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.

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- *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	• Trace number (check or EFT number) • Payer Tax ID (for match with a 1099 form)
	BPR	• Total payment amount • Payment method • Payment date • EFT bank account information
	N1	• Payer Name • Payer ID • Provider/Payee Name • Provider/Payee ID (National Provider Identifier [NPI])
	REF	• Payee Tax ID
	PER	• Payer health care policy website
Detail	CLP	• Claim/account number • Status of the claim • Submitted charge • Claim payment • Total patient responsibility amount
	NM1	• 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	• Adjudicated and submitted procedure codes • Paid and submitted units of service • Service paid amount
	CAS	• Reduction and denial reasons (CARCs; see *ERA Codes* on next page) and amounts
	LX	• Support information (RARCs; see *ERA Codes* on next page)
	AMT	• Allowed amount
Trailer	PLB	• 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.
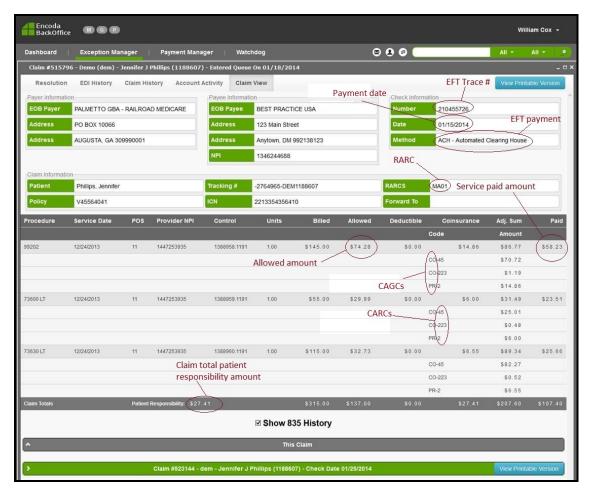
When an adjudicated claim falls within one of those scenarios, payers are required to use codes in the combinations specified by CAQH CORE. CAQH CORE updates the list of allowable code combinations several times per year. The mandated code combinations bring further uniformity to ERA reporting and facilitate providers' understanding of ERA messages.
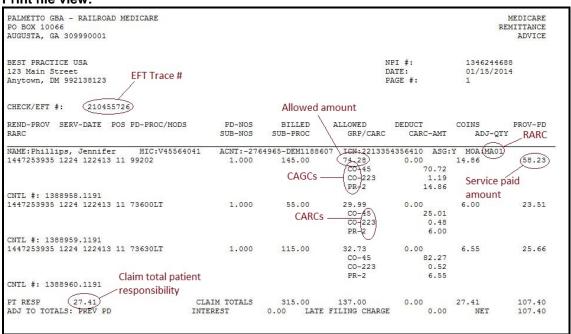
ERA sample displays

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.
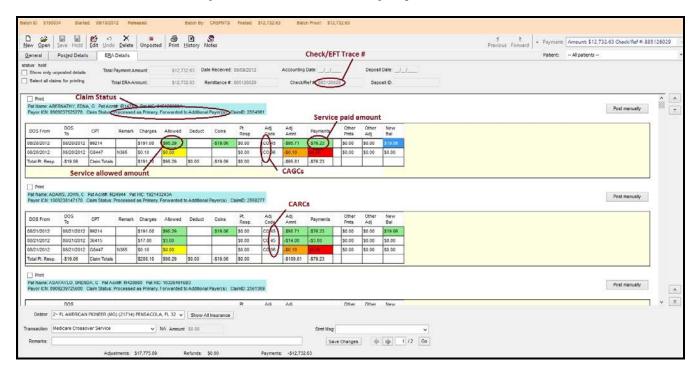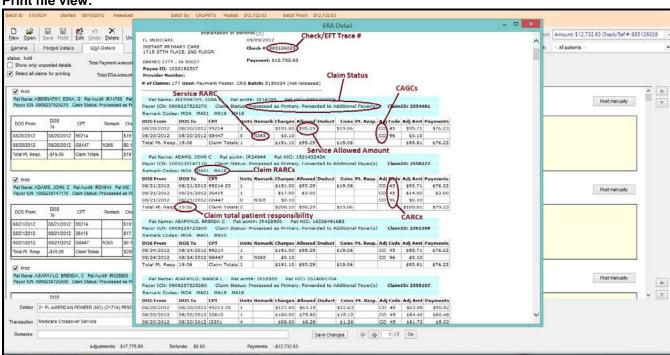
Encoda, LLC: Sample ERA screen display

Print file view:

Practice Admin: Sample ERA screen display

Print file view:

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.