



Electronic Remittance Advice

Overview

Electronic Remittance Advice (ERA) is available through your practice management system (PMS) or hospital information system (HIS) via Emdeon. For Mail Handlers Benefit Plan questions about ERA's, go to: ERAquestions@cvty.com.

Electronic Remittance Advices allow providers to post payments quickly and efficiently. To sign up for ERAs, the provider should call their practice management software (PMS) vendor or hospital information system (HIS) vendor for details. If ERA's are not available through your current vendor, please call Emdeon at 877-469-3263 to have ERA's set up directly through Emdeon.

Features

- Immediate access to remittance advice
- Can eliminate the manual posting of payments
- Files available in standard 835 (4010) format
- System is HIPAA secure
- Information available 24/7

Who Benefits?

- Billing office personnel and Managers responsible for payment postings
- Facilities that file claims electronically
- Sites that either have or are considering acquiring Electronic Transfer Payments
- Organizations that have accounts receivable software with the ability to accept ERA's

Large facilities that want to increase billing office productivity

Frequently Asked Questions

About Electronic Remittance Advices (ERA)

Mail Handlers Benefit Plan (MHBP) uses the ASC X12 Health Care Claim Payment/Advice (835) transaction version 4010A1 mandated by HIPAA for the transfer of Electronic Remittance Advice (ERA) information to health care providers. Mail Handlers adheres to the HIPAA Implementation Guide for the ASC X12 Health Care Claim Payment/Advice (835) transaction, version 4010A1. The HIPAA Implementation Guide is available at www.wpc-edi.com/products/publications. Currently Coventry Health Care utilizes Emdeon to route 835 transactions to practice management vendors or other provider clearinghouses. Emdeon distributes 835's to providers who are enrolled with Emdeon to obtain Coventry transactions.

NOTE: Effective September 15, 2008, electronic payments via Electronic Funds Transfer (EFT) are NOW available for the Mail Handlers Benefit Plan business.

1. What is an Electronic Remittance Advice (ERA)?

An ERA is an electronic file that contains claim payment and remittance information. It is often referred to by its HIPAA transaction number, 835.

2. What are the advantages of receiving ERAs?

In conjunction with practice management software package that can handle an ERA (also known as an 835 file), it is possible to reduce manual posting of claim payments and reconciling patient accounts, thereby saving your practice time and money.

3. How much does it cost to receive ERAs?

Set-up and ongoing costs vary depending on whether or not your practice management system or clearinghouse currently supports ERA's.

Getting your ERA

1. How do I sign up to receive ERAs?

You should call your practice management software vendor or clearinghouse to see if they can receive the ANSI X12 Health Care Claim Payment/Advice (835) transaction, version 4010A1. If so, follow their procedures for enrolling to receive ERA's. If your vendor cannot support this format, contact your Provider Representative.

2. Can I receive ERAs directly from Mail Handlers Benefit Plan?

At this point in time you or your practice management software vendor can only receive ERA's through select clearinghouses, such as Emdeon and GatewayEDI (in select markets only).

3. Do I need special computer software to use ERAs?

In order use our ERA you will either need practice management software that can import an ASC X12 Health Care Claim Payment/Advice (835) transaction, version 4010A1; or you will need to contract with a clearinghouse that can translate this format to one that your practice management system can import (i.e. NSF).

4. When can I expect to receive ERAs? How will I be informed of delays to this schedule?

Mail Handlers Benefit Plan submits ERA's to Emdeon according to a general schedule. ERA files should generally be available from Emdeon after 2:00 PM EST on the days indicated. However, your practice management vendor or clearinghouse may require additional time to process them and make them available to you. Please check with your practice management vendor or clearinghouse regarding their processing time requirements.

5. Do I have to get Electronic Funds Transfers (EFT) to receive ERAs?

No, you are not required to receive direct deposit payments via EFT in order to receive ERA's. EFT payments follow a different process and are not included in ERA's. However, if you are interested in receiving EFT payments you should contact your Provider Representative. However, we encourage sites who are interested in receiving direct deposit payments to get ERA's in conjunction with EFT's.

NOTE: EFT's become available for Mail Handlers Benefit Plan business effective

9/15/2008.

