



Does understanding an Explanation of Benefits (EOB) seem like deciphering Egyptian Hieroglyphs?

This guide can help you find your way through an EOB, allowing you to accurately apply the appropriate payment, contractual write-off and patient responsibility.

Below is a sample EOB based upon the standard Medicare Remittance Notice. Since most payers have their own formats and terminology, we will also provide a table that will “crosswalk” other terms to the ones found on the sample.

PALMETTO GBA
23711 LA
PASADENA, CA 911850001
8669313903
TECHNICAL DEPARTMENT CONTACT: PALMETTO GBA; TELEPHONE8669313903;
TELEPHONE8669313901; FACSIMILE8034623912;

MEDICARE REMITTANCE NOTICE

BEST MEDICINE
3267164 KINGSTON EXTENSION
BLDG 13
RENO, NV 89521
108-431-3560

PROVIDER #:
PAGE #: Page 1 of 1
DATE: 10/15/2012
CHECK/EFT 881815057

REND PROV	SERV DATE	POS	NOS	PROC	MODS	BILLED	ALLOWED	DEDUCT	COINS	GRP/RC-AMT	PROV PD
NAME	CANNON, SIDNEY V			HIC 841313019M		ACCT 873961758B		ICN 998025763L		ASG Y	MOA MA01 MA18
	09/20/2012	11	1	77290 TC		1934.54	486.22	0.00	97.24	CO-45	1448.32 388.98
	09/20/2012	11	1	77014 TC		360.00	107.73	0.00	21.55	CO-45	252.27 86.18
	09/20/2012	11	1	77334 TC		1363.62	92.97	0.00	18.59	CO-45	1270.65 74.38
PT RESP	137.38			CLAIM TOTALS		3658.16	686.92	0.00	137.38		2971.24 549.54
ADJ TO TOTALS:	PREV PD			INTEREST		0.00	LATE FILING CHARGE			0.00	NET 549.54
CLAIM INFORMATION FORWARDED TO: BLUE CROSS OF NEVADA											
TOTALS:	# OF CLAIMS	BILLED AMT	ALLOWED AMT	DEDUCT AMT	COINS AMT	TOTAL RC-AMT	PROV PD AMT	PROV ADJ	CHECK AMT		
	1	3658.16	686.92	0.00	137.38	2971.24	549.54	0.00	549.54		

GLOSSARY: GROUP, REASON, MOA, REMARK AND ADJUSTMENT CODES

MA01 If you do not agree with what we approved for these services, you may appeal our decision. To make sure that we are fair to you, we require another individual that did
MA18 The claim information is also being forwarded to the patient's supplemental insurer. Send any questions regarding supplemental benefits to them.
45 45-Charges exceed your contracted/ legislated fee arrangement.
CO Contractual Obligations

Medicare Terms	Definitions	Terms Used by Other Payers
Remittance Notice	Title given to the report issued by the payer summarizing the processing details of the claim.	Explanation of Benefits, Explanation of Payment, Remittance Advice, Statement of Payments
Billed/Billed Amt	Represents the fee charged for the services.	Charge Amount, Charges, Requested Amount, Submitted Expenses.
Allowed/Allowed Amt	Equals the amount of the fee that is allowed per the contracted rate with the payer.	Eligible Expense or Amount, Approved, Covered Charges.
Deductible/Deductible Amt	Indicates if any of the allowed fee was applied to outstanding deductible on the patient's policy.	Annual Deductible.
Coins/Coins Amt	Indicates the amount of the allowed fee that the patient must pay per their policy terms.	Customer or Patient Liability. Out of Pocket Amount (OOP). Commercial payers may also indicate Copayment on a service which is a flat rate charged independent of the fee.
Grp/RC-Amt/Total RC Amt	Grp stands for Group and RC stands for Reason Code. These are codes that abbreviate the basis for any amounts not paid by the payer. See section below for further details.	Adjustment Grp and Reason Code, Not Covered Reason, Payment Codes.
Prov Pd/Prov Pd Amt	This is the amount of money paid for the claim.	Amount Paid, Payment, Benefits Paid, Pay Amount, Net \$, Total Benefit, Policy Pays.
HIC	The health insurance identification number for the patient.	Subscriber ID, Member Number, Policy Number.
ICN	This is the Internal Control Number assigned to the claim once processed by the payer. This is used for their internal tracking.	Claim Number, Payer Claim Control Number.
Pt Resp	This is the amount of money the patient can be billed for the services on the claim.	Customer or Patient Liability. Out of Pocket Amount (OOP). This will typically be the summary of Deductible, Coinsurance and Copayment amounts applied to the services.
Prov Adj(Prev Pd,Interest,Late Filing Charge)	When the payer has additional adjustments to apply to the provider's portion of the payment, this area is used. It may increase the base payment as in the case of interest paid. It would decrease the base payment if a portion of the service had been previously paid on another ICN.	Penalty, Recoupment.
Remark Codes	These codes are used to provide additional explanation for an adjustment already described by an Adjustment Group/Reason Code. See section below for further details.	Abbreviations of REM or RMK.

