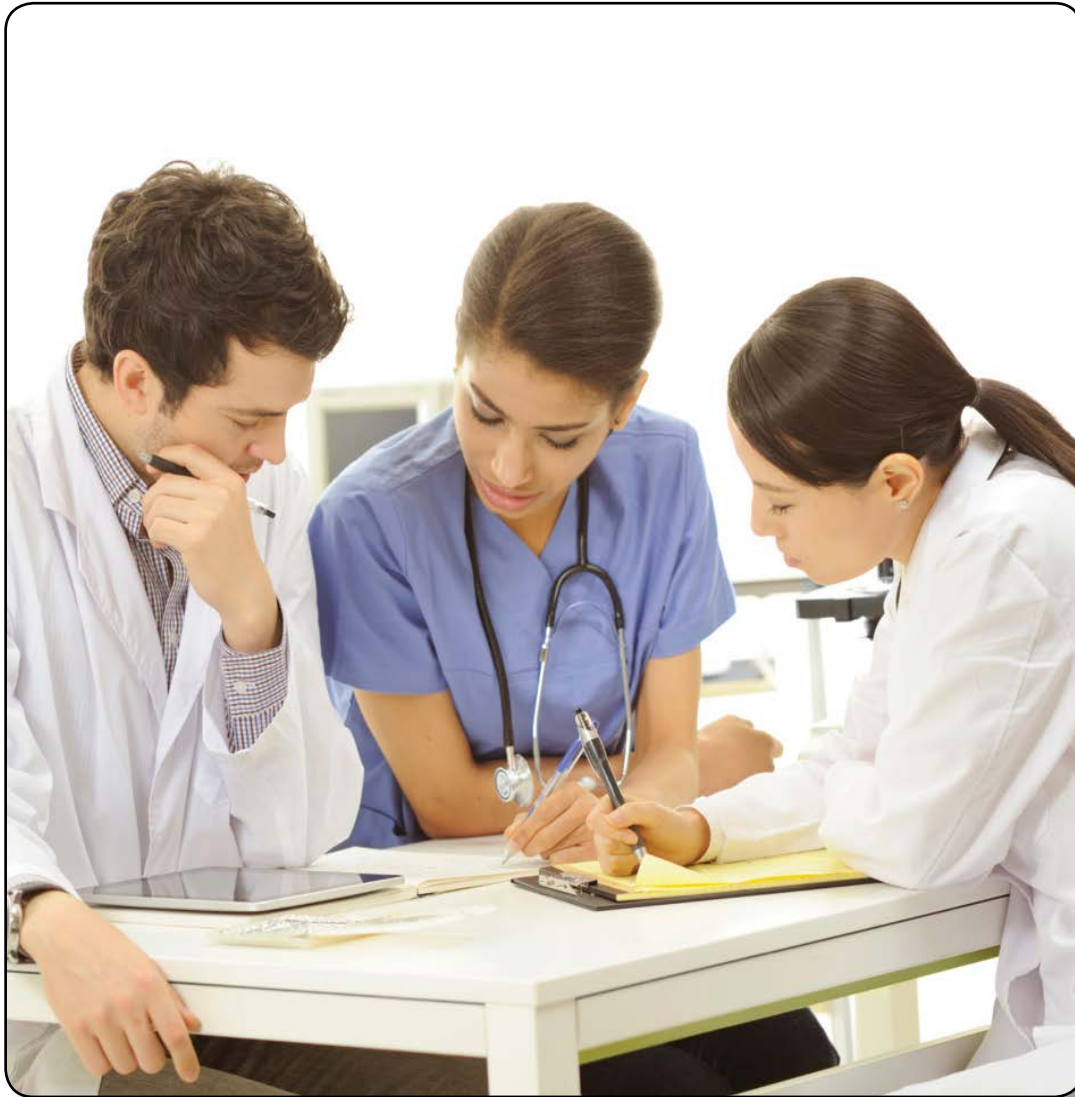**mln**
BOOKLET

KNOWLEDGE • RESOURCES • TRAINING

Remittance Advice Resources and FAQs

Target Audience: Providers, Physicians, Suppliers, and
Medicare Fee-For-Service Program (also known as Original Medicare)

The Hyperlink Table at the end of this document provides the complete URL for each hyperlink.

CMS
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INTRODUCTION

The Centers for Medicare & Medicaid Services (CMS) prepared this Remittance Advice (RA) booklet for Medicare Providers so you may conveniently access RA information. This booklet contains consolidates information and allows different provider types to easily navigate to topics pertinent to them. **To go directly to a section, click on the topic below**.

GENERAL INFORMATION

Professional and Institutional RAs

Part A, Institutional Providers, submit claims to Medicare Administrative Contractors (MACs). After MACs process these claims, they generate an **Institutional RA** as a companion to the payment or as an explanation of no payment.

Part B Providers also submit claims to MACs. After the MACs process the claims, they generate an RA as a companion to the payment or as an explanation of no payment. Providers submitting professional claims to MACs receive a **Professional RA**.

MACs send claim adjudication and payment information to providers, suppliers, and billers using an Electronic Remittance Advice (ERA) or a Standard Paper Remittance (SPR) along with payments. These RAs give explanations and guidance as to whether a payment was or was not made, or if the payment differs from what the provider submitted. The ERA or SPR conveys itemized information for each claim and/or line enabling the provider to associate the adjudication decisions with those submitted claims/lines. The ERA or SPR reports the reason for each adjustment, and the value of each adjustment. Adjustments can happen at line, claim, or provider level. An ERA reports the adjustment reasons using standard codes. For any line or claim level adjustment, three sets of codes may be used:

1. Claim Adjustment Group Code (Group Code)
2. Claim Adjustment Reason Code (CARC)
3. Remittance Advice Remark Code (RARC)

Group Codes assign financial responsibility for the unpaid portion of the claim/service line balance, for example, Contractual Obligation (CO) Group Code assigns responsibility to the provider and Patient Responsibility (PR) assigns responsibility to the patient. Medicare beneficiaries may be billed only when Group Code PR is used with an adjustment. CARCs provide an overall explanation for the financial adjustment and RARCs supplement the CARCs with the addition of a more specific explanation. While providers receive an ERA or SPR, Medicare beneficiaries receive a Medicare Summary Notice (MSN) indicating how much financial responsibility the beneficiary incurs as a result of the claim.

At the provider level, adjustments are usually not related to any specific claim or service line in the RA, and Provider Level Balance (PLB) reason codes are used to explain the reason for the adjustment. Some examples of provider level adjustment are:

1. An increase in payment for interest due as a result of the late payment of a clean claim by Medicare

2. A deduction from payment as a result of a prior overpayment

3. An increase in payment for any provider incentive plan

Note: The SPR also reports these standard codes, and provides the code text as well. One check or electronic funds transfer (EFT) is issued when payment is due, representing all benefits due from Medicare for the claims itemized in that ERA or SPR.

Payees use RA information as inputs to patient accounting system/accounts receivable (A/R) and general ledger applications. In addition, RA information may indicate a need for you to resubmit a claim with corrected information. RA information also indicates whether you can appeal the payment.

SPR vs ERA

You may receive an RA from Medicare in an ERA, or an SPR. Although the information on ERAs and SPRs is similar, the two formats are arranged differently. The ERA offers some data and administrative efficiencies not available in an SPR.

The Health Insurance Portability and Accountability Act (HIPAA) does not cover the SPR, so service-line information may not appear on some Institutional SPRs like it does on an ERA. The SPR shows the same segments, fields, and codes that are on the ERA, which helps you to make sure that the 835 balances at three levels (transaction, claim, and service-line).

Any health care professional who is active in the Medicare Program and submits claims, may receive an ERA. If you submit your claims on paper, or if you send claims electronically and do not have your own submitter number and want to receive ERAs directly, you must complete the Separate Remittance Agreement form. You may allow a billing service or clearinghouse to receive the ERA files on your behalf by completing the Provider/ Submitter Agreement form. Should you need assistance in preparing the necessary paperwork, contact your MAC's EDI Helpline.

There are a number of advantages to using the ERA versus the SPR. The amount payable for each line and/or claim as well as each adjustment applied to a line or claim can be automatically posted to accounting or billing applications from an ERA, eliminating the time and cost for staff to post this information manually from an SPR.

ERAs generally contain more detailed information than SPRs. Additionally ERAs may enable providers to automate follow-up actions after receiving an RA.

Note: MACs do not send SPRs if you have been receiving ERAs for more than 31 days (Institutional Providers) and 45 days (Professional Providers) respectively. If you submit claims through a billing service or clearinghouse, or a submitter/sender ID that is currently receiving ERAs, you will no longer receive your SPR effective with the date of completion of the ERA setup.

Data Elements in the RA

The basic data elements of the RA can be alphabetic, numeric, or alphanumeric. The HIPAA-compliant Accredited Standards Committee (ASC) X12 835 format standards define data elements that appear on all Medicare RAs as **Required** or **Situational**.

- The required fields are mandatory for MACs to include in the RA
- The use of situational fields depends on data content and business context (Medicare requirements), and providers use them if the situation applies

If your MAC bases payment on a procedure code (Healthcare Common Procedure Coding System/Current Procedural Terminology (HCPCS/CPT) code) that is different from the procedure code you submitted on the claim (for example, your MAC revised the HCPCS/CPT code during processing), both procedure code fields appear in the 835.

If there is no difference between the adjudicated procedure code (required field) and the submitted procedure code (situational field), only the adjudicated procedure code field appears in the 835. The submitted code field does not appear because the situation does not apply.

Enrolling in ERA

Directions for enrolling in ERA are available on your MAC's website. That website is available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/.

ERA is an outbound electronic data interchange (EDI) transaction that enables you to receive payment information in an electronic file format. If you have software capability in place in your system your MAC can automatically post an ERA file created by Medicare to your accounts receivable system. Once the ERA is in place for you, the payment posting process is more efficient and accurate.

Free Medicare ERA Software

Medicare provides free downloadable translator software that can both read ERAs as well as print the equivalent of an SPR. **PC Print is available for Institutional Providers**, and **Medicare Remit Easy Print (MREP) is available for Professional Providers**. These software products enable you to store, view, and print RAs when you need them, thus eliminating the need to request or await mail delivery of SPRs. The software also enables you to export special reports to Excel and other application programs you may have.

> **Note:** CMS provides these software tools in downloadable form at no charge. However, MACs may charge a small fee for those providers requesting an alternative delivery method for any of these products.

Commercial ERA Software

Although Medicare offers free ERA software, you may decide to purchase software that better fits your business needs. For example, you may seek RA software that is totally integrated with other office management suite applications you use for billing, accounts receivables, reporting capabilities, and other purposes. Otherwise, you may prefer the flexibility of web-based application options eliminating the need to download software updates. Additionally, you may seek integrated software packages that are designed for your type of facility, specialty, or the relative size of your practice.

If you use proprietary software you must confirm that the software version in use meets HIPAA-compliant American Standards Committee (ASC) X12 835 format standards and includes required and situational data elements that comply with Medicare guidelines.

MACs provide directories of approved HIPAA-compliant software vendors, billing services, and clearinghouses. Medicare and its MACs do not endorse any particular commercial ERA product. We encourage you to do your own thorough research when considering purchasing or using software outside of that which CMS provides. Please direct any questions about the features and functionality of such software to the software vendors themselves and not to CMS or its MACs.

> **Note:** Regardless of what software is used for ERA, you should monitor CMS MLN Matters® Article releases for updates to:
>
> 1. **CMS provided PC Print or Medicare Remit Easy Print (MREP)**
> 2. **Claim Adjustment Reason Codes (CARCs)**
> 3. **Remittance Advice Remark Codes (RARCs)**
>   - The CARC and RARC lists are updated three times per year. CMS publishes a MLN Matters® Article advising providers of each update. Updates usually occur on March 1, July 1, and November 1.
>   - Reviewing these articles will help you assure that your ERA software has the proper code updates.