6. How do I receive my ERA?

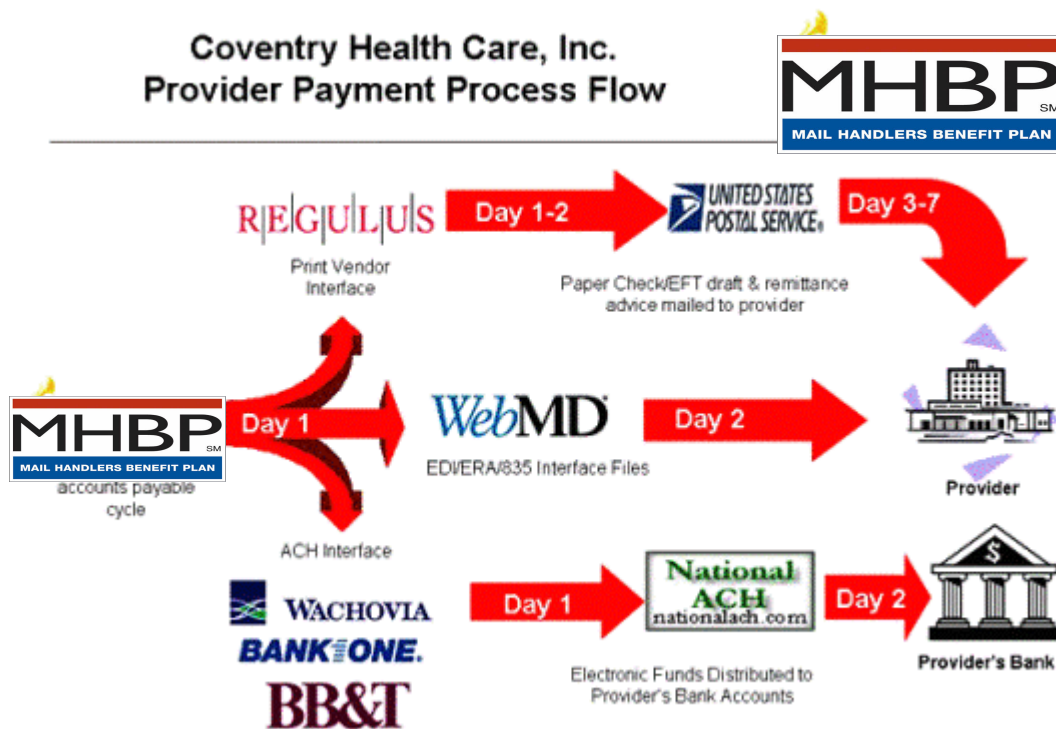
Once claims have been adjudicated to a final paid or denied status, Mail Handlers sends all ERA's to Emdeon. If your practice management system or clearinghouse can receive an 835 transaction, then your software vendor can obtain ERA's from Emdeon.

7. Can we still receive paper remittance advices if we sign up for ERAs?

Yes, paper remittance advices will continue to be sent.

8. Why do my paper remittance advices, ERAs and EFTs arrive at different times?

Mail Handlers Benefit Plan (MHBP) paper remittance advices/checks, ERA's, and EFT's follow independent processes and go through different steps to be accessible to providers. The diagram below indicates when you should generally expect information once it is generated by MHBP.



9. Will we continue to receive our ERA if our electronic funds transfer (EFT) payment is interrupted for some reason?

The ERA process is separate from the EFT process. You will continue to receive your ERAs. If you have an interruption in your EFT payments, please contact your health plan provider representative immediately.

NOTE: EFT's become available for Mail Handlers Benefit Plan business effective

9/15/2008.

Data in the ERA

1. What information is available in an ERA?

The ERA file contains payment information on final status claims, whether they were paid or denied. It also contains information on any adjustments that Mail Handlers Benefit Plan (MHBP) has made to your billed amount. For information about specific data elements included please review the HIPAA implementation guide for the ASC X12 Health Care Claim Payment/Advice (835) transaction version 4010A1 on the web at www.wpc-edi.com/products/publications

2. How do I know the ERA information is accurate?

We will continue to send paper remittance advices so that you can use them to cross check the information in the ERA file.