A Claim Adjustment **Group Code** consists of two alpha characters that assign the responsibility of a Claim Adjustment on the insurance Explanation of Benefits.

These 5 EOB Claim Adjustment **Group Codes** are:

Code Abbreviation	Full Code Description	Indicated Action
CO	Contractual Obligation	This represents amount of the fee that must be written off as uncollectable based on provider's agreement with the payer. It will most commonly indicate the amount billed over the allowed payer fee schedule amount. As a contracted provider, contractual obligation amounts cannot be passed on to the patient,
CR	Corrections and Reversal	This code is mainly utilized to indicate a service has been reprocessed by the payer. It would apply if a denial was overturned indicating additional payments were sent. It can also be used when the payer overturns an original payment, making the provider aware of an overpayment on the service.
OA	Other Adjustment	You can relate this to a "miscellaneous" category. The Reason Code that is attached will be the key to understanding the impact and proper processing of this adjustment. It will be typically seen on a secondary payer EOB to show the amount paid by the primary carrier and how it affected the payment issued.
PI	Payer Initiated Reductions	A payer may use this code to explain monies withheld from the claim payment. If a provider has an outstanding refund due the payer, they can withhold payments on new services.
PR	Patient Responsibility	Of all the codes, this is probably the most logical. Any amounts to be passed on the patient, or in some cases a secondary payer, will have this indicator. It would apply to Deductible, Copayment and Coinsurance .

These **Group Codes** are combined with Claim Adjustment **Reason Codes** that can be numeric or alpha-numeric, ranging from 1 to W2. For a complete list of Claim Adjustment **Reason Codes**, visit Washington Publishing Company's website by [clicking here](#). Claim Adjustment **Reason Codes** communicate an adjustment, meaning that they must 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.

Top 5 examples of EOB Claim Adjustments are:

Grp/RC	Indicated Action
CO-45	Indicates claim amount that must be written off based on payer contracted fee schedule.
CO-97	Indicates the benefit for this service is included in the payment/allowance for another service or procedure that has already been adjudicated.
OA-23	Indicates the impact of prior payer(s) adjudication including payments and/or adjustments.
PR-1	Indicates amount applied to patient deductible.
PR-2	Indicates amount applied to patient co-insurance.

Each **Remark Code** will corresponds to either a standard message found in the Remittance Advice Remark Code List or will reference a payer specific message that will be shown on the EOB. For a complete list of **Remark Codes**, visit Washington Publishing Company's website by [clicking here](#).

Remark Code	Expected Use
M2	Would be applied to a denied or bundled service to indicate the service was not paid separately when the patient is an inpatient.
M25	Gives further details as to why a service would have been paid at a lower than expected contractual rate based on the information furnished does not substantiate the need for this level of service.
M25	If a service requiring documentation was denied, it would indicate there was a missing operative note/report.
MA18	Used for Medicare payers to show the claim information was sent electronically to a secondary payer.
MA40	Explanation for denied inpatient service that was missing or contained an incomplete/invalid admission date.

As explained above, on the standard Medicare Remittance, the column heading **Grp/RC-Amt** shows the combined alpha-numeric adjustment code for the service billed. You may have also observed directly to the right of the code, a number as shown here: CO-45 1448.32. This represents the **Disallowed Amount** for the service line. Other payers may indicate the same by using other terms, such as: Non-allowed Amount, Not Covered, Discount, Ineligible, or Policy Does Not Cover.



Just remember, all the information on the Explanation of Benefits are just the pieces to the payment puzzle. Once you fit them all together, the whole picture becomes clear.

You can also consider purchasing a sophisticated **Practice Management Software** such as [Iridium Suite](#). This product from [Medical Business Systems](#) can be used to increase the automation of your practice. With one of the many advanced features available in this **physician billing system**, your Electronic Remittance Advices (ERAs) are automatically retrieved and adjudicated from many of the large payers. Your time consuming manual EOB posting can be almost eliminated.