How Is the ERA available?

ERAs are available electronically to providers for a specified period of time after the MAC processes your claims. Your MAC determines how long the ERA is available. ERAs offer you additional flexibility when you view your remittance information. This flexibility includes a specialized data view, the ability to create various reports, the ability to search for information in claims and the ability to export data to other applications. ERAs also may enable you to automate follow-up actions like billing the beneficiary for deductible/co-pay.

How Is the ERA Generated?

MACs produce the ERA in the HIPAA-compliant ASC X12N 835 format, often referred to as Transaction 835, or **the 835**.

The 835 that your MAC sends to you is a variable-length record designed for electronic transmission and is not suitable for use in application programs or for viewing by provider personnel. Providers, or the entity receiving the 835, convert this file after transmission into a flat file for manipulation within their systems. This booklet refers to the 005010A1 version of the ASC X12N 835, which is the current adopted HIPAA standard.

Providers who do not receive the 835 directly from Medicare need to confirm receipt of all information from the entity receiving the 835 on their behalf, for example, a financial institution. It is possible that the entity receiving the 835 may not regularly send the RARCs that explain adjustments in reimbursement.

READING AN INSTITUTIONAL RA

This section tells Institutional Providers and billers how to read a Standard Paper Remittance Advice (SPR) and an Electronic Remittance Advice (ERA) using PC Print software. There are three major sections:

- **Reading an Institutional ERA:** This section provides guidance for reading an Institutional ERA
- **Reading an Institutional SPR:** For providers who elect to receive this information on paper, this section provides similar guidance for reading an Institutional SPR
- **Balancing the Institutional RA:** Presents guidance and examples for balancing the ERA or the SPR so providers' records are consistent with Medicare's records

Introduction

Institutional Providers submit claims to Medicare Administrative Contractors (MACs). After MACs process these claims, they generate an Institutional RA as a companion to the payment or as an explanation of no payment.

Are the RAs Standardized?

Both the Institutional SPR and ERA (when you view them using the free PC-Print software Medicare provides) are standardized to ensure that you receive the necessary information. Institutional Providers using proprietary software to receive an ERA should confirm with their MAC that the software meets the HIPAA-compliant ASC X12N 835 format standards and includes required, as well as situational data elements that comply with the Medicare business context. The SPR mirrors the information provided in an ERA.

For more information on the Medicare standardized data requirement companion guides for the ASC X12N 835, refer to http://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/index.html.

How Do I View the Information in an Institutional ERA?

Since the 835 format is meant for electronic transfers only, you cannot easily read the data. Your staff may view and print the information in an ERA using special translator software like the Medicare PC Print translator software program. The PC-based PC Print translator program is an interactive program. It allows you to view, search, and print the Medicare Part A ERA containing all of the data residing within the 835 ERA transmission.

PC Print software produces one of four print versions of data contained in an 835. This allows you to choose how much or how little 835 data to print and offers an advantage over the SPR. The number of Institutional claims you submit in batches, as well as the number of service lines, can be very large. MACs do not include service-line level data in the SPRs they send to Institutional Providers that still prefer to receive SPRs, since such large paper files would be very bulky and expensive to ship.

If you want access to service-line level information you must accept an 835. A number of commercial software vendors also include software in their HIPAA suite that you may use to print a paper version of the 835.

How Do I Get the PC Print Software Program and User Guide?

Medicare provides free downloadable translator software that can both read the ERA as well as print an equivalent of the SPR. Institutional Providers can get PC Print from their MACs.

This software product enables you to store, view, and print RAs when you need them, thus eliminating the need to request or await mail delivery of SPRs. The software also enables you to export special reports to Excel and other application programs you may have and manage. MACs inform you of necessary updates to accommodate code set changes, typically three times a year. Register on your MAC's website to get automatic notifications of updates.

How Does the PC Print Present the ERA Information?

PC Print offers four different options to display and print data contained within the ERA.

Option 1: The All Claims (AC) screen: The AC screen displays 835 data in a manner similar to the format and content of an SPR. This screen lists all of your claims that completed processing on the date indicated on the ERA, but does not show service-line data for these claims.

Option 2: The Single Claim (SC) screen: The SC screen provides a detailed summary of data from a single claim. An SC screen is available for each claim listed on the AC screen. This screen provides information about denied or non-covered claims. You may use this to send a claim to a secondary or tertiary payer. Service-line data, if applicable, appears on this screen.

Option 3: The Bill Type Summary (BS) screen: The BS screen provides a summary of claims you billed for each Type of Bill (TOB), for each provider number and for each Fiscal Year (FY). For example, if a Home Health Agency (HHA) billed 32X and 33X claims for FY 16 and FY 17, it would receive the following four billing summaries:

- TOB 32X for FY 16	- TOB 32X for FY 17
- TOB 33X for FY 16	- TOB 33X for FY 17

The provider only receives a bill summary for those TOBs that were processed on this ERA. Therefore, if the MAC only processed 32X claims for FY 16 on this ERA, the HHA only receives one bill summary.

Option 4: The Provider Payment Summary (PS) screen: The PS screen provides a summary of your payments from this ERA, regardless of the TOB or Fiscal Year End (FYE). However, if you billed claims using more than one provider number, a PS screen appears for each provider number.

Note: MACs will allow only one receiver of an ERA per National Provider Identifier (NPI). Your MAC can tell you if you are set up on its files for multiple receivers of the ERA.

Please note that the options below provide high level overviews of the screens available for the RAs. You should refer to the Medicare Claims Processing Manual, Chapter 22, Remittance Advice for complete details of headings, fields, and codes used in the RAs. Chapter 9 of the PC Print User Guide provides the information necessary to see and understand the mapping of data for each report.

Option 1: The AC Screen (Institutional ERA)

The AC screen allows you to view information for multiple claims at a glance. This screen provides a listing of all of your claims that completed processing on the date indicated on the ERA. The AC Screen lists claims in alphabetical order by the beneficiary's last name.

Figure 1 Institutional shows an example of the Institutional ERA AC Screen, which contains RA information for two separate claims. The bold lines and bold numbers on the left designate particular sections of the ERA.

Figure 1 Institutional - The Institutional ERA AC Screen

Section 1 contains the field names of each position in each AC record.

Section 2 contains the data for each of the two claims. In this section, there may be HHA Claims Only Information:

- There are six fields that are unique to HHAs who have PC Print Version 2.01 or higher.

FIELDS	DESCRIPTION
SN DAYS	Skilled Nursing Days
PT DAYS	Physical Therapy Days
ST DAYS	Speech Therapy Days
OT DAYS	Occupational Therapy Days
MS DAYS	Medical Social Days
NA DAYS	Nurse Aide Days

- Four fields, SN DAYS, PT DAYS, ST DAYS, and OT DAYS, replace the following four fields seen by all other provider types and HHAs who do not have PC Print version 2.01 or higher: DRG NBR, DRG AMOUNT, DRG O-C, and NEW TECH.
- The other two fields MS DAYS and NA DAYS, replace the following two fields seen by all other provider types and HHAs who do not have PC-Print version 2.01 or higher: OUTLIER AMT and DEDUCTIBLES.

Option 2: The SC Screen (Institutional ERA)

The SC screen provides a detailed summary of data from a single claim. An SC screen is available for each claim on the AC screen. This screen provides information about denied or non-covered claims. You can also find important information such as Claim Adjustment Reason Codes (CARCs) and RARCs on this screen.

Figure 2 Institutional contains an example of the Institutional ERA SC Screen. While the AC screen shows information for multiple claims at once, the SC screen only shows one claim at a time. Use the arrow buttons in the PC Print software to move from claim to claim.

Section 1 of the SC Screen contains the field names of each position in each SC record. Note in this section the field for the NPI: this field displays the NPI of the facility receiving the ERA. The NPI is the number assigned to the provider for billing and identification purposes. For more information about the NPI, refer to the NPI website.

Section 2 contains the charges for the claim. To determine why the charges may be non-covered/denied, see the Adjustment Claim (ADJ) REASON CODES and REMARK CODES fields on the SC screen in Section 5. For the current codes refer to WPC References.

Section 3 shows the days/visits.

Section 4 contains payment data.

Section 5 contains space where Group Codes, CARCs, and RARCs for Institutional Providers generally appear. You can review a full list of current CARCs and RARCs to find important information regarding claims adjustments. For the current codes refer to WPC References.

Section 6 contains a breakout of charges and adjustments for a single claim on a service-line level. This section may contain data for SNF or HHA claims. These fields only appear when an Institutional Provider submitted Part B charges. The first row is column headings and subsequent rows contain data for each service line submitted on that claim. You can find CARCs and RARCs based on a service-line level in this section. For the most current code lists refer to WPC.

There are 12 field headers that are unique to HHAs or hospices that have PC-Print Version 2.01 or higher. These 12 fields: HHA SN AMT, HHA PT AMT, HHA ST AMT, HHA OT AMT, HHA MS AMT, HHA NA AMT, HSP ROUT CARE, HSP CONT CARE, HSP GENERAL, HSP RESPITE, HSP PHYS SVC, AND HSP OTH, replace the following nine fields seen by all other provider types and Home Health Agencies or hospices who do not have PC-Print Version 2.01 or higher: DRG, DRG AMOUNT, DRG/OPER/CAP, OUTLIER, CAP OUTLIER, BLOOD DEDUCT, PROF COMPONENT, ESRD AMOUNT, and PER DIEM AMT.

Figure 2 Institutional - The Institutional ERA SC Screen
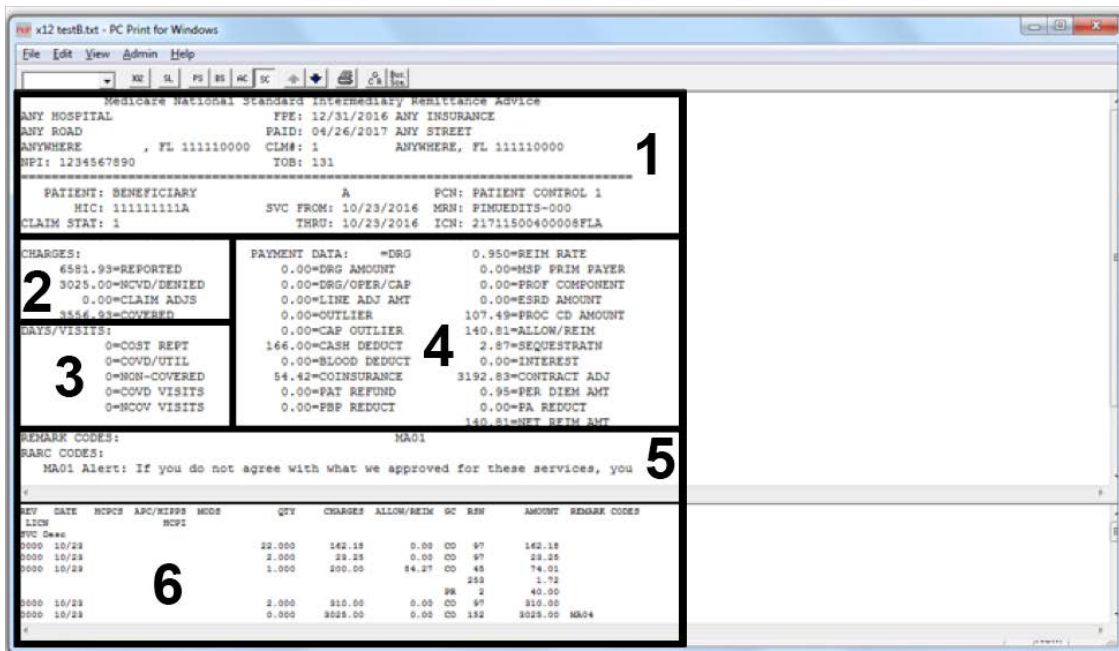
Option 3: The Bill Type Summary (BS) Screen (Institutional ERA)

Each BS screen provides a summary of claims billed for each TOB, for each provider number, and for each FY. For example, if an HHA billed 32X and 33X claims, for FY 16 and FY 17, it would receive the following four billing summaries:

- TOB 32X for FY 16	- TOB 32X for FY 17
- TOB 33X for FY 16	- TOB 33X for FY 17

You only receive a bill summary for those TOBs that were processed for this ERA. Therefore, if only 32X claims for FY 16 were processed for this ERA, the HHA only receives one bill summary.

