DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

Reading the Institutional Remittance Advice (RA)

ICN 908326/ October 2015

Reading the Institutional Remittance Advice (RA)

This is one of a series of booklets about the Remittance Advice (RA). This booklet informs 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; and
- **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.

What Are the Data Elements in the RA?

The basic data elements of the RA can be alphabetic, numeric, or alphanumeric. The Health Insurance Portability and Accountability Act of 1996 (HIPAA)-compliant Accredited Standards Committee (ASC) X12N 835 (the 835) format standards define data elements that appear on all Medicare RAs as "Required" or "Situational."

- Required fields are mandatory for MACs to include in the RA.
- Situational fields depend on data content and business context (Medicare requirements) and are used if the situation applies.

If the MAC bases payment on a Healthcare Common Procedure Coding System (HCPCS) or Current Procedural Terminology Code (CPT-4) that is different from the procedure code you submitted on your claim (for example, the MAC revised the HCPCS/CPT-4 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 procedure code field does not appear because the situation does not apply.

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 HIPPA-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, visit **http://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/index.html** on the CMS website.

Reading an Institutional Electronic Remittance Advice (ERA)

How Is the ERA Available?

You can access an ERA electronically for a specified period of time after a MAC processes your claim. The MAC determines the period of time it will be available. ERAs provide additional information that is not available on the SPR. This includes more detailed claim-level information, a summary based on bill type, and additional summary information. Some fields may or may not be populated depending on the claim.

The MACs produce the ERA in the HIPAA-compliant ASC X12N 835 format, often referred to as Transaction 835 (“the 835”).

The 835, which MACs send to providers, 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, which allows for manipulation within their systems.

This booklet refers to the 005010A1 version of the ASC X12N 835, which Health and Human Services (HHS) has adopted under HIPAA as the standard beginning on January 1, 2012. The prior version was known as the 004010A version. You can find information and the latest news for the 5010 at **http://www.cms.gov/Versions5010andD0/01_overview.asp** on the CMS website.

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, financial institution). For example, the entity that receives the 835 may not send Remittance Advice Remark Codes (RARCs) explaining any adjustment in reimbursement.

How Do I View the Information in an ERA?

Since the 835 format is meant for electronic transfers only, you cannot easily read the data. Your staff can 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 can use to print a paper version of the 835. If you have this software, we encourage you to test its capabilities to format and report 835 data.

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. Go to the **PC Print website**. 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. The four options include:

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 can provide information about denied or non-covered claims. You can 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 14 and FY 15, it would receive the following FOUR billing summaries:

- TOB 32X for FY 14
- TOB 32X for FY 15
- TOB 33X for FY 14
- TOB 33X for FY 15

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 FY14 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/Legacy ID. Your Medicare contractor 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. The PC Print User Guide is available on the Internet.

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

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

Section 2 contains the data for each of the five 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	Nurses 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.

