



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](#).