You may switch between the different BS screens by clicking on the arrow buttons in the PC-Print software.

Figure 3 Institutional gives an example of a BS screen. We divided the screen into four separate sections for easy reference. We briefly describe the sections below.

Section 1 of the BS Screen contains a summary of the contents of the advice.

Section 2 shows a summary of the charges.

Section 3 contains a summary of the DAYS/VISITS.

Section 4 contains a summary of the PAYMENT DATA.

Figure 3 Institutional - The Institutional ERA BS Screen
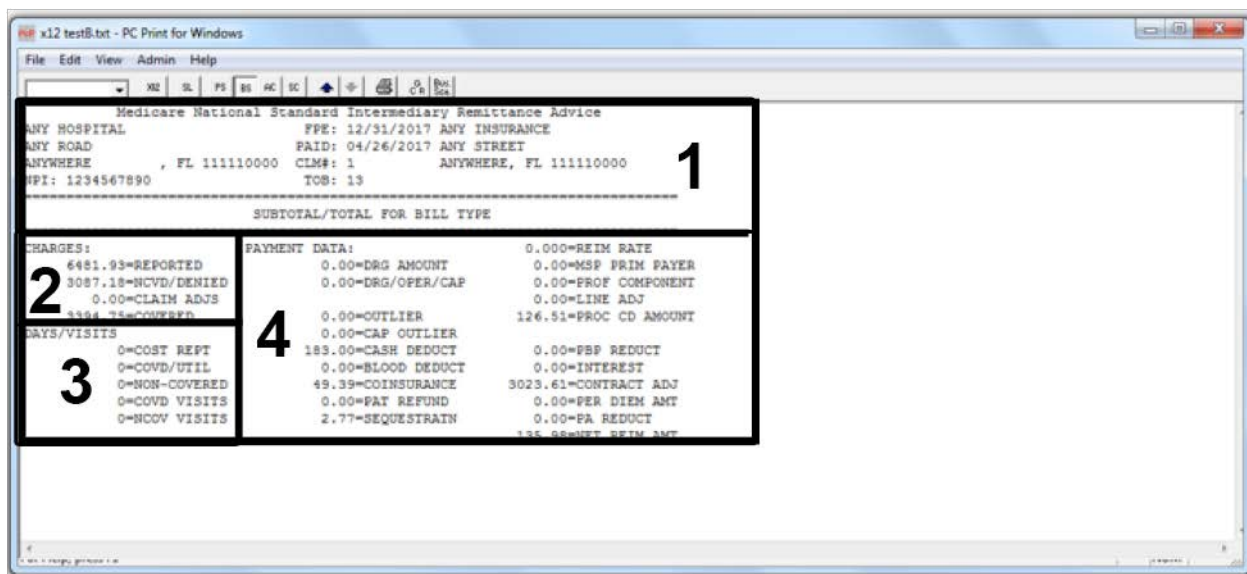
Option 4: The Provider PS Screen (Institutional ERA)

The Provider PS screen provides a summary of the provider's payments on an ERA, regardless of the TOB or FYE. Therefore, if you bill multiple claims using more than one NPI, a PS screen displays for each NPI.

For a complete listing of Provider-Level Adjustment Reason Codes, refer to the WPC References.

Figure 4 Institutional - The Institutional ERA Provider PS Screen
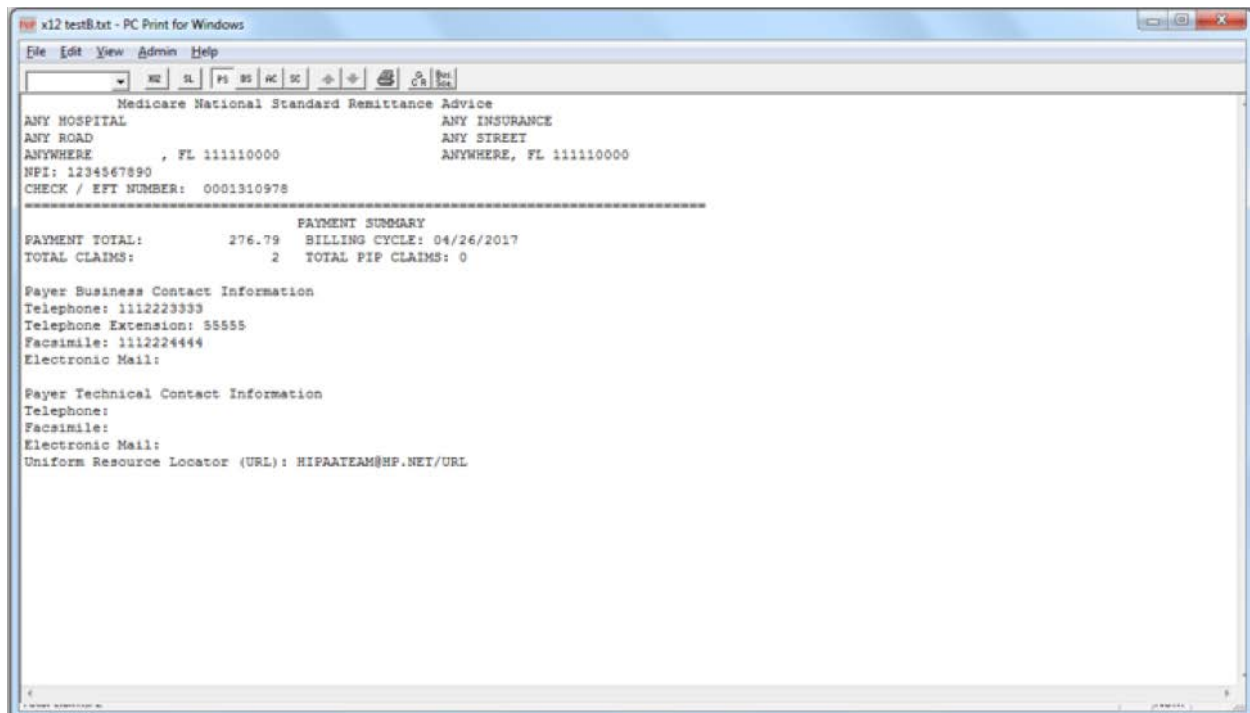
Reading an Institutional SPR

The Components of an Institutional SPR

Institutional SPRs are split into two sections:

- All Claims (AC) Page: These pages of the SPR provide detailed information for each individual claim, but not for the individual services included in a claim. Institutional Providers who sometimes submit claims for Part B services, for example, outpatient SNFs, may receive an RA with information regarding both Part A and Part B services. In this case, claims for Part A and Part B services are listed on separate pages of the SPR.

- Summary Page: This page of the SPR provides information that spans all the claims included in the AC section of the SPR. For example, many of the fields in this section are totals of fields on the AC pages.

The AC Page (Institutional SPR)

The AC pages of an Institutional SPR provide a line-item account for each claim represented on the RA. **Figure 5 Institutional** is an example page from the AC section of an SPR.

Section 1 of **Figure 5 Institutional** contains general MAC and provider information. The information in this section is header information for the SPR. This header information appears at the top of every page of the SPR. The only information that should change in this section for a given SPR is the page number.

Section 2 provides a list of the fields that appears for each claim.

Section 3 displays the data for each claim in the AC page of the SPR. Each claim consists of nine columns and four lines. The Institutional SPR lists claims in alphabetical order by the beneficiary's last name. This section also shows the subtotal sections on the SPR. The SPR provides subtotals for each FY. Sometimes Institutional Providers can bill Part B services. In this case, Part A and Part B (if applicable) information would appear on separate pages of the SPR with respective subtotals.

Note that claims are grouped by FY. If multiple FYs are present on a single SPR, a FY subtotal appears after each group of claims.

Figure 5 Institutional - An Example Page from the AC Page of an Institutional SPR

The Summary Page (Institutional SPR)

The Summary Page of an Institutional SPR provides a summary of all the claims present on the SPR. **Figure 6 Institutional** is an example of a summary page from an Institutional SPR. We divided this page into six separate sections for easy viewing. We added the lines and large bold numbers to designate particular sections of the summary page.

Section 1 of the Summary Page contains information identical to the header information described in the AC section. The only information that differs in this section is the page number.

Section 2 of the Summary Page displays totals for all the claims referenced on this SPR.

Section 3 shows the fields containing Pass-Through Amounts. These fields apply to hospitals paid under a prospective payment system (PPS). Pass through amounts are cost reimbursed services Medicare pays on a biweekly basis in addition to the Claim Payment Amount for claims processed on this RA. Therefore, Medicare has paid any amounts you see in these fields in addition to any claims processed on this RA.

Section 4 contains additional payment fields, refunds, and penalty releases.

Section 5 contains withholding from payments.

Section 6 displays all provider payments on this SPR.

Figure 6 Institutional - Summary Page from an Institutional SPR

Balancing an Institutional RA

Remittance balancing reconciles differences between payment amounts on the RA with the amounts you actually billed. Balancing requires that the total paid is equal to the total billed, plus or minus any payment adjustments. According to HIPAA, every electronic transaction a MAC issues must balance at the service-line, claim, and transaction levels.

General Rules for Remittance Balancing

The following ERA field completion and calculation rules apply to the corresponding fields in the SPR:

- The CHECK AMT (BPR02 field in the 835) is the sum of all claim-level payments, less any provider-level adjustments (PLB segment in the 835).
- Any adjustment the MAC applied to the submitted charge and/or units appears in the claim or service adjustment segments with the appropriate Group Codes, CARCs, and RARCs explaining the adjustments. The same adjustment may not appear at both the claim and the service-line level of an RA. Every provider-level adjustment likewise appears in the provider-level adjustment section of the SPR (PLB segment in the 835).
- Any positive adjustments (for example, deductible paid by the beneficiary) reduce the provider's amount of payment from Medicare.
- Any negative adjustments (for example, interest on a clean claim that is paid after the 30th day from receipt) increase the amount of the payment from Medicare. Any adjustment reported with a negative sign reflects an increase in Medicare payment.

How Do I Use Transaction-Level Balancing of an Institutional RA?

Transaction-level balancing reconciles the total of all adjustments for all claims listed on the RA. Use transaction-level balancing to reconcile the check amount with the total or sum of all provider-level adjustments.

The transaction-level balancing formula is:

> Total of claim payment amounts included in this RA
> − Provider-level adjustment(s) made to the claim payments
>
> **Total Payment Amount**
> (This should match the check or EFT amount)

On an Institutional ERA

You may use the Provider Payment Summary (PS) screen to perform transaction-level balancing. This screen provides a summary of the provider's payments, shown in the PAYMENT TOTAL field, regardless of the TOB or FYE (see **Figure 7 Institutional**). This screen may also include a FINANCIAL ADJUSTMENTS field that appears only if there were financial adjustments. Use the amount in the FINANCIAL ADJUSTMENTS field to determine total provider adjustments. If claims are billed using more than one NPI, there is a separate PS screen for each NPI.