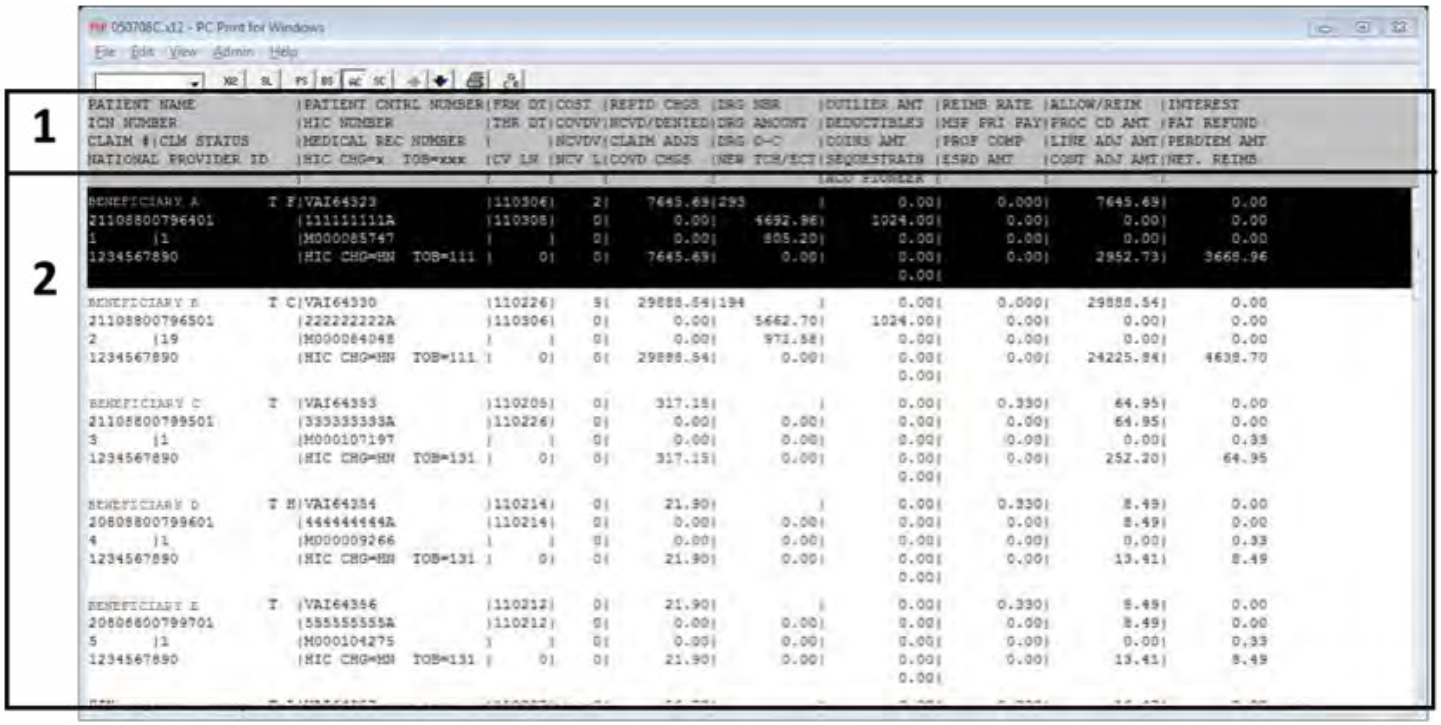


Figure 1. The Institutional ERA AC Screen

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 can provide 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 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. Of note in this section is the field for the National Provider Identifier (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, visit 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. You can find the current codes at **http://www.wpc-edi.com/reference** on the Internet.

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. You can find the current codes at **http://www.wpc-edi.com/reference** on the Internet.

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. To access the most current code lists, visit **http://www.wpc-edi.com/reference** on the Internet.

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 9 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.

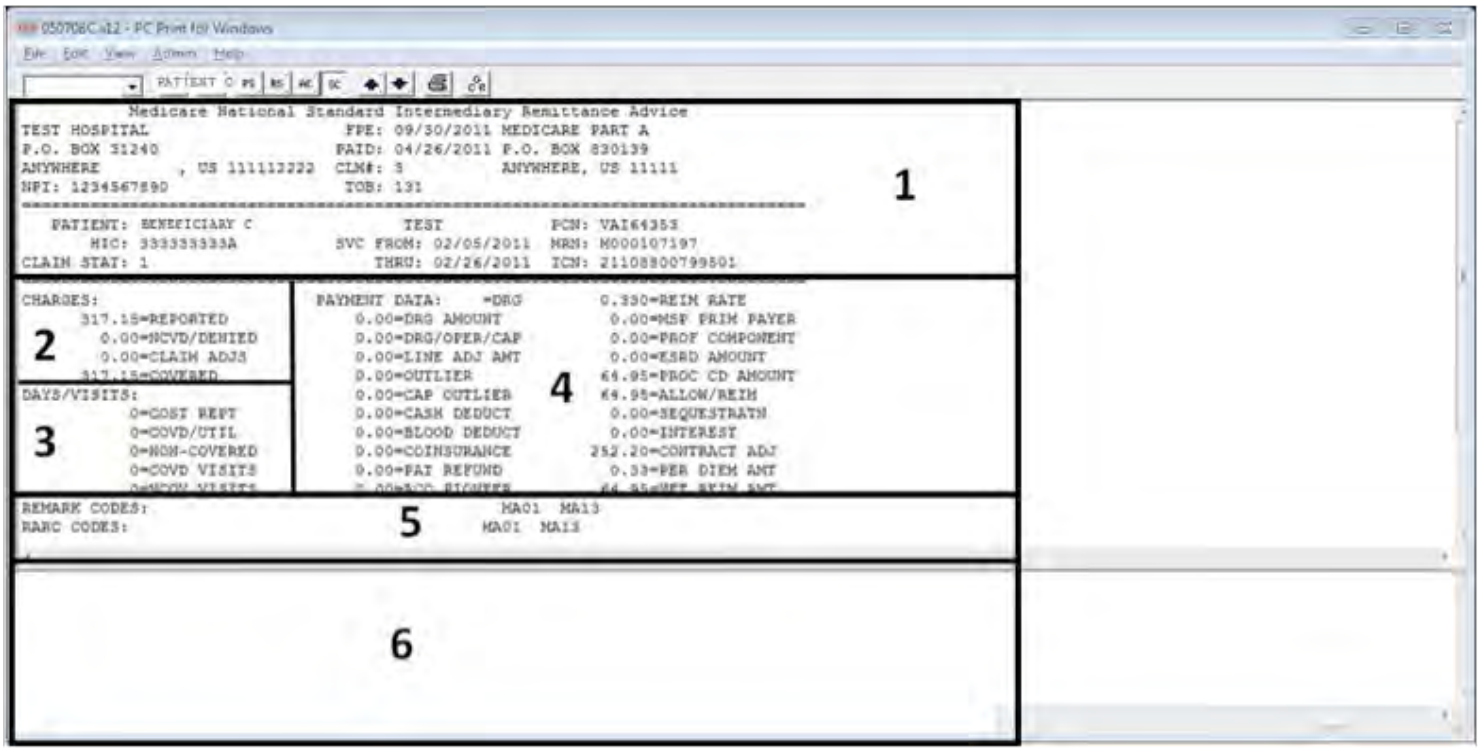


Figure 2. The Institutional ERA SC Screen

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 14 and FY 15, it would receive the following FOUR billing summaries:

- TOB 32X for FY 14
- TOB 32X for FY 15
- TOB 33X for FY 14
- TOB 33X for FY 15

You only receive a bill summary for those TOBs that were processed on this ERA. Therefore, if only 32X claims for FY 15 were processed on 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 gives an example of a BS screen. We have divided the screen into four separate sections for easy reference. We have briefly described the sections below.

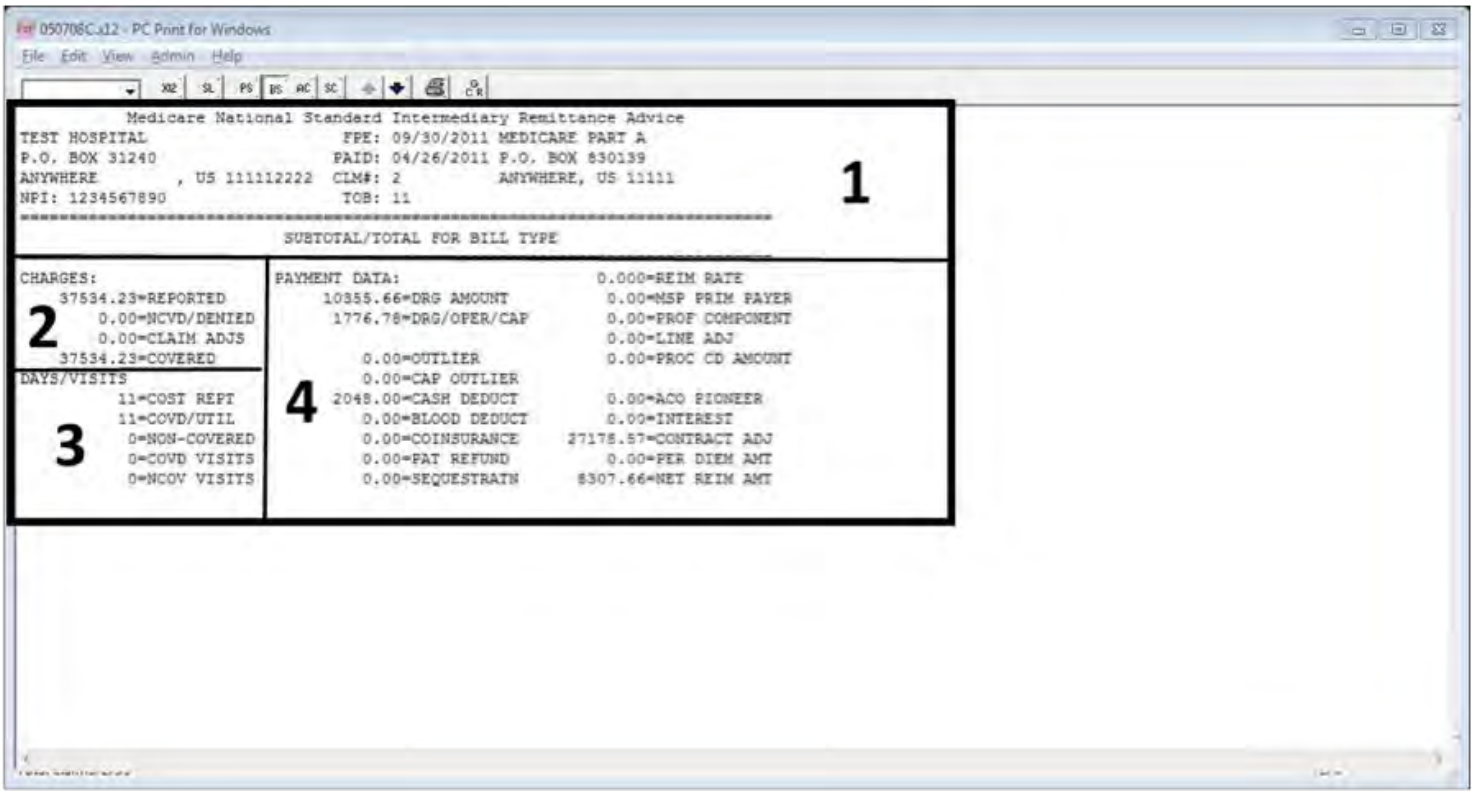


Figure 3. The Institutional ERA BS Screen

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

