



# 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 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.