Figure 7 Institutional - The PS Screen of an Institutional ERA Used for Transaction-Level Balancing
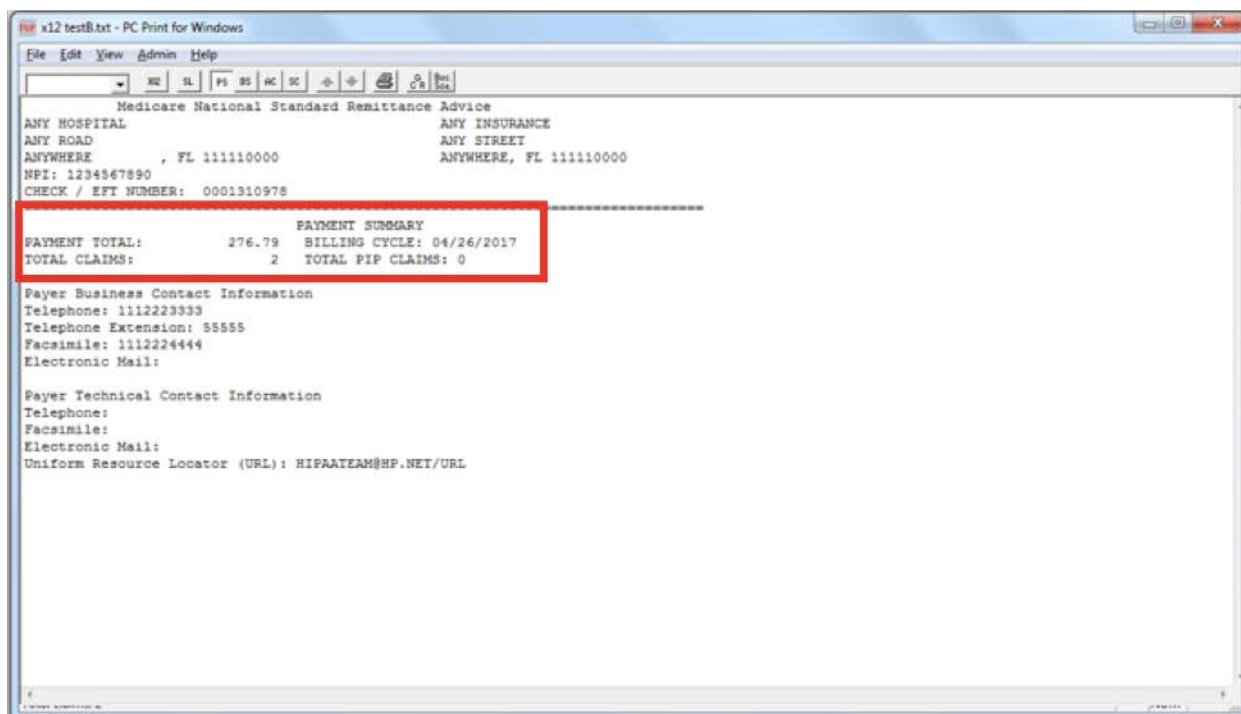
On an Institutional SPR

You may use the PROVIDER PAYMENT RECAP section on the Summary Page to locate fields involved in transaction-level balancing (see **Figure 8 Institutional**). To obtain the total payment amount, add all the amounts in the PAYMENTS section (including DRG OUT AMT, INTEREST, PROC CD AMT, NET REIMB, TOTAL PASS THRU, PIP PAYMENTS, SETTLEMENT PYMTS, ACCELERATED PAYMENTS, REFUNDS, PENALTY RELEASE, TRANS OUTP PYMT, HEMOPHILIA ADD-ON, NEW TECH/ECT ADD-ON, VOID/REISSUE, BALANCE FORWARD, WITHHOLD, and ADJUSTMENT TO BALANCE). The WITHHOLD field is a negative amount which represents the total provider adjustments, found in **Figure 8 Institutional** Section 5. This should result in the amount of the provider's reimbursement check (NET PROVIDER PAYMENT in **Figure 8 Institutional** Section 6).

Figure 8 Institutional - The Summary Page of an Institutional SPR Used for Transaction-Level Balancing

Table 1 Institutional shows the figures and fields that you can use to balance the SPR shown in **Figure 8 Institutional** at the transaction level.

Table 1 Institutional - Example Transaction-Level Balancing an Institutional RA

DOLLAR AMOUNT	FIELD USED FOR BALANCING THIS SPR	DESCRIPTION
7,817.66	NET REIMB plus interest	Total of claim payment amounts.
1,563.54	WITHHOLD	Total Provider-Level Adjustments
6,254.12	NET PROVIDER PAYMENT	The Check/EFT Amount. This amount equals the total of claim payment amounts minus the total provider-level adjustments. Therefore, this SPR balances at the transaction level.

Claim-Level Balancing an Institutional RA

Claim-level balancing encompasses the entire claim for one beneficiary. You may use claim-level balancing to settle an individual claim. Claim-level balancing subtracts the sum of all adjustments applied to a claim from the submitted charges for a claim. You may not take the same adjustment at both the service-line and the claim levels.

The claim-level balancing formula is:

> Total submitted charge for this claim
> − Monetary adjustment amounts applied to this claim
> **Paid Amount for this Claim**

On an Institutional ERA

On an Institutional ERA, you can find all the fields you need for claim-level balancing in the Payment Data Section of the Single Claim (SC) screen (see **Figure 9 Institutional** Section 4). The DRG AMOUNT field is the total submitted charge for the claim, and you may find the paid amount for the claim in the NET REIM AMT field. All the other fields in this section of the SC screen constitute the monetary adjustment amounts applied to this claim portion of the equation. These fields include DRG/OPER/CAP, LINE ADJ AMT, OUTLIER, CAP OUTLIER, CASH DEDUCT, BLOOD DEDUCT, COINSURANCE, PAT REFUND, MSP LIAB MET, REIM RATE, MSP PRIM PAYER, PROF COMPONENT, ESRD AMOUNT, PROC CD AMOUNT, ALLOW/REIM, G/R AMOUNT, INTEREST, CONTRACT ADJ, and PER DIEM AMT.

When service-line payment information is present, adjustments appear either at the claim level or the service-line level, but not in both. When specific service-line details are present (these appear in **Figure 9 Institutional** Section 6), the claim-level balancing includes balancing the total claim charge to the sum of the related service charges.

Figure 9 Institutional - The SC Screen of an Institutional ERA Used for Claim-Level Balancing
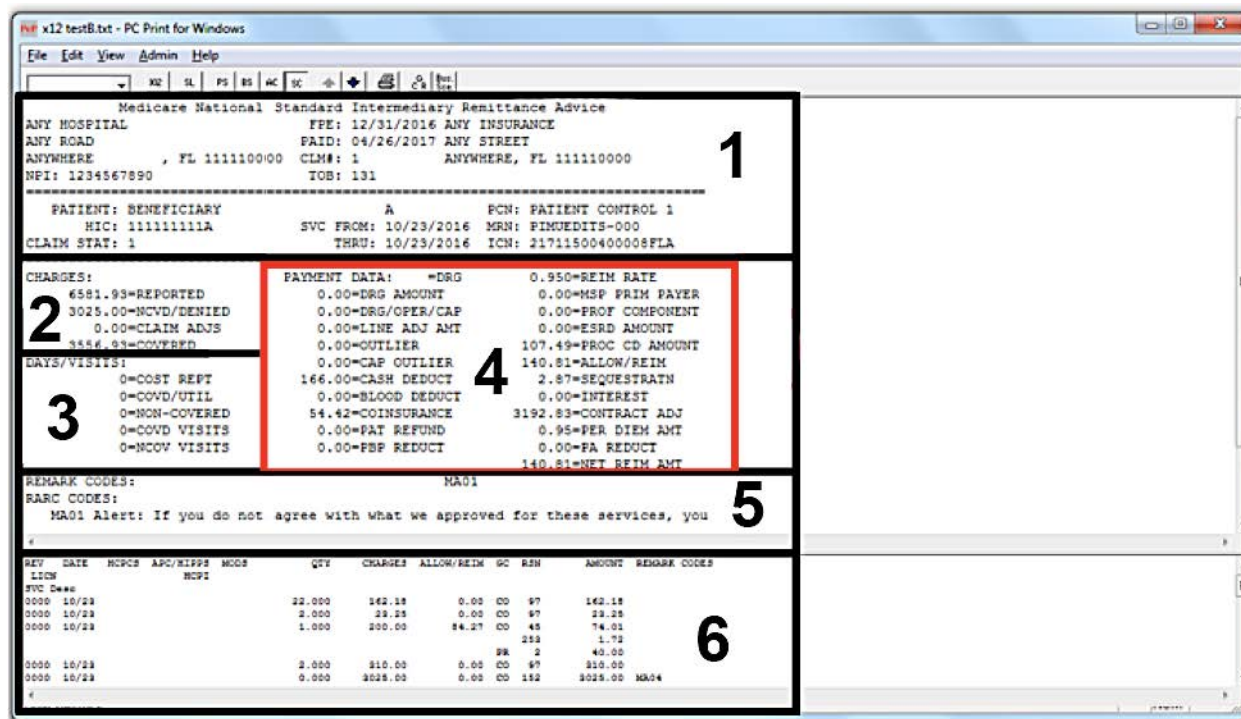
On an Institutional SPR

To perform claim-level balancing on an Institutional SPR, subtract all adjustments (which are in DRG OUT AMT, NEW TECH, MSP PAYMT, DEDUCTIBLES, COINSURANCE, DENIED CHGS, PAT REFUND, ESRD NET ADJ, INTEREST, PRE PAY ADJ, CONTRACT ADJ, PER DIEM RTE, and PROC CD AMT) from the COVD CHGS field. The resulting amount should equal the NET REIMB (see **Figure 10 Institutional**). These amounts are on the AC Page of an SPR in **Figure 10 Institutional** Section 3.

Figure 10 Institutional - The AC Page of an Institutional SPR Used for Claim-Level Balancing

Table 2 Institutional shows the figures that you can use to balance a claim from the SPR shown in **Figure 10 Institutional**.

Table 2 Institutional - Example Claim-Level Balancing Fields

DOLLAR AMOUNT	FIELD USED FOR BALANCING THIS CLAIM	DESCRIPTION
86,545.00	COVD CHGS	Total submitted charge for this claim.
-81,245.84	CONTRACT ADJ	A claim-level adjustment due to a contractual agreement between the payer and the payee.
5,299.16	NET REIMB	The paid amount for this claim. This amount equals the total claim payment amount minus the total claim-level adjustments. Therefore, this claim balances.

Service-Line-Level Balancing an Institutional RA

Service-line-level balancing allows you to reconcile totals for service-line entries on individual claims. Most Institutional Providers do not perform service-line-level balancing.

The service-line-level balancing formula is:

$$\begin{array}{r} \text{Submitted charge for this service} \\ - \quad \text{Monetary adjustment amount applied to this service} \\ \hline \textbf{Paid Amount for this Service} \end{array}$$

On an Institutional ERA

To complete service-line-level balancing, use the SC screen. In **Figure 11 Institutional**, the service-line fields are located in Section 6 of the SC screen. You will find submitted service-line charges under the CHARGES field header, adjustments under the ALLOW/REIM field header, and the paid amount for the service under the AMOUNT header. CMS only requires service-line-level balancing when Institutional Providers bill Part B services.