3. Can I receive ERAs from multiple payers in a single ERA file?

Please check with your practice management vendor or clearinghouse.

4. Are claims for Administrative Services Only (ASO) employer groups included in ERAs?

Yes.

5. Can I print out reports from my Electronic Remittance Advice?

Mail Handlers Benefit Plans' ERA file contains information that can be printed. Please check with your practice management vendor or clearinghouse to see what reports they have available for ERA's.

6. Why doesn't the information on my ERA match my paper remittance advice?

Paper remittance advices are a proprietary product of the Mail Handlers Benefit Plan (MHBP) so we can utilize a custom design and proprietary code sets. However, ERA's are regulated by HIPAA and must use mandated data elements and code sets, such as claims status codes and adjustment reason codes. These are not the same as the MHBP internally developed codes available on paper remittance advices. Consequently, the wording for these codes may not match, but they will still convey the same general meaning. For your convenience, we have provided a Microsoft Excel "crosswalk" document that maps our proprietary codes to the HIPAA mandated codes. To access this document go to www.cvty.com, select the health plan from the drop down box, click the red "Go" icon, click the "Providers" icon, click the "Electronic Transactions" link, click the "Claim Status Explanation" link, and then the "Status and Disposition Codes" link. The lists of required data elements and codes sets are available in the HIPAA implementation guide for the ASC X12 Health Care Claim Payment/Advice (835) transaction, version 4010A1 at www.wpc-edi.com/products/publications .

7. Are pending claims included in ERAs?

No. ERA's only include final status paid or denied claims.

8. Can I see if a payment has been paid via electronic funds transfer (EFT) or paper check?

Yes. The check number that appears in the ERA will start with "EFT" if the payment was made electronically.

NOTE: EFT's are NOW currently available for the Mail Handlers Benefit Plan business.

ERA Support

1. Who should providers call for questions regarding ERAs?

Please call the Mail Handlers Benefit Plan Customer Service Organization or your Coventry Health Care Provider Relations Representative. Email questions to ERAquestions@cvty.com.

2. What if I have a check/paper remittance, but I'm missing the ERA?

First contact your practice management system vendor or clearinghouse to verify whether they have received the ERA from Emdeon. If they have not, ask them to contact Emdeon Clearinghouse Support at 888-305-3756. If they supply your nine-digit Tax ID Number, as well as the date, check number, and amount of the missing ERA, Emdeon will resend the file. If Emdeon has not received the ERA in question, they will contact Mail Handlers on your behalf.

3. What do I do if I have the ERA, but I'm missing the check/paper remittance?

Please call the Mail Handlers Benefit Plan Customer Service Organization or your Coventry Health Care Provider Relations Representative. Email questions to ERAquestions@cvty.com.

4. How will we know if there are significant problems with ERA file delivery?

You should receive a bulletin from your practice management vendor or clearinghouse with relevant information about the problem. The Mail Handlers Benefit Plan will also be informed of any significant ERA problem.

5. I am having difficulty getting ERAs to automatically post payments. Who can I call about this?

Please call your software vendor. If they are unable to help you, call your Mail Handlers Representative or email ERAquestions@cvty.com.

ERA - Technical Specifications

1. What is the relationship between ERAs (835), Electronic claims (837), and other transactions?

A one-for-one relationship does not exist among the claim transaction (837), the claim status acknowledgement transaction (277) and the electronic remit (835). One 835 transaction set can account for claims submitted using multiple 837 transactions or multiple paper claims. For tracking purposes, the patient control number from the CLM01 segment in the 837 is returned in the CLP01 segment of the 835. There is no requirement that providers submitting electronic claims (837) must receive an ERA (835). Conversely, providers that choose to submit both electronic and paper claims may elect to receive an ERA.

The 277 acknowledgement transaction's primary use is to convey status information on non-adjudicated claims, whereas the 835 is used to transmit data needed for posting of payments subsequent to the adjudication of a claim. The claim status inquiry and

response (276/277) can account for claims already paid in an 835, pending or denied claims.

