CHAPTER 13:

Understanding the Remittance Advice

Reviewed/Revised: 9/24, 01/24, 5/25, 12/25

13.0 GENERAL INFORMATION

A Remittance Advice (RA) is sent with each claim payment, (see Exhibit 13.1, Sample Medical Remittance or Exhibit 13.2, Sample Dental Remittance). Providers are responsible for reviewing and reconciling their accounts receivable to all remittance advices accompanying payments. Each RA will contain a payment status or reason for denial.

The ACA StandardHealth with Health Choice Remittance Advice provides information about adjudicated claims, including claims paid or voided and claims which were denied. The Remittance Advice is generated with each payment cycle.

A provider will receive the Remittance Advice by one of two ways:

1. A Paper Remittance Advice is mailed to the billing provider or
2. An Electronic Remittance Advice (ERA) is transmitted through the HIPAA-compliant 835 format.

All claims adjudicated during the processing cycle are listed on the RA, along with the payment status or reason for denial. The provider should use the RA to identify reasons for denial(s) to determine whether to resubmit the claim or take alternative action. See Exhibit 13.3, Denial Codes for explanations of the denial codes.

If the billing provider has submitted claims for multiple service providers, the Remittance Advice will contain a section for each. This chapter primarily addresses the Paper Remittance Advice only.

Sign-up for Electronic Remittance Advice
Providers can expedite cash flow with ERA. Contact your Provider Performance Rep to sign up today!

Electronic Funds Transfer
Through Electronic Funds Transfer (EFT), providers have the ability to direct funds to a designated bank account. ACA StandardHealth with Health Choice encourages you to take advantage of EFT.

Since EFT allows funds to be deposited directly into your bank account, you will receive payment much sooner than waiting for the mailed check.

If you need additional services or have questions please contact your Provider Performance Representative or Claims Customer Service at (800) 322-8670

13.1 REMITTANCE ADVICE

Each Remittance Advice contains the following information:

- Paid claims
- Voided claims
- Denied claims

The last page provides an alphabetical listing of denial reason codes and pricing explanation codes.

- Each is listed only once even if it applies to multiple claims.

13.2 CLAIM DISPUTES

This page informs providers of their claim dispute rights. (See Chapter 15: Claim Disputes, Member Appeals and Member Grievances) for specific instructions and guidance.

Information reported on the Remittance Advice (RA) page includes:

- Billing Provider ID number
- Check date
- Invoice Number which links payments to the services that generated the payment
- Service Code
- Quantity billed (units #)
- Amount billed
- Excluded and non-allowed amounts
- Allowed amounts
- Amount of other payer's payment
- Member Co-pay amount
- Contractual write off amount/Quick Pay Discount "Withhold Amount" (if applicable)
- Amount paid
- Adjustment/Denial code

13.3 WORKING THE REMITTANCE ADVICE

Here are some suggestions for working the ACA StandardHealth with Health Choice Remittance Advice to reconcile claims billed to the Plan and the status of those claims:

NOTE: ACA StandardHealth with Health Choice highly recommends that resubmissions should be done using the Health Choice Secure Online Provider Portal:

- Review the RA to determine which claims have been paid and if the claims are paid correctly.
    - Any errors, such as claims that have not paid the correct number of units, should be marked for resubmission/replacement, noting the appropriate CRN. (See Chapter 7:

General Billing Rules, for information and guidance on resubmitting a paid claim).

- Review the RA to determine if any claims submitted by the provider as replacements are adjusted correctly. If problems still exist with a claim, it may be submitted again as a replacement, noting the appropriate CRN. The RA will also report any claims that were adjusted by ACA StandardHealth with Health Choice as a result of an audit or review. (See Chapter 7: General Billing Rules, for information and guidance on resubmitting a paid claim).
- Review the RA for any claims submitted by the provider as void transactions. There are many reasons a claim may be voided. These may be claims that have been paid by other insurance and now need to be voided so that ACA StandardHealth with Health Choice can recoup its payment. The RA will also report any claims that were voided by ACA StandardHealth with Health Choice as a result of an audit or medical review recoupment. Providers who believe that a claim was voided in error should contact the ACA StandardHealth with Health Choice Claims Customer Service Unit. (See Chapter 7: General Billing Rules, for information and guidance on resubmitting a paid claim)
- Review the RA for denied services. Review each denial reason and determine the action necessary to correct the claim. (See Chapter 7: General Billing Rules, for information and guidance on resubmitting a paid claim).

Providers who have questions about the Remittance Advice or about resubmitting, adjusting, or voiding a claim should contact ACA StandardHealth with Health Choice at (800) 322-8670.