Figure 11 Institutional - The SC Screen of an Institutional ERA Used for Service-Line-Level Balancing
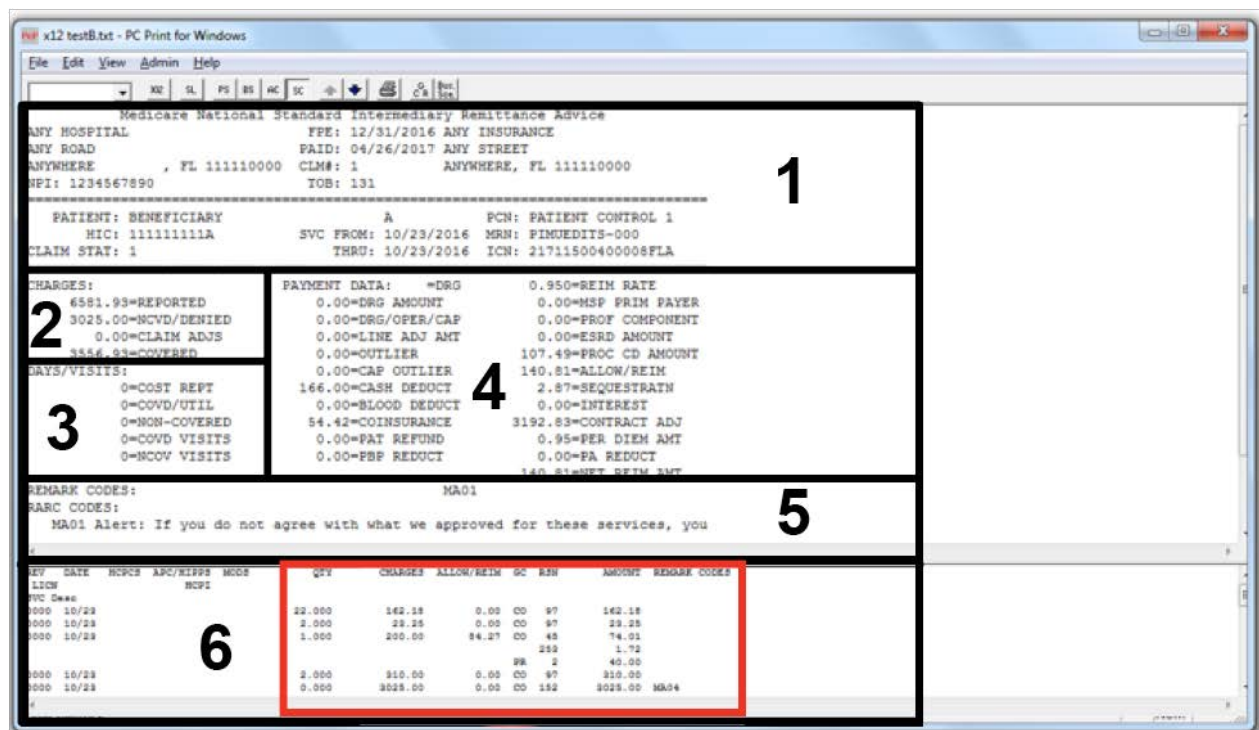
On an Institutional SPR

Since HIPAA does not cover the SPR, service-line information may not appear on some Institutional SPRs like it does on an ERA. The SPR shows the same segments, fields, and codes that are on the ERA that help you to make sure that the 835 is balanced at three levels: transaction, claim, and service-line. You may refer to the previous section regarding service-line-level balancing of an Institutional ERA for an idea of how this may be performed.

READING A PROFESSIONAL REMITTANCE ADVICE (RA)

Viewing the information in an ERA:

You can view and print the information in an ERA using special translator software. The ASC X12N 835 format is meant for electronic transfers only. Professional Providers can get free translator MREP software for viewing HIPAA 835 files from their MAC. You can use either the free MREP software or purchase other proprietary translator software. If you use proprietary software to view and print ERAs, you must confirm that the software meets HIPAA-compliant ASC X12N 835 format standards and includes required and situational data elements that comply with Medicare guidelines.

The MREP software allows you to view and print the ERA, to run special reports and to search the ERA to find information easily. You may use the MREP software by importing 835s received from your MAC. Once imported, you may print these files in a format similar to a Standard Paper Remittance (SPR), or view them directly in the MREP software. In addition, you can save these files in your system for any length of time as you need.

Presentation of ERA information Using MREP software:

The entire remittance report allows you to view or print your remittance information quickly in a format similar to an SPR.

A tabbed information view allows six selections from a particular ERA:

1. Select specific claims
2. View and print claim information for the selected claims
3. View and print summary information for the entire ERA
4. View ERA data in loops and segments
5. Search claims for specific information
6. View a glossary of all CARCs and RARCs that appear on the ERA

Special Reports provides information specific to:

- Claims containing adjusted service lines
- Coordination of Benefits (COB) and Non-COB claims
- Deductible and coinsurance service lines
- Denied service lines
- Other adjustments

To print quickly from an 835, you can use the Report function, as shown in **Figure 1 Professional**. When you select the Entire Remittance report, options to view or print a paper remittance (for the 835 currently highlighted in the upper portion of the screen) appear.

Figure 1 Professional - Using the Entire Remittance Report in the MREP Software to Print an SPR
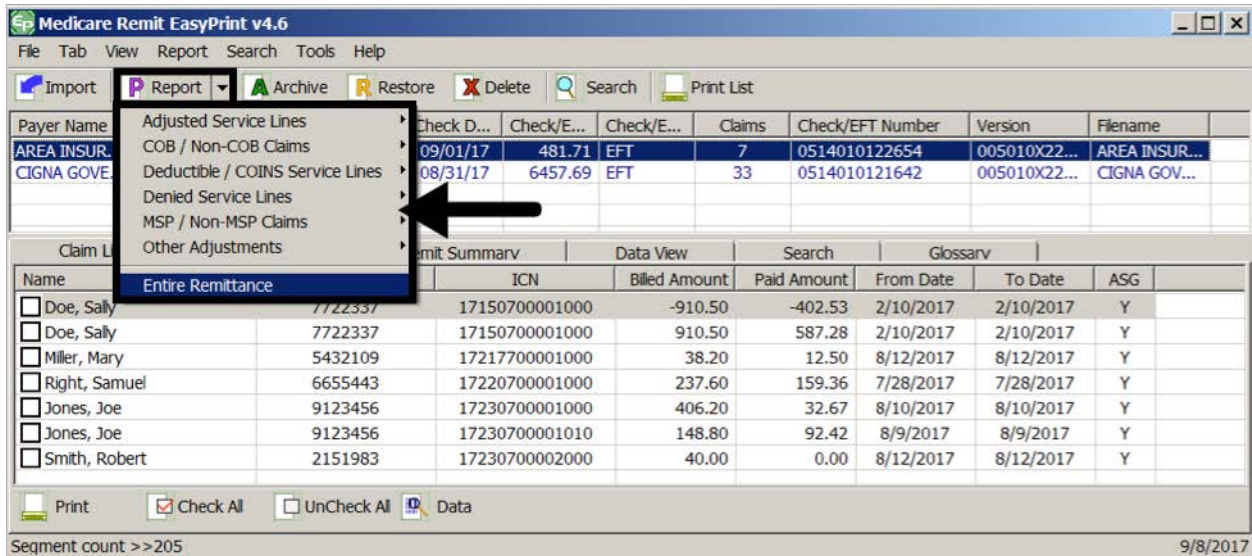
Please note that the options in this booklet provide high level overviews of the screens available for the RAs. For more information, refer to the Medicare Claims Processing Manual, Chapter 22 (Remittance Advice), for complete details of headings, fields, and codes used in the RAs. The appendix of the Medicare Remit Easy Print User's Guide provides the information necessary to see and understand the mapping of data for each report.

The differences that currently exist between SPRs received from MACs and paper remittances MREP software generates are:

- The totals section:
    - The paper remittance from MREP software includes totals for all claims, assigned and unassigned
- The handling of adjusted claims:
    - Paper remittance from MREP software mirrors the 835 by showing the adjusted and the replacement claim
- The bulletin board section:
    - MREP software omits this section because it is not included in the HIPAA-compliant 835 format

Future revisions to the 835 may result in additional differences, as not all 835 revisions may occur in exactly the same manner in the SPR as they do in the paper remittances from MREP software.

Viewing Remittance Information using the MREP Software

Figure 2 Professional shows the MREP software after the provider has imported several 835s.

Figure 2 Professional Section 1 provides a list of imported 835s. When you select an 835 from this list, information about that 835 appears in **Figure 2 Professional** Section 2. The six tabs that you use to view remittance information are discussed on the following pages.

Figure 2 Professional - The MREP Software with Multiple 835s Ready for Viewing

The Claim List tab (**Figure 3 Professional**) provides the ability to view information for any number of claims within an 835. After selecting an 835 from the top window, select individual claims from this tab. Then select claims by clicking on the check box to the left of each claim. The Claim Detail tab will display information only for the claims you selected.

Figure 3 Professional - The Claim List Tab

The Claim Detail tab (**Figure 4 Professional**) shows you detailed information for the claims you selected in the Claim List tab. You may use this tab to view or print information for specific claims you want to forward to other payers for secondary/tertiary payment. Glossary information, including Group Codes, CARCs, and RARCs, appears for only those claims you selected in the Claim List tab.

The information in the Claim Detail tab appears in a format similar to an SPR. However, total information across all selected claims does not appear the way it does at the end of an SPR. For a description of how to read the detailed claim information in this tab, refer to sections titled Header Information and Assigned Claims – Claim Level Information through Assigned Claims – Adjustments Line of this Booklet (See **Figure 11 Professional** and **Figure 12 Professional**)

Figure 4 Professional - The Claim Detail Tab
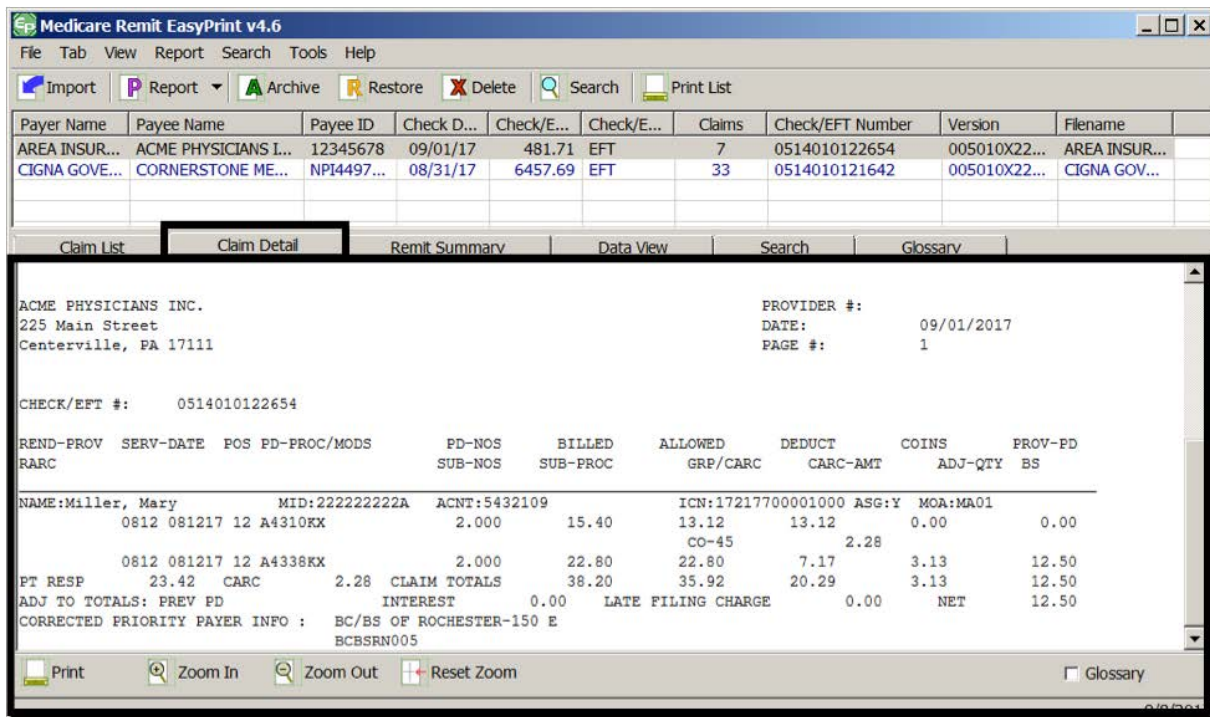
The Remit Summary Tab

The Remit Summary tab displays totals for all claims in this RA. These are the totals that appear in the totals section at the end of a paper remittance the MREP generates. Notice a difference in the way totals for the entire RA appear on the SPR (**Figure 5 Professional**) and on the Remit Summary tab (**Figure 6 Professional**) in the MREP software. Although most of the information in this tab is the same as the information in the TOTALS section of the SPR, the formatting differs.

