration.
3. *Denied claims*
 - a) Compare denial reason and responsibility (contractual obligation or patient responsibility) to the PMS's payer configuration (instructions in the PMS that identify whether the practice is in-network with the payer/product and what the contract requires for obligations related to denials where the patient is not liable for the balance). Is this combination accepted without staff review? **Yes** – Write-off accepted contractual reductions or denial; **No** – Send to staff to submit appeal and applicable additional information to the payer.
 - b) Is there a remaining balance? **Yes** – Bill secondary/tertiary insurance or the patient; **No** – Account is settled.
4. *Claim reversal* (a readjudication by the payer resulting in a change in payment or patient responsibility)
 - a) Identify any original claim contractual reduction and post the opposite amount.
 - b) Identify any original claim payment and post the opposite amount.
 - c) Archive information about patient responsibility amounts that may no longer be accurate.
 - d) Note the reversal on the account and any additional payer claims or patient bills that have been sent out.
 - e) Identify the claim in the PMS as pending payer response and await the new payment information (the corrected claim).

Managing payment errors in ERAs

The ERA includes information that allows the PMS to identify possible payment errors and flag these discrepancies for review by the practice staff. Important ERA data elements for payment accuracy verification include:

- *Allowed amount:* Each service for which coverage is approved includes the allowed amount for the service by the plan and contract in an AMT segment. (For more information on ERA segments, see [“ERA anatomy” in Getting started with ERA.](#))
- *Class of Contract Code:* This record identifies the product or contract under which a specific claim was adjudicated. This is contained in an REF segment.
- *Fee schedule:* If a health plan provides its fee schedule in a downloadable, machine-readable format, the PMS can verify that the correct fee schedule was used in adjudication.
- *Claim Adjustment Group Code (CAGC):* The CAGC identifies if any reduction to the allowed amount is considered to be in or out of network, indicating practice

or patient responsibility. The PMS can then report to the practice staff any instances where the claim payment is inappropriate or was reported as a provider write-off when it should be the patient's responsibility.

Taken together, these data elements allow the PMS to validate that the practice was paid the proper amount by the health plan for the service. The practice staff can then use this information to appeal any inappropriate payments or write-offs with the payer.

The AMA offers additional resources to assist practices in claim denial management. The [Claims Workflow Assistant](#) provides detailed workflows for denial management related to ERA codes. The AMA's [appeal resources](#) assist with identifying when to file appeals and offer template appeal letters for various situations.

ERA and overpayment recovery

Overpayment recovery can be one of the most trying processes for practices due to the challenges involved in tracking information across both manual communication channels and ERAs. Frequently, the overpayment notification is manual in the form of a letter, facsimile or email, but it can also be sent within the ERA.

Overpayment recovery processing can be further complicated when recoupments are delayed. An overpayment recovery delay entry in the PLB segment represents the delayed recovery of an overpayment amount reported within the claim section of the ERA. Within the claim section, the amount of the recovery is associated with the specific claim. However, some state regulations or payer contracts require that physicians be given time to remit the overpayment by check (30, 60 or 90 days). The ERA uses offsetting adjustments to return the overpayment recovery amount to the practice until the physician's settlement check is received or the recovery is recouped in a later ERA. As a result, the overpayment needs to be tracked against future ERAs and related practice activity (i.e., any checks sent to the health plan) and entered into an accounts payable system.

PMS storage and tracking of overpayment-related actions can validate appropriate reductions and automate the process. The practice's PMS should have the ability to track the following items related to overpayment recovery:

- Overpayment notices from payers (whether in the ERA or a mailed letter),
- Checks sent to the payer as settlement of the overpayment,
- Delayed recovery of overpayments in the ERA and
- Acknowledgment of receipt and crediting of settlement checks.

The PMS can then report on outstanding overpayments, identify recoupments automatically and minimize staff time managing this process. Human intervention should only be needed when an overpayment is first reported (to allow for an appeal, if appropriate) or if the actions do not represent offsetting entries, indicating an error by the payer.

For more information on how to minimize the administrative burden of overpayment recovery through ERA processing and automation, see the AMA's resource titled "[Automating the overpayment recovery process.](#)"

Managing provider-level adjustments

The ERA supports multiple categories of payments or reductions in payment that are categorized as “provider-level adjustments” and are not related directly to specific, current claims. As such, these adjustments may require additional tracking or attention from the practice. Provider-level adjustments include, but are not limited to:

- Capitation payments
- Capitation related withholdings
- Direct Medical Education Passthru
- Interest
- Internal Revenue Service levies
- Overpayment Recovery
 - Delayed recovery
 - Financial recovery
 - Payment acknowledgment and crediting
- Periodic Interim Payment entries
- Prompt payment discounts
- Forwarding Balance

Generally, these amounts would be posted to the practice’s general ledger system or tracked for association with related future provider-level entries. Each type of adjustment has its own business requirements and needs to be handled in an appropriate manner. For instance, interest needs to be validated against the reported interest payments on claims within the ERA and then posted to the appropriate practice account (general ledger).

Some provider-level adjustments involve a two-step process, as one adjustment must be offset by another adjustment in the same or a future ERA. For example, Periodic Interim Payments begin with a lump-sum payment at the start of a period, then deduct claim payments from that sum in future ERAs. The original amount and a running total must be maintained by the PMS, using the adjustment identifier as the link from the payment to the deductions.

Forwarding Balance provides another example of a multiple-step provider-level adjustment. Forwarding Balance takes a deficit from one ERA (where the payer applied an overpayment recovery that exceeded the available payment in the ERA) and moves it into the next ERA. The adjustment identifier allows for a quick and simple link from one ERA to the next. The PMS can easily store and track the movement of these offsetting adjustments to ensure that all of the actions are appropriate.

Maximizing practice automation with electronic remittance and payment

Automated Clearing House Electronic Funds Transfer (ACH EFT) is a HIPAA-mandated transaction, just like the claims and ERA transactions. As such, a health plan must offer payment via ACH EFT at a provider’s request. The ERA and the EFT transactions have been designed to work synergistically to

maximize practice automation and provide administrative simplification. Implementing ERA and EFT together will offer your practice the greatest opportunities for improved efficiencies.

The most complete automation is achieved when a practice's PMS automatically integrates the ERA with EFT information supplied by the bank. The process of connecting the payment information in the ERA to the payment dollars in the related EFT is referred to as reassociation. The [EFT/ERA reassociation operating rule](#) requires that payers and banks support sending specific information to assist practices in connecting the ERA with the related EFT. The ERA identifies when payment is scheduled to be made by EFT and provides the amount, related account, payer tax ID for identification and date when the money will be available, along with a unique identification number known as the Reassociation Trace Number (TRN). ACH EFT uses a standard format called Cash Concentration and Disbursement Plus Addenda, or CCD+, and contains the same TRN record as the ERA, enabling easy connection of the ERA with the EFT. You will need to ask your bank to provide the TRN record by sending it to you electronically or by displaying the detail on your bank statement portal.

Practices can maximize the efficiency of the reassociation process by requesting that their bank provide EFT payment information in an electronic format that can be downloaded into the PMS. When the PMS is configured to receive the ERA from the payer or clearinghouse, as well as the EFT notice from the bank, reassociation can be automated to minimize the need for staff manual processing and intervention.

For more information about how to implement standard EFT, see the AMA's [EFT toolkit](#).