2. How does the Mail Handlers Benefit Plan ERA handle the following segments?

| Question | Segment | Response |
|----------------------------------|---------|---|
| Health Care Remark Codes | LQ | This segment is optional under HIPAA and it is not currently populated. |
| Provider Summary Information | TS3 | This segment is optional under HIPAA and it is not currently populated. |
| Provider Supplemental Summary | TS2 | This segment is optional under HIPAA and it is not currently populated. |
| Patient's Plan Type/Product Name | REF*CE | This segment is optional under HIPAA and it is not currently populated. |

3. How are claims with interest penalty reported?

Mail Handlers Benefit Plan follows the recommendations outlined in the Health Care Claim Payment/Advice implementation guide. As per the implementation guide, when there are claims that have interest penalty owed to you, this interest amount is reported in the *Claim Supplemental Information segment (AMT segment, claim payment loop 2100)*. The *Amount Qualifier Code field (AMT01)* will have an "I" for Interest and the *Monetary Amount field (AMT02)* will have the interest amount for the claim. This interest amount will be included in the *Total Actual Provider Payment Amount field (BPR02)*. However, this isn't reported in any of the *Claim Payment Amount fields (CLP04)* because the interest isn't something that you actually billed for on the claim. Therefore, in order to make the transaction balance according to the Implementation Guide (IG) rules (see IG pages 21-22), a negative provider adjustment (PLB segment) is created equal to the sum of all AMT02 fields in the transaction. The *Adjustment Reason Code (PLB03-1)* will have an "L6" for *Interest Owed*, while the adjustment amount will be reported in the *Monetary Amount (PLB04)* field. Please see the example below for more information.

Notes: Remember that a negative adjustment actually increases the payment amount for the transaction.

Example: The following 835 transaction only has a single claim, which will be paid \$915.00 (CLP04). However, this claim has accrued \$1.23 in interest penalty (AMT02). This amount is included in the Total Actual Provider Payment Amount (BPR02), so a negative provider adjustment of \$1.23 is added in the PLB04 to balance the transaction.

Sum of CLP04's – Sum of PLB04's = BPR02.
 915.00 – (-1.23) = 916.23

```
BPR*I*916.23*C*CHK*****20040719~
TRN*1*111*125345~
...
CLP*1010101*1*940*915*25*HM*222222~
...
AMT*I*1.23~
...
PLB*12345*20041231*L6*-1.23~
```

4. How are back-outs and replacement claims reported on ERAs?

Mail Handlers follows the recommendations outlined in the Health Care Claim Payment/Advice implementation guide. As per the implementation guide, ERA's will have several fields to indicate that a back-out or replacement exists:

1. The *Claim Status Code (CLP02)* field will have a value of "22", which stands for "Reversal of Previous Payment". The *Total Claim Charge Amount (CLP03)*, *Claim Payment Amount (CPL04)*, and *Patient Responsibility Amount (CLP05)* fields will also have negative monetary amounts as applicable to back-out the values on the original claim.
2. The *Reference Identification Qualifier (REF01)* field of the *Other Claim Related Identification segment (REF segment, Loop 2100, Position 040)* will have a value of "F8", which stands for "Original Reference Number". Also, the *Other Claim Related Identifier (REF02)* field will contain the original claim number.
3. The *Line Item Charge Amount (SVC02)* field and the *Line Item Provider Payment Amount (SVC03)* fields will have negative monetary amounts. Also, the *Units of Service Paid Count (SVC05)* field will also have a negative quantity count.
4. The *Claim Adjustment Group Code (CAS01)* field will have a value of CR, which stands for "Correction and Reversals". Also, the *Adjustment Amount (CAS03)* and *Adjustment Quantity (CAS04)* fields will have also negative amounts as applicable.

See the following example for more information:

```
CLP*5535943*22*-35*0**HM*123123123~  
NM1*QC*1*JOHN*DOE*Q***MI*11122333301~  
NM1*82*2*NORTH HILLS PASS CARDIOLOGY  
ASSOC*****F|*999887777~  
REF*1L*10~  
REF*F8*321321321~  
REF*G2*7954~  
DTM*050*20040611~  
SVC*HC>93010*-35*0**-1~  
DTM*150*20040505~  
DTM*151*20040505~  
CAS*CR*38*-35*-1~  
REF*LU*22~  
REF*6R*5535943~  
REF*1C*7954~
```

5. How are mixed-statistical claims reported on ERAs?

Mail Handlers follows the recommendations outlined in the Health Care Claim Payment/Advice implementation guide. As per the implementation guide, capitated claim lines in mixed statistical claims will be reported using a CAS*CO adjustment with a code 24 for "CHARGES DENIED-CHARGES COVERED UNDER A CAPITATION AGREEMENT".