Figure 5 Professional - Totals as Shown on the SPR

Figure 6 Professional - The Remit Summary Tab

The Data View Tab

The Data View tab (**Figure 7 Professional**) allows you to view the loops and segments of the ASC X12N 835 005010A1 format. For more information about how to read the loops and segments of the 835, refer to the "ASC X12N 835 Implementation Guide: Health Care Claim Payment/Advice", available for purchase at http://www.wpc-edi.com/products/healthcare/4010/combined-guides/.

Figure 7 Professional - The Data View Tab
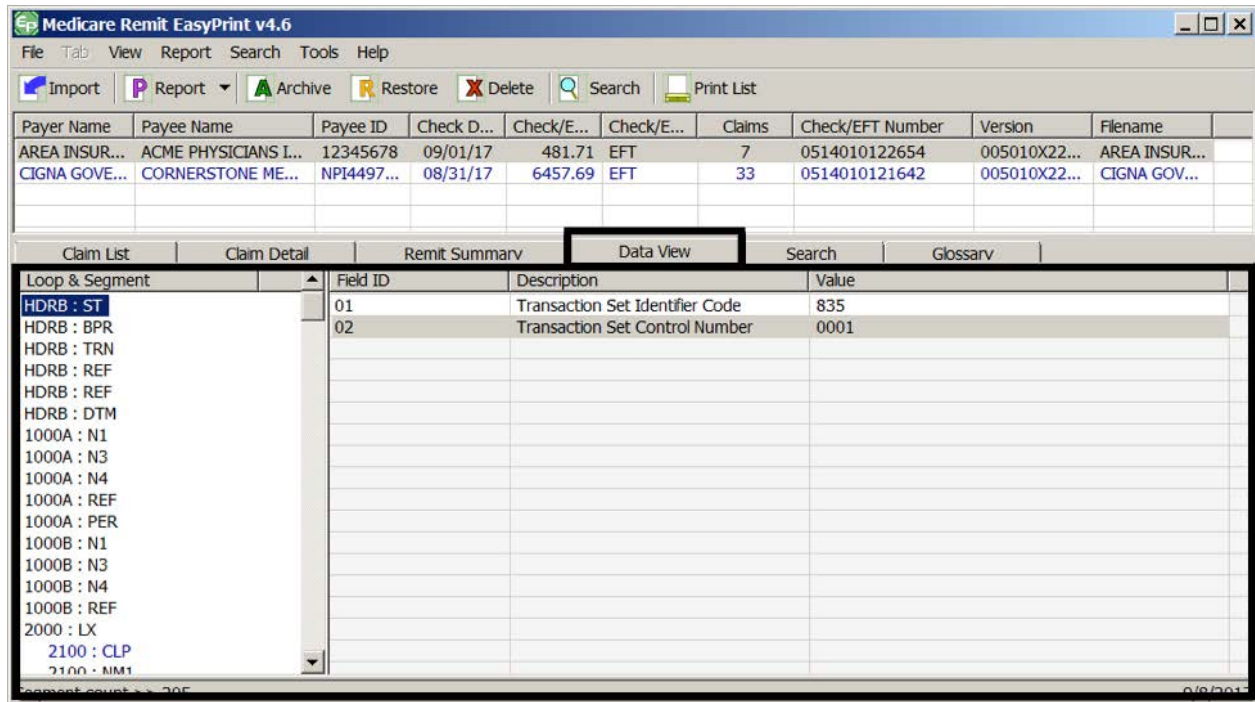
The Search Tab

The Search tab (**Figure 8 Professional**) provides the ability to search for specific information within claims on an RA. You may search using the following fields:

Adjusted Lines	Health Insurance Claim Number (HICN)
Beneficiary Account Number (as assigned by the provider)	Internal Control Number (ICN)
Beneficiary Last Name	National Drug Code (NDC)
COB Claims	Non-COB Claims
Coinsurance Lines	Other Adjustments
Deductible Lines	Procedure Code
Deductible/Coinsurance Lines	Rendering Provider Number (includes the NPI and legacy provider numbers)
Denied Lines	Service Date

Once the search is complete, the software provides a list of claims that matched the search criteria. Click on the **Claim Detail** button at the bottom of the screen to select those claims automatically and view them in the **Claim Detail** tab.

Figure 8 Professional - The Search Tab
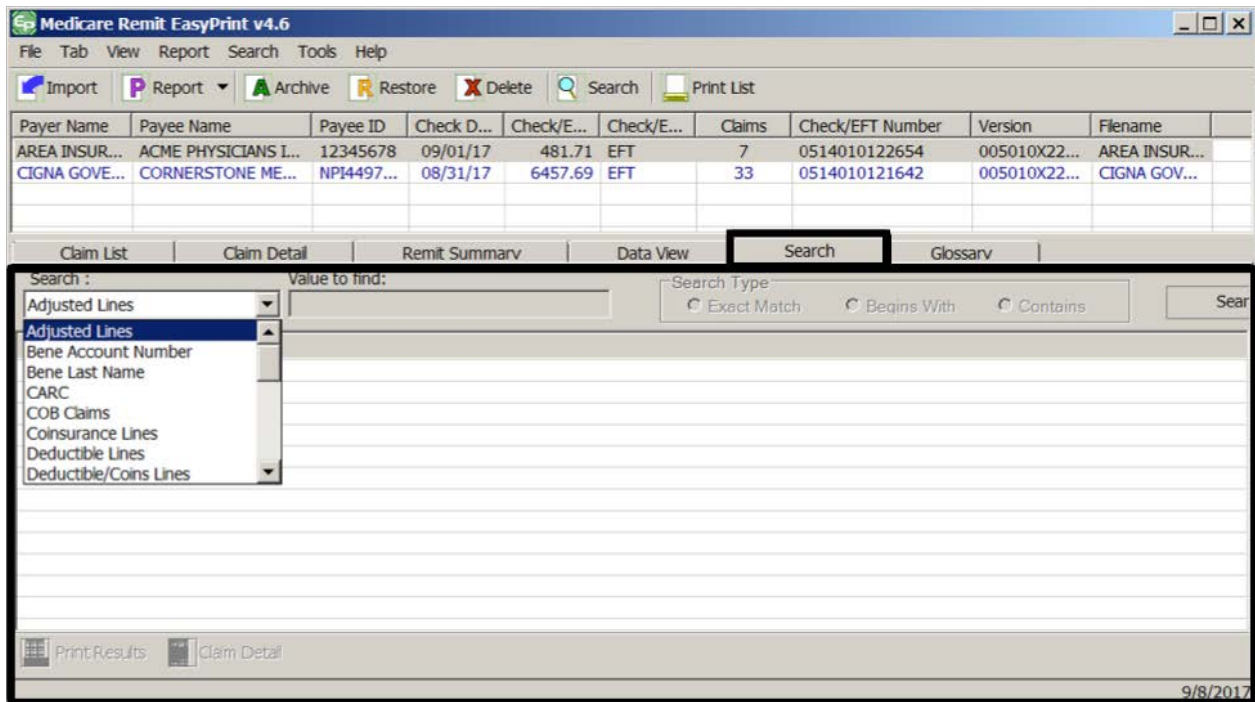
The Glossary Tab

The Glossary tab (**Figure 9 Professional**) provides a list of all Group Codes, RARCs, CARCs, and Provider-Level Adjustment Reason Codes that appear on any claim in the ERA. Your MAC will notify you of necessary updates for the MREP software to accommodate code set changes. File updates are available three times a year. You can sign up with your MAC to be notified automatically when updates are available.

Figure 9 Professional - The Glossary Tab

Generating Special Reports Using the MREP Software

Adjusted Service Lines Report	Shows claims that have a status of 22 (reversal of previous payment). This report does not show the adjustment claim that reflects the corrected dollar amounts, but shows only the negative amount that the reversed claim provides to negate the original claim.
COB Claims and Non-COB Claims Reports	Shows all claims that your MAC has forwarded to an additional payer(s). Alternatively, the Non-COB Claims report shows all claims that the MAC did not forward to an additional payer. These reports allow you to quickly view claims by their COB status. You can access these two reports from the COB / Non-COB Claims option under the Report menu in the MREP software.
Deductible and Coinsurance Service Lines Reports	The MREP software provides the following three reports for viewing deductible and coinsurance services lines: 1. The Deductible Service Lines report lists all service lines that have a deductible amount 2. The Coinsurance Service Lines report lists all service lines that have a coinsurance amount 3. The Deductible/Coinsurance Service Lines report is a combination of the first two reports, and lists all service lines that have deductible or coinsurance amounts associated with them. These reports allow you to quickly view those claims for which beneficiaries (or other insurer, if applicable) must pay coinsurance or some portion of the deductible. You may access these three reports from the Deductible / COINS Service Lines option under the Report menu in the MREP software.
The Denied Service Lines Report	Shows all service lines that have an allowed amount equal to zero and are associated with a claim that does not have a claim status 22 (reversal of previous payment).

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Generating Special Reports Using the MREP Software Continued

The Other Adjustments Report	Shows those claims that include some type of adjustment. This report shows claims that have late filing and interest, and remittances that have withholding and forwarding balances.
Fields Appearing on MREP Special Reports	**Figure 10 Professional** contains an example of one of the special reports you can generate from the MREP software. The special reports share the same general formatting and have many of the same fields.

Fields Appearing on MREP Special Reports

Figure 10 Professional contains an example of one of the special reports that you can generate from the MREP software. The special reports share the same general formatting and have many of the same fields.

Figure 10 Professional - The Denied Service Lines Report
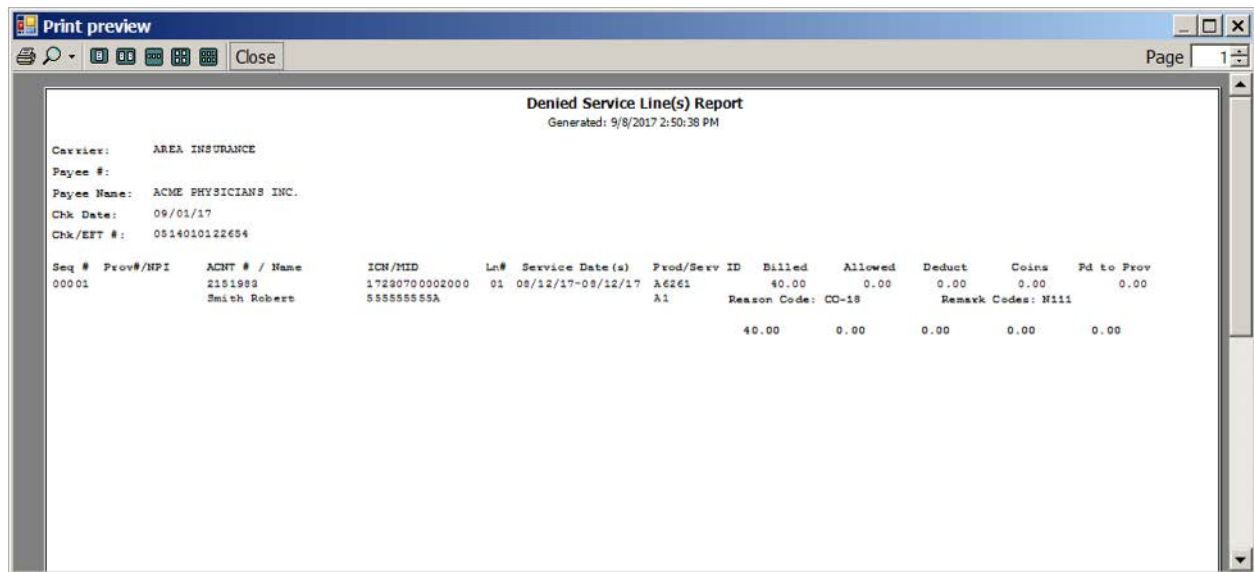
Reading a Professional SPR

Providers who elect to receive a paper RA receive the SPR. Recipients of an SPR receive the same critical remittance information as recipients of the ERA. However, SPRs do not contain as many fields as ERAs and are organized differently. SPRs look different based on the type of provider. SPRs for institutional providers (for example, hospitals) look different from those for professional providers (for example, physicians). Additionally, SPR formats may vary by the MAC that provides the SPR. Figures (example SPRs) in this section are meant as a reference, and may vary from what providers actually see.

