Provider Guide

Explanation of Payment

An Explanation of Payment (EOP) provides information regarding the adjudication of your claims. This brief guide illustrates how to read your EOP and identify the differences for a paid or denied claim. An EOP will be posted to the provider portal once the claim processes.

A. Individual Claims Summary

Patient: John Doe	**Claim #:** 123456789101	**Patient Ctrl:**
PMI:	**DOS:**	**Med Rec #:**
Patient ID: 123456789-01	**DRG:**	**Rend Prov ID**
Group: ABCDEF	**DRG Weight:**	**Rend Prov:**
Contract: XX	**Discharge Frac:**	**Grp CD:**
		Clm Adj Rsn Cd

B. Claims Payment Breakdown

Claim Charge:	9,418.97
Payer Adj Amt:	5,167.09
Patient Resp:	1,776.31
Claim Payment:	2,475.57
Other Cont Oblig:	14.95

C. Service items, charge and allowed amount **D. Adjustments** **E. Payment Codes**

Summary

Line Ctrl #	Dates of Service	Auth #	Adj Prod/	Revenue Code	Mod	Units	Charge	Allowed Amount	Adjustment Amount	Other Cont	Denied	Patient Costshare	Payment	Group Code	Clm Adj Rsn Cd	Remark Code	Adj Qty
0100	022817-022817		59515			1	3,296.00	2,379.42	916.58				1,314.11	CO	45	MA125	1
0100	022817-022817		59515			1						879.55		PR	1		1
0100	022817-022817		59515			1						185.76		PR	2		1
0200	022817-022817		58611			1	198.00	149.70	48.30				149.70	CO	45	MA125	1
0300	022817-022817		E0191			1	14.00	14.00			14.00			PR	96	N425	1
0400	022817-022817		72170			1	75.00	34.43			75.00			CO	97	M15	1
0500	022817-022817		A0428			1	597.00	233.87	363.13					PR	45	MA125	1
0500	022817-022817		A0428			1						233.87		PR	1		1
0600	022817-022817		66984			1	2,446.00	1,034.31	1,411.69				919.36	CO	45	MA125	1
0600	022817-022817		66984			1				14.95				CO	253		1
0600	022817-022817		66984			1						100.00		PR	3		1
0700	022817-022817		A9276			1	2,792.97	924.00	1,868.97				92.40	CO	45	MA125	1
0700	022817-022817		A9276			1			831.60					OA	23		1
				Sub Totals			9,418.97	4,769.73	5,440.27	14.95	89.00	1,399.18	2,475.57				

G. Additional Payee information

F. Sums of all of the individual claim amounts

Statement Totals

Charge Amount	Allowed Amount	Adjustment Amount	Other Contactual Obligtion	Denied	Patient Costshare	Provider Adjustment Amount	Payment Amount	Unused Negative Balance
9,418.97	4,769.73	5,440.27	14.95	89.00	1,399.18		2,475.57	

A. Individual Claims Summary

This section contains information pulled from the submitted claim, including patient and claim information, coverage information and medical records.

B. Claims Payment Breakdown

Payment totals can be readily pulled.

- **Claim Charge** - The amount charged to UCare on the individual claim.

- **Payer Adjustment Amount** - The sum of all payment adjustments. Payment adjustments are defined as any adjustment with a group code indicating contractual obligation (CO) or other adjustment (OA), not including sequestration.
- **Patient Resp** - The sum of all patient responsibility adjustments, indicated with a group code of patient responsibility (PR), which is more than a costshare amount and can include other adjustments.
- **Claim Payment** - The amount of payment UCare owes to the provider for this individual claim.
- **Other Contractual Obligation** - UCare uses this to display sequestration.

C. Service Items, Charge and Allowed Amount

Service line items are details about the submitted claim. UCare adjudicates each service line item with thousands of regulations, policies and rules. UCare then reviews each item for coding issues, such as unbundling, modifiers, appropriateness and mutual exclusive services. We then show the charge made in the claim and the allowed amount based on this analysis.

- **Charge** - Reflects the amount billed.
- **Allowed Amount** - Represents the amount UCare allows for the service.

D. Adjustments

Adjustments are applied to the amount charged on a claim. Below are UCare's adjustment categories:

- **Adjustment Amount** - Reflects the difference between your Charge Amount and Allowed Amount.
- **Other Contractual** - Represents sequestration, the spending cuts applied to several government programs including Medicare. Doctors, hospitals and providers are reimbursed at 98 cents on the dollar by Medicare.
- **Denied** - The full charged amount for that service line item regardless of the responsible party.
- **Patient Costshare** - The amount members pay based on their coverage (contract).

E. Payment Codes

The last three columns display payment codes by line item.

- **Group Codes** - Financial responsibility for the unpaid portion of the claim balance, i.e., CO, PR, OA, etc.
- **Claim Adjustment Reason Codes (CARC)** - The reason code for a service line that was paid differently from what was billed. Common codes include PR 3-Co-payment amount, CO 45-charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement and OA 253-Sequestration - reduction in federal payment.
- **Remark Code** - Explain an adjustment or convey information about remittance processing. Also known as Remittance Advice Remark Codes (RARC), common codes include MA15-Separately billed services/tests separate payment is not allowed and MA125-Per legislation governing this program, payment constitutes payment in full.

For additional information about CARC and RARC codes, please visit External Code Lists | X12.

F. Sums of All of the Individual Claim Amounts

The bulk payment sum of the **Charge Amount, Allowed Amount, Adjustment Amount, Other Contractual Obligation, Denied** and **Patient Costshare**.

G. Additional Payee Information

- **Provider Adjustment Amount** - The unreimbursed amount owed to UCare (negative balance) that was applied against the payment made.
- **Payment Amount** - Total bulk payment sum.
- **Unused Negative Balance** - The remaining negative balance that has not been applied, often published in a recent EOP from a previous claim.