Example:

The following mixed statistical claim has two service lines. The first line is billed for \$75 and is paid \$75. The second service is capitated, so its billed amount of \$25 will be negated with a CAS*CO*24 adjustment.

CLP*20202020*1*100*75*0*HM*123123123*13*1~
NM1*QC*1*DOE*JANE****MI*99988777701~
NM1*82*2*YORK HOSPITAL****FI*231352222~
REF*1L*18~
REF*G2*43995~
DTM*050*20040312~
SVC*HC>80051*75*75**1~
DTM*150*20040305~
DTM*151*20040305~
REF*LU*22~
REF*6R*123123-1~
REF*1C*43995~
SVC*HC>G0001*25*0**1~
DTM*150*20040305~
DTM*151*20040305~
CAS*CO*24*25~
REF*LU*22~
REF*6R*123123-1~
REF*1C*43995~

6. How is patient responsibility reported on ERAs?

Mail Handlers follows the recommendations outlined in the Health Care Claim Payment/Advice implementation guide. As per the implementation guide, there are several indications on an ERA that a claim has a patient responsibility amount. First, the *Patient Responsibility Amount field (CLP05)* of the *Claim Payment Information* segment (CLP) will have a positive value. Second, at least one of the service lines will have a CAS*PR adjustment with an appropriate adjustment reason code (i.e. 3 - Co-Payment, 2 - Coinsurance, 1 - Deductible Amount, etc.) that reduces the payment amount of the applicable service line.

Example:

The following claim has a co-payment amount of \$15.00. It is reflected in the CLP05 and in the CAS*PR adjustment for \$15.00 below.

CLP*20202020*1*100*85*15*HM*123123123*13*1~
NM1*QC*1*DOE*JANE****MI*99988777701~
NM1*82*2*YORK HOSPITAL****FI*231352222~
REF*1L*18~
REF*G2*43995~
DTM*050*20040312~
SVC*HC>80051*100*85**1~
CAS*PR*3*15~
DTM*150*20040305~
DTM*151*20040305~
REF*LU*22~
REF*6R*123123-1~
REF*1C*43995~

7. How are zero-payment transactions reported on ERAs?

Payment/Advice implementation guide. Occasionally an ERA will have a zero amount in *Total Actual Provider Payment Amount field (BPR02)* either because all of the claims in the transaction have been denied or all of the claim lines are capitated and therefore the overall payment amount for the transaction is zero. Since there is no payment due, a check was never drafted for this transaction. However, the *Check or EFT Number (TRN02)* is a required field in the 835 transaction, so in this case Mail Handlers populates it with a "0".

Mail Handlers Benefit Plan also populates the *Transaction Handling Code (BPR01)* with an "H" for Notification Only and a *Payment Method Code (BPR04)* of "NON" for Non-Payment Data to further identify that this transaction will not have a check or EFT number.

Mail Handlers has run test and production files through Claredi's HIPAA compliance checking engine and they have been accepted. See example below for more information.

Example:

The following 835 transaction has a single claim with no payment information because it has been denied. The *Claim Payment Amount (CLP04)* and the *Line Item Provider Payment Amount (SVC03)* fields are 0, so the resulting in *Total Actual Provider Payment Amount field (BPR02)* is also 0. Since this is the case, the *Check or EFT Number field (TRN02)* is also populated with 0 because there is no check number. As a result, the *Transaction Handling Code (BPR01)* has an "H" for Notification Only and the *Payment Method Code (BPR04)* is "NON" for Non-Payment Data. Providers need to have logic in their system to know that if the TRN02 is 0 it is not a legitimate check number.

```
BPR*H*0*C*NON*****20040719~  
TRN*1*0*111*12345~  
...  
CLP*1010101*4*65*0*0*HM*222222~  
...  
SVC*HC>99312*65*0**1~  
...  
CAS*CO*38*65*1~
```