Types of SPRs Available

You may generate your own SPR by choosing to receive an electronic 835 file and using the MREP software to view and print the 835 in SPR format. There are slight differences between SPRs you receive from a MAC and SPRs you generate from the MREP software (referred to as the MREP SPR). The remainder of this chapter addresses how to read SPRs you receive from a MAC.

How Do I Switch from an SPR to an ERA?

If you currently receive SPRs and are interested in switching to ERAs, contact the Electronic Data Interchange (EDI) department of your MAC at their toll free number. Note: MACs no longer send the SPR to professional providers who also have been receiving ERAs for 45 days or more.

Components of the Professional SPR

Professional SPRs are split into four basic sections:

1. Header Information (Section 1 of **Figure 11** and **12 Professional**) – This section contains header information and a bulletin board section

2. Assigned Claims (Sections 2 and 3 of **Figure 11 Professional**) – This section provides detailed information for each individual assigned claim

3. Unassigned Claims (Section 2 of **Figure 12 Professional**) – This section provides detailed information for each individual unassigned claim

4. Glossary (Section 3 of **Figure 12 Professional**) – This section lists all CARCs and RARCs and their appropriate text that appear on the SPR

The example SPR shown in **Figure 11** and **12 Professional** consists of two pages. Header information and the assigned claims are on the first page (**Figure 11 Professional**) while unassigned claim information and the glossary are on the second page (**Figure 12 Professional**).

Figure 11 Professional - Example of a Professional SPR – Page 1

Figure 12 Professional - Example of a Professional SPR – Page 2

```
1  EXAMPLE MEDICARE CARRIER                                           MEDICARE
   NPI:  1234567890              GOODHEALTH GROUP PRACTICE            REMITTANCE
   CHECK/EFT:   00234569                 PAGE  2 OF 2                 NOTICE

   SUMMARY OF UNASSIGNED CLAIMS

   PERF PROV    SERV DATE POS NOS  PROC   MODS   BILLED   ALLOWED   DEDUCT   COINS   GRP/RC   AMT   PROV PD

2  NAME BETA, KEN          HIC 9999999999 ACNT   BETA7-002        ICN 0202199000150  ASG N         MOA MA28
   123456ABC  0526 052602 11   1  99214          60.47     52.58    0.00    10.52   CO-42   0.00      7.89
   PT RESP      60.47       CLAIM TOTALS          60.47     52.58    0.00    10.52           0.00
   ADJ TO TOTALS:    PREV PD   0.00. INT    0.00  LATE FILING CHARGE     0.00

   NAME SIGMA, HELEN       HIC 9999999999 ACNT   SIGM4-667        ICN 0202199140370  ASG N         MOA MA28
   123456ABC  0222 022202 11   1  99214          60.47     52.58    0.00    10.52   CO-42   0.00      7.89
   PT RESP      60.47       CLAIM TOTALS          60.47     52.58    0.00    10.52           0.00
   ADJ TO TOTALS:    PREV PD   0.00  INT    0.00  LATE FILING CHARGE     0.00

   GROUP CODES:
   PR       Patient Responsibility
   CO       Contractual Obligation
   OA       Other Adjustment

   GLOSSARY:  Group, Reason, MOA, Remark and Adjustment Codes
3  CO       Contractual Obligation. Amount for which the provider is financially liable. The patient may
            not be billed for this amount.
   PR       Patient Responsibility. Amount that may be billed to a patient or another payer.
   42       Charges exceed our fee schedule or maximum allowable amount. (Use CARC 45)
   96       Non-covered charge(s)
   B15      Payment adjusted because this service/procedure requires that a qualifying service/procedure be
            received and covered. The qualifying other service/procedure has not been received/adjudicated.
   M80      Not covered when performed during the same session/date as a previously processed service for
            the patient.
   MA01     Alert: 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 not
            process your initial claim to conduct the appeal. However, in order to be eligible for an
            appeal, you must write to us within 120 days of the date you received this notice, unless you
            have a good reason for being late.
   MA07     Alert: The claim information has also been forwarded to Medicaid for review.
   MA28     Alert: Receipt of this notice by a physician or supplier who did not accept assignment is for
            information only and does not make the physician or supplier a party to the determination. No
            additional rights to appeal this decision, above those rights already provided for by
            regulation/instruction, are conferred by receipt of this notice.
   50       Late Filing Reduction
   FB       Forwarding Balance
```

Header Information

Section 1 of **Figure 11** and **12 Professional** shows the header information that appears on all pages of a Professional SPR. This section contains provider and MAC information for the SPR. **Figure 13 Professional** shows the header information on page one of the Professional SPR. One area of the header information contains the bulletin board section. This area, boxed in with asterisks, contains MAC-specific information. The bulletin board section only appears on the first page of the SPR. It does not appear on a paper remittance you print from the MREP software.

Figure 13 Professional - Introductory Information on Page 1 of the Example Professional SPR

```
   EXAMPLE MEDICARE CARRIER
   1000 SOMEPLACE LANE
   FAIRFAX, VA 22033-0000                                  MEDICARE
   1-877-555-1234                                          REMITTANCE
                                                           NOTICE
1  EXAMPLE MEDICARE PROVIDER                         NPI:  1234567890
   200 DOCTORS DRIVE                                 PAGE #:  1 OF 2
   SUITE 200                                         DATE:
   SOMEWHERE, NJ   16666-0200                        CHECK/EFT #:  000234569
   ****************************************************************************
   *                                                                        *
   *            WELCOME TO THE MEDICARE PART B STANDARD PAPER REMITTANCE      *
   *                                                                        *
   *                                                                        *
```

Assigned Claims

Figure 14 Professional shows the assigned claims section of the Professional SPR. The assigned claims section starts with a header row. This header row (shown in Section A of **Figure 14 Professional**) provides a reference for the service-line-level and claim-level data that are displayed for each claim in the assigned claims section.

Figure 14 Professional - The Assigned Claims Section of the Professional SPR

After the header row claims appear individually (shown in Section B of **Figure 14 Professional**). Each claim starts with **NAME** in the upper left, and ends with **NET** and an amount in the lower right. A single line separates each claim. The Professional SPR displays names in alphabetical order by last name. **Figure 15 Professional** shows a single claim from the assigned claims section. The fields displayed for each claim are described in the following sections.

Figure 15 Professional - Information for an Individual Claim

Assigned Claims - Claim-Level Information

The first six fields apply to the claim as a whole. Claim information is then broken out at a service-line level.

Assigned Claims - Service-Line-Level

Information after this initial line of claim-level information is broken out by service lines. In the example shown in **Figure 15 Professional**, there are three separate service lines.

Some claims have additional RARCs that apply to the claim at a service-line level. These codes appear immediately under that service-line. An example of this is the **REM: M80** text as shown in **Figure 16 Professional**.

Assigned Claims - Totals

After the service lines are broken out, there is some additional information that is included for each claim. These fields start with the PT RESP field. **Figure 16 Professional** shows a closer view of this portion of the SPR. These fields are described in this section.

Figure 16 Professional - Information for an Individual Claim

```
NAME   KAPPA, MARY          HIC 9999999999 ACNT KAPP33-721      ICN 0202199306880   ASG Y  MOA MA01 MA07
123456ABC   0314 031402 11   1  99213            66.00     49.83     0.00      9.97  PR-96   16.17      39.86
123456ABC   0314 031402 11   1  82962            10.00      4.37     0.00      0.00  CO-42    5.63       4.37
123456ABC   0314 031402 11   1  94760            12.00      0.00     0.00      0.00  CO-B15  12.00       0.00
REM: M80
PT RESP      9.97           CLAIM TOTALS   88.00     54.20     0.00      9.97          33.80    44.23
                                                                                   NET    44.23
```

Some claims, as shown in **Figure 17 Professional**, show the **CLAIM INFORMATION FORWARDED TO** field. This field is displayed when a claim is being forwarded to a beneficiary's supplemental insurer. The supplemental insurer's name usually appears in this field.

Figure 17 Professional - Information for an Individual Claim

```
NAME   GAMMA, RAYMOND       HIC 9999999999 ACNT    GAMM861-316   ICN 0202199306870   ASG Y  MOA MA01 MA07
123456ABC   0209 020902 11   1  99213            66.00     49.83     0.00      9.97  PR-96   16.17      39.86
PT RESP      9.97           CLAIM TOTALS   66.00     49.83     0.00      9.97          16.17      39.86
ADJ TO TOTALS:     PREV PD   10.00     INT   0.00      LATE FILING CHARGE   0.00
CLAIM INFORMATION FORWARDED TO:   NEW JERSEY MEDICAID                              NET    29.86
```

Assigned Claims - Adjustments Line

The adjustments line appears for assigned claims, if applicable. These fields are described in this section.
Note: Paper remittances you print from the MREP software handle adjusted claims differently from the SPR. When the MAC generates the SPR, it nets the amount it paid on the original claim to the amount it paid on the adjusted claim. The **NET** amount for the claim reflects the original and the adjusted claim. On a paper remittance you generate from the MREP software, the **PREV PD** field will always be blank. The MREP software handles this situation by showing both the original claim reversed, and then the adjusted claim with the current amounts allowed. MREP shows the whole correction and reversal process, while the SPR only shows the **NET** result.

Assigned Claims - Totals for All Assigned Claims

The assigned claims section of the SPR includes the totals line shown in **Figure 18 Professional**. These totals are for all assigned claims. On paper remittances you generate from the MREP software the totals section includes totals for all claims, assigned and unassigned.

Assigned Claims - Provider-Level Adjustment Detail

Below the claim totals is a section that lists provider-level adjustment details. This section shows adjustments that are not specific to a particular claim or service on this SPR. These appear as an adjustment from the provider's payment at the summary level.

The Use column indicates situations where Medicare uses codes that differ from the Provider-Level Adjustment Reason Codes to further clarify the reason for the financial adjustment.

Figure 18 Professional - Totals for the Assigned Claims and Provider Adjustment Details Sections

Unassigned Claims

Figure 19 Professional shows the unassigned claims section of a Professional SPR. Unassigned claims appear separately in this section. All claims in this section display an "N" in the ASG field. Claims and service-line-level information appear in the same manner as in the assigned claims section. The RARC for unassigned claims always displays a MA28 code.

Unassigned Claims - Adjustments Line

The adjustments line may be displayed for unassigned claims. If the payment is going to the beneficiary it may be suppressed.

