SelectHealth
Remittance Advice Redesign:

Overview of Changes
Why is change necessary? One of the biggest changes in the healthcare industry is technology which allows fast and accurate service to customers. It is because of these technological advances we are required to assess whether the information on our paper Remittance Advice, or RA, gives providers the necessary information to accurately post payments and bill secondary payers.
Electronic submissions are standardized and governed by HIPAA, to ensure the information is consistent. Here in Utah, most providers send their electronic transactions through the Utah Health Information Network (UHIN).

In a meeting at UHIN it was discussed that many providers are struggling to bill a secondary payer accurately when the primary payer sends a paper RA. This is because many payers are not providing the standardized codes necessary for billing an electronic COB claim.

UHIN requested all payers look at the information provided on their paper RA's, and try to find a way to provide the national standard Group Codes, Claim Adjustment Reason, and Remittance Advice Remark Codes necessary for electronic COB claim submission.
What are Group Codes, CARCs, and RARCs?

Group Codes (GCs), Claim Adjustment Reason codes (CARCs), and Remittance Advice Remark Codes (RARCs) are the HIPAA approved codes used to report dollars that were not paid to the provider for a particular claim.
The GC, CARC, and RARC code sets were created for the Electronic Claim Remittance Advice (835 transaction) to explain why an ‘Adjustment’ was made to a claim line. An ‘Adjustment’ is any difference between the billed charges and the payment amount, i.e. contractual obligations, deductible, coinsurance, copayments, other carrier payments, denied services, etc…

These code sets are the national standard, and are maintained by the Health Care Code Maintenance Committee.

For more information go to www.wpc-edi.com

Detailed lists of these codes are available through the Washington Publishing website at www.wpc-edi.com
A Group Code is a two letter code used to indicate the type of adjustment being made to the claim line. The Group Code also assists the provider in determining who is liable for the adjusted dollars. The current Group Codes are as follows:

- **CO** - Contractual Obligations
- **OA** - Other Adjustments
- **PI** - Payer Initiated Reductions
- **PR** - Patient Responsibility
Claim Adjustment Reason Codes (CARC)

Claim adjustment reason codes communicate an adjustment, meaning that they communicate why a claim or service line was paid differently than it was billed. If there is no adjustment to a claim/line, then there is no adjustment reason code.

Common Examples:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Deductible Amount</td>
</tr>
<tr>
<td>2</td>
<td>Coinsurance Amount</td>
</tr>
<tr>
<td>3</td>
<td>Co-payment Amount</td>
</tr>
<tr>
<td>45</td>
<td>Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement</td>
</tr>
</tbody>
</table>

Claim Adjustment Reason Codes (CARC)

Any dollars adjusted on a claim must include a CARC to explain why the adjustment was made. Claim adjustment reason codes communicate why a claim or service line was paid differently than it was billed. If there is no adjustment to a claim/line, then there is no adjustment reason code. These are some common examples you may see:

Deductible Amount

Coinsurance Amount

Co-payment Amount

Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement
Remittance Advice Remark Codes (RARC)

Remittance Advice Remark Codes are used to provide a supplemental explanation for an adjustment already described by a Claim Adjustment Reason Code (CARC). Each Remittance Advice Remark Code identifies a specific message.

*Note: A RARC cannot be reported without a CARC.*

### Common Examples:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>MA67</td>
<td>Correction to a prior claim</td>
</tr>
<tr>
<td>N383</td>
<td>Services deemed cosmetic are not covered</td>
</tr>
<tr>
<td>N4</td>
<td>Missing/incomplete/invalid prior insurance carrier FOB</td>
</tr>
</tbody>
</table>

Remittance Advice Remark Codes (RARC)

Occasionally a CARC does not supply sufficient information to explain the adjustment. In these cases a RARC will be supplied to further define the adjustment. Since the RARC is a supplemental code to the CARC, a RARC will never be reported without a CARC.
Let’s review an example of how these codes are used to report adjusted dollars. Here is a claim with a billed amount of $100 and a paid amount of $10.

We will see how the dollars were adjusted to reflect the difference of $90 between the billed and paid amounts.
The first adjustment is $25 for the difference between the billed and allowed charges. The Group Code ‘CO’ indicates the dollars are a contractual obligation for the provider. The CARC '45' gives additional information to explain why these dollars were adjusted.
The second adjustment is $50 that applied to the member’s deductible. The Group Code ‘PR’ indicates the dollars are patient responsibility. The CARC ‘1’ gives additional information to explain why these dollars were adjusted.
The remaining $15 was adjusted because the member has a copayment for this claim. The Group Code ‘PR’ indicates the dollars are patient responsibility. The CARC ‘3’ gives additional information to explain why these dollars were adjusted.

The three adjusted dollar amounts account for the $90 that was not paid. In this particular example the CARC’s supplied were sufficient explanation to not require a RARC.
What needs to change with our existing paper RA in order to report adjusted dollars using the standard codes?
We are removing some columns and fields. All information will still be provided, but in a different manner.

We will be reporting additional modifiers, total interest recovered, remaining recovery amounts, and forward balance detail.

