American Society of Anesthesiologists®

Timely Topics

PAYMENT AND PRACTICE MANAGEMENT

December 2016

"EOBeware"!

Each payer sends an Explanation of Benefits (EOB) and/or a remittance advice (RA) to you after a claim has been filed and processed. Understanding how to read an EOB and RA, and what to do with that information, can affect your bottom line.

Each EOB/RA identifies the payer, your practice, the patient, and the claim information. Payer information includes the name of the payer, type of plan, and contact information. Your practice information includes your Pay To name and address, the name of the performing provider if different from the Pay To name, your National Provider Identifier (NPI) and the place of service. Claim information includes a claim number or identifier, the date of service, CPT/HCPCS codes, modifiers and the charge for each service that was billed.

In addition, the EOB/RA includes information about how the claim was processed. The document will show the amount allowed for the service billed, the amount of the insurance payment, the amount to be adjusted by participating providers, and the amount for which the patient is responsible.

If a claim is not paid as expected, or if the payment is not received as detailed on the EOB/RA, what do you do? Review all this information to confirm that it matches the information in your billing system and that it accurately represents the service that was provided.

Payers respond to each claim line with at least one reason and remark code. These reason and remark codes are used on the EOB/RA to identify how the claim was processed.

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 mandated all covered entities conduct standard electronic transactions and use a standardized set of codes. These codes are maintained by the Centers for Medicare & Medicaid Services (CMS). All payers that are covered entities under HIPAA are required to use the latest approved and valid codes in their claims adjudication processes. Prior to HIPAA, each payer developed its own internal remark and reason codes. To understand how your claim was processed you had to review each payer's specific code set and associated reasons. HIPAA standardized the code sets, making it easier to maintain and develop electronic processing of remits and payments in all billing software and decreasing delays and errors in payment posting.

There are three types of reason codes: Group Codes, Claim Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs).

Group Codes identify who is financially responsible for the unpaid portions of the claim balance and are used in conjunction with a CARC. There are five group codes:

- CO Contractual Obligation,
- CR Corrections and Reversal,
- OA Other Adjustment,
- PI Payer Initiated Reductions, and
- PR Patient Responsibility.

CARCs are required on the EOB to report payment adjustments and coordination of benefits transactions. A CARC communicates why the claim line paid differently than it was billed. *Reading the combination of Group Codes and CARCs correctly can make a significant difference in how you pursue payment on the remaining balance.* For example a PR-45 defines a balance after the insurance payment or adjustment that exceeds the allowed payment from the insurance carrier and assigns that balance as the patient's responsibility. However, a CO-45 identifies a dollar amount left after the insurance payment that must be adjusted off by the provider due to the contracted fees between the payer and the provider. Understanding the remark codes and applying their instruction accurately may make the difference between making an adjustment or pursuing additional payment. Following the instruction correctly can also make a difference between compliance with your provider contracts or possible risk in pursing inappropriate payments.

Another common combination is CO-97. Again the group code CO indicates that the balance should be adjusted due to contraction obligation. CARC 97 identifies that the service billed is part of another service already paid. Any amounts with the remark codes CO-97 should be adjusted per your contract with the carrier.

The group codes and CARCs can also identify claim form errors. While these remark codes may identify adjustments, correcting the error and resubmitting a corrected claim may result in payment. For example, OA-146 identifies an other adjustment because the diagnosis code submitted was not valid on the date of service. In this situation, both the date of service and the diagnosis code(s) should be reviewed to determine the information that should have been reported.

RARCs provide either supplemental explanation for a monetary adjustment identified in a CARC or informational alerts about the claim processing. An N439 indicates that the anesthesia physical status indicators are missing and N430 indicates the physical status modifiers are incomplete or invalid. In both these cases review the claim to confirm the correct physical status modifiers were included and submit a corrected claim as indicated. Another example of possible action to take in response to a RARC is illustrated with N472. This code indicates that payment for the service was already made to another provider. In this case, review items such as the Pay To information, the billing provider and/or the

CPT/HCPCS modifiers to determine if the correct performing provider was identified on the claim.

Understanding the CARCs and RARCs will help you know what actions may be appropriate in follow up to the claim. "EOBeware" of how to read your EOB's and RA's so you don't miss out on possible payments or other proper handling of your claims.