Figure 19 Professional - The Unassigned Claims Section of a Professional SPR

```
SUMMARY OF UNASSIGNED CLAIMS


PERF PROV    SERV DATE  POS NOS  PROC   MODS   BILLED   ALLOWED    DEDUCT    COINS   GRP/RC   AMT   PROV PD
NAME  BETA, KEN              HIC 9999999999  ACNT  BETA7-002        ICN 0202199000150    ASG N         MOA MA28
123456ABC   0526 052602 11   1  99214              60.47    52.58     0.00   10.52  CO-42  0.00      7.89
PT RESP     60.47          CLAIM TOTALS            60.47    52.58     0.00   10.52         0.00
ADJ TO TOTALS:    PREV PD   0.00. INT    0.00  LATE FILLING CHARGE    0.00

NAME  SIGMA, HELEN           HIC 9999999999  ACNT  SIGM4-667        ICN 0202199140370    ASG N         MOA MA28
123456ABC   0222 022202 11   1  99214              60.47    52.58     0.00   10.52  CO-42  0.00      7.89
PT RESP     60.47          CLAIM TOTALS            60.47    52.58     0.00   10.52         0.00
ADJ TO TOTALS:    PREV PD   0.00  INT    0.00  LATE FILLING CHARGE     0.00
```

The Glossary Section

The glossary section of a Professional SPR (**Figure 20 Professional**) contains a list of all Group Codes, RARCs, CARCs and Provider-Level Adjustment Reason Codes that appear on the SPR. Each code appears with its appropriate text. Look at this section for an explanation regarding the adjustments your MAC made on the SPR. You may find all RARCs and CARCs at http://www.wpc-edi.com/reference. For a complete listing of Provider-Level Adjustment Codes, refer to the "ASC X12N 835 Implementation Guide: Health Care Claim Payment/Advice", which is available at http://www.wpc-edi.com/products/healthcare/4010/combined-guides/.

Figure 20 Professional - The Glossary Section of a Professional SPR

Balancing a Professional RA

Remittance balancing reconciles differences between payment amounts on the RA with the amounts you actually billed. Balancing requires that the total paid is equal to the total billed, plus or minus any payment adjustments. According to HIPAA, every electronic transaction a MAC issues must balance at the service-line, claim, and transaction levels.

General Rules for Remittance Balancing

The following ERA field completion and calculation rules apply to the corresponding fields in the SPR:

1. The CHECK AMT (BPR02 field in the 835) is the sum of all claim-level payments, less any provider-level adjustments (PLB segment in the 835).

2. Any adjustment applied to the submitted charge and/or units appears in the claim or service adjustment segments with the appropriate Group Codes, CARCs, and RARCs explaining the adjustments. The same adjustment may not appear at both the claim and the service-line level of an RA. Every provider-level adjustment appears in the provider-level adjustment section of the SPR (PLB segment in the 835).

3. The computed NET field must include PROV PD (the calculated payment to the provider), interest, late filing charges, and previous payments.

4. Any positive adjustments (for example, deductible paid by the beneficiary) reduce the provider's amount of payment from Medicare.

5. Any negative adjustments (for example, interest on a clean claim that is paid after the 29th day from receipt) increase the amount of the payment from Medicare. Any adjustment with a negative sign reflects an increase in Medicare payment.

Transaction-Level Balancing

Within the transaction, the sum of all claim payments minus the sum of all provider-level adjustments equals the total payment amount. Use transaction-level balancing to reconcile the check amount with the total submitted charges and the sum of all adjustments.

The transaction-level balancing formula is:

> Total of claim payment amounts included in this RA
> − Provider-level adjustment(s) made to the claim payments
> **Total Payment Amount**
> (This should match the check or EFT amount)

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On a Professional ERA

You can balance a Professional ERA at the transaction-level by viewing or printing a paper remittance using the MREP software and following the instructions below for transaction-level balancing of a Professional SPR. Providers using proprietary software should contact their vendor for instructions regarding balancing.

On a Professional SPR

The sum of all provider paid amounts is located in the PROV PD AMT field in each claim segment (**Figure 21 Professional**). The sum of total provider adjustment amounts appears in the PROV ADJ AMT field.

Figure 21 Professional - Highlighted Claim Segments and Fields Used for Transaction-Level Balancing on a Professional SPR

Table 1 Professional shows the figures that are used to balance the SPR shown at the transaction level in **Figure 21 Professional**.

Table 1 Professional - Example Transaction-Level Balancing Fields

DOLLAR AMOUNT	FIELD USED FOR BALANCING THIS SPR	DESCRIPTION
161.25	PROV PD AMT	Total of claim payment amounts.
-25.44	PROV ADJ AMT	Total Provider-Level Adjustments.
135.81	CHECK AMT	The Check/EFT Amount. This amount equals the total of claim payment amounts minus the total provider-level adjustments. Therefore this SPR balances at the transaction level.

Claim-Level Balancing

Claim-level balancing encompasses the entire claim for one beneficiary. Providers should apply claim-level balancing to settle an individual claim. Claim-level balancing subtracts the sum of all adjustments applied to this claim from the submitted charges for this claim. You cannot take the same adjustment at both the service line and claim levels.

The claim-level balancing formula is:

> Total submitted charge for this claim
> −   Monetary adjustment amounts applied to this claim
> **Paid Amount for this Claim**

On a Professional ERA

You can balance a Professional ERA at the claim-level by viewing or printing a paper remittance using the MREP software and following the instructions below for claim-level balancing of a Professional SPR. Providers using proprietary software should contact their vendor for instructions regarding balancing.

On a Professional SPR

The information necessary to perform claim-level balancing on a Professional SPR appears on the CLAIM TOTALS field (in the middle left-hand side of the SPR in **Figure 22 Professional)**. This field horizontally lists the total BILLED, ALLOWED, DEDUCT, COINS (coinsurance), AMT (this is the adjustment amount), and PROV PD amounts for a single claim (**Figure 22 Professional**). Subtracting the DEDUCT, COINS, and AMT amounts in this CLAIM TOTALS from the BILLED amount yields the amount in the PROV PD field.

Figure 22 Professional - Highlighted SPR Fields Page Used for Claim-Level Balancing on a Professional SPR

Table 2 Professional shows the figures that are used to balance the SPR shown in **Figure 22 Professional** at the claim level.

Table 2 Professional - Example Claim-Level Balancing Fields

DOLLAR AMOUNT	FIELD USED FOR BALANCING THIS CLAIM	DESCRIPTION
66.00	BILLED	Total submitted charge for this claim.
-9.97	COINS	A claim-level adjustment due to the coinsurance amount.
-16.17	AMT	A claim-level adjustment. This adjustment would be explained by the Group and Claim Adjustment Reason Code (PR-96, in this case).
39.86	PROV PD	The paid amount for this claim. This amount equals the total claim payment amount minus the total claim-level adjustments. Therefore, this claim balances.

Service-Line-Level Balancing

	Submitted charge for this service
−	Monetary adjustment amount applied to this service
	Paid Amount for this Service

ERA

You can balance a Professional ERA at the service-line-level by viewing or printing a paper remittance using the MREP software and following the instructions below for service-line-level balancing of a Professional SPR.

Providers using proprietary software contact your vendor for instructions regarding balancing.

SPR

Service-line-level balancing subtracts the total amount of all adjustments (including amounts in the DEDUCT, COINS, and AMT columns) from the total amount the provider billed (found in the BILLED column). The resulting amount should equal the amount the MAC paid the provider (found in the PROV PD column).

Figure 23 Professional - Highlighted Fields Used for Service-Line-Level Balancing on a Professional SPR

Table 3 Professional shows the figures that are used to balance the SPR shown in **Figure 23 Professional** at the service-line level for a selected service line (the example is based on the service line with PROC 82962).

Table 3 Professional - Example Service-Line-Level Balancing Fields

DOLLAR AMOUNT	FIELD USED FOR BALANCING THIS CLAIM	DESCRIPTION
10.00	BILLED	Total submitted charge for this service line.
-5.63	AMT	A service-line-level adjustment. This adjustment would be explained by a Group Code and a CARC (CO-42, in this case),
4.37	PROV PD	The paid amount for this service line. This amount equals the total submitted charge for this service line minus the total service line-level adjustments. Therefore this service line balances.

FREQUENTLY ASKED QUESTIONS (FAQS)

TOPIC/ISSUE	ANSWER
PC-Print	• PC-Print is free software, which is a Personal Computer (PC)-based ANSI ASC X12 835 translator interactive program. It allows you to view and print the Medicare Part A ERA. • PC Print software is available for Medicare Part A providers to view and print HIPAA-compliant ERAs from their own computer. If your current system does not have ERA capability, PC Print software is available at no cost. This software is easy to use and will save you both time and money if you are currently receiving SPR and transition to ERA. • Your MAC makes PC Print software available to you as a download for no charge. Your MAC may charge up to $25.00 per mailing to recoup cost if the software is sent to you on a CD/DVD or by any other means at provider's request when the software is available for downloading. You may contact your MAC's EDI Helpline if you need assistance in obtaining PC-Print.
Does PC-Print provide an option for viewing/printing the ERA that mimics the paper remittance?	• Yes, you may view or print the ERA in a format similar to the SPR. • To view the entire ERA, import the ERA that you wish to view and click on the button for the All Claims (AC) screen. This screen displays the data in a manner similar to the content and format of an SPR. • To print the entire ERA, after selecting the AC screen, just click on the printer button and this allows you to print the entire ERA in a format that is similar to the SPR.
How long is the ERA available in PC-Print? After PC-Print is closed, how can we access the ERA?	• Once you have downloaded an ERA from your EDI mailbox and saved it to your office computer, open it in PC-Print. • Browse to the directory where you saved your 835 ERAs. • If there is a problem retrieving your RA, reload it to your EDI mailbox. Please contact Medicare EDI at 1-888-670-0940, option one.

FREQUENTLY ASKED QUESTIONS (FAQS) CONTINUED

TOPIC/ISSUE	ANSWER
What is MREP?	• CMS provides this free software for Part B professional providers and suppliers. This software allows viewing and printing of the HIPAA-compliant 835. You can use this software to access and print RA information including special reports from the HIPAA 835. MREP enables you to print HIPAA ASC X12 835 version 5010A1 files to a format that is similar to the traditional SPR format. You can use MREP to view, search, and print RAs; and print and export reports containing RA information.
If I sign up for ERA will it affect how I receive my payment?	• No, ERA and Medicare payments are two separate functions. If you sign up for ERA, it will not impact the way Medicare pays your claims.
Will I be able to access ERAs that Medicare issued prior to the date I signed up for ERA?	• No, ERA becomes effective the day you sign up. You cannot access RAs that were issued before you signed up.

RA RESOURCES

FOR MORE INFORMATION	RESOURCE
Medicare Claims Processing Manual Chapter on Remittance	Chapter 22
Electronic Remit Advice (ERA) and Standard Paper Remit (SPR)	Health Care Payment and Remittance Advice
Remittance Advice Information: An Overview Booklet, ICN 908325	RA Overview Booklet
Washington Publishing Company (WPC) website	Washington Publishing Company

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EMBEDDED URL	COMPLETE URL
ASC X12N 835	https://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/index.html
ASC Companion Guide	http://www.wpc-edi.com/reference/repository/006020CC.pdf
Chapter 22	https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c22.pdf
Electronic Data Interchange (EDI) Support	https://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/index.html
Health Care Payment and RA	https://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/Remittance.html
MAC's EDI Helpline	https://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/Downloads/EDIHelplines.pdf
MREP User's Guide	https://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/AccesstoDataApplication/downloads/EasyPrintUserGuide.pdf
NPI	https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/NationalProvIdentStand/
PC Print User Guide	https://medicare.fcso.com/PC-Print_software/210042.pdf
RA Overview Booklet	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Remit-Advice-Overview-Fact-Sheet-ICN908325.pdf
WPC Reference	http://www.wpc-edi.com/reference/
5010 Resources	https://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/Versions5010andD0/Version_5010.html

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