We have also simplified the balancing of the RA. The paper RA will now balance at a claim, claim line, and payment summary level.
Here is a look at our RA as it exists today.
The circled information will not change on the new RA, however the location or format for how this data is displayed will change.
All of the fields or columns that can be reported as adjustments will be removed, and will appear differently on the new RA. These include:

- Claim Discount
- Not Covered
- Withhold Amounts
- Other Carrier Paid
- Patient Responsibility
- Deductible
- Copayment
- Coinsurance
- Remark Codes
Here is what the new RA will look like

Let's look at the changes piece by piece, and compare the old RA with the new so it is more clear what is changing.
First, we will look at the Header information. Here is a sample of how our current Header information appears.
And here is a look at our new Header information. Placing the data in this format makes it easier to read and it looks like our member explanation of benefits.
Here we have a sample of the current and new Claim Header information. The only change in this section is we are now reporting the full 12 digit Claim Id in one field. The ‘Suffix’ field used in the current RA will be removed and the two digit suffix will be added as the last two digits of the Claim ID.
The Claim detail section is where the bulk of the changes are being made. Note how the Service Code column has been expanded to allow the reporting of more than one modifier. Also, note how all of the columns and fields that can be reported as adjustments have been moved to one section on the right side of the RA.

The Adjustment dollars section allows for two adjustments to be reported on the same line as the Service Code. If there are more than two adjustments for a particular Service Code, a second, third, or fourth line will be created to report the additional adjusted dollars.

For the example shown here, the total Adjustment dollars add up to $914.69 (Fee Charge - Provider Paid = Adjustments ($1802.00 – $887.31 = $914.69)). Since there is a difference between the billed and paid amounts, we know that adjustments were made to one or more of the claim lines.
**Claim Detail Information**

**Totals:**

<table>
<thead>
<tr>
<th>SERVICE CODE</th>
<th>DATE RANGE</th>
<th>SERVICE CODE</th>
<th>DATE RANGE</th>
<th>SERVICE CODE</th>
<th>DATE RANGE</th>
<th>SERVICE CODE</th>
<th>DATE RANGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>06/01/09</td>
<td>06/01/09</td>
<td>66304</td>
<td>06/01/09</td>
<td>06/01/09</td>
<td>06/01/09</td>
<td>06/01/09</td>
<td>06/01/09</td>
</tr>
<tr>
<td>177.00</td>
<td>108.82</td>
<td>163.92</td>
<td>108.82</td>
<td>152.94</td>
<td>1196.58</td>
<td>176.58</td>
<td>120.00</td>
</tr>
<tr>
<td>25.43 CO</td>
<td>25.43 CO</td>
<td>25.43 CO</td>
<td>25.43 CO</td>
<td>100.00</td>
<td>0.00</td>
<td>0.00</td>
<td>100.00</td>
</tr>
<tr>
<td>0.00</td>
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<td>100.00</td>
<td>0.00</td>
<td>0.00</td>
<td>100.00</td>
</tr>
<tr>
<td>1000.00</td>
<td>120.00</td>
<td>0.00</td>
<td>0.00</td>
<td>1000.00</td>
<td>0.00</td>
<td>0.00</td>
<td>1000.00</td>
</tr>
<tr>
<td>TOTAL</td>
<td>1000.00</td>
<td>120.00</td>
<td>0.00</td>
<td>1000.00</td>
<td>0.00</td>
<td>0.00</td>
<td>1000.00</td>
</tr>
</tbody>
</table>

Fee Charge, Allowed Amount, Provider Paid, Patient Responsibility, and Interest will be summarized for each claim.

**Patient Responsibility = Sum of all Adjustment amounts reported with a ‘PR’ Group Code**

A Total line is provided for each claim to summarize the Fee Charges, Allowed Amount, Provider Paid, Patient Responsibility, and Interest paid for the claim.
Let’s review how corrections and reversals will appear on the RA. In this example we have been asked to take these dollars back because the claim was billed in error. Here is how we would report this correction:

The reversal claim information will appear as negative dollars in the body of the RA. The recovery status of the claim will appear in the Recovery and Forward Balance Detail at the end of the RA.

A new claim will be processed to correct the mistake that was made and it will be necessary to look at the new claim to determine the reason for the correction.
Now we move on to the Summary & Recovery sections of the RA. Currently, we provide on the last page of the RA, a summary of all the claim dollars along with itemized detail for all recoveries. The Product Totals do not always balance with the actual payment amount of the check. This is because we include reversal dollars in the summation, but do not include actual Recovered dollars. This causes two balancing problems: 1) A claim may be reversed on a payment, but we may not be able to recover those dollars on the same payment and 2) By not including actual recovered dollars in the totals, the Provider Paid column will not balance with the Net Check Payment amount whenever there is a recovery.
Our new RA Totals will balance with the Net Check Payment amount. We do not consider reversals as part of this calculation, and we have added columns to report the Recovery and Interest dollars that are used to make up the check amount.

The Recoveries section now also includes more detailed information. If dollars are recovered for a specific claim and there are additional dollars to recover the Forward Balance column will show the amount leftover.

Additionally, if a claim is reversed on the current payment and we are not able to recover anything for that claim, the claim will appear in the Recovery Detail section with Forward Balance detail to indicate how much we will attempt to recover on a future payment.

It is important to remember that the Recovery and Forward Balance section is not intended to be an overall summary of all outstanding claims still pending recovery. Only those claims where an actual recovery or reversal occurred on the current payment will appear in this section. Reversed or Pending Recovery claims with a remaining forward balance will not appear again until dollars are actually recovered.
On the final page of the RA we will provide definitions for all of the CARCs and RARCs that appear on the payment. We will also provide definitions of the Group Codes and Forward Balance.
All RA Reprints will be generated in the new format, even if the original remittance advice was sent in the old format.
Now that we have reviewed the changes, let's discuss when we are hoping to put these changes into place.
Please contact Member Services or your Provider Relations Representative with any questions regarding these changes.

We hope that by creating a more uniform RA, and using the standard codes already used by many other payers, we will make your jobs a little easier. We appreciate your participation and look forward to presenting you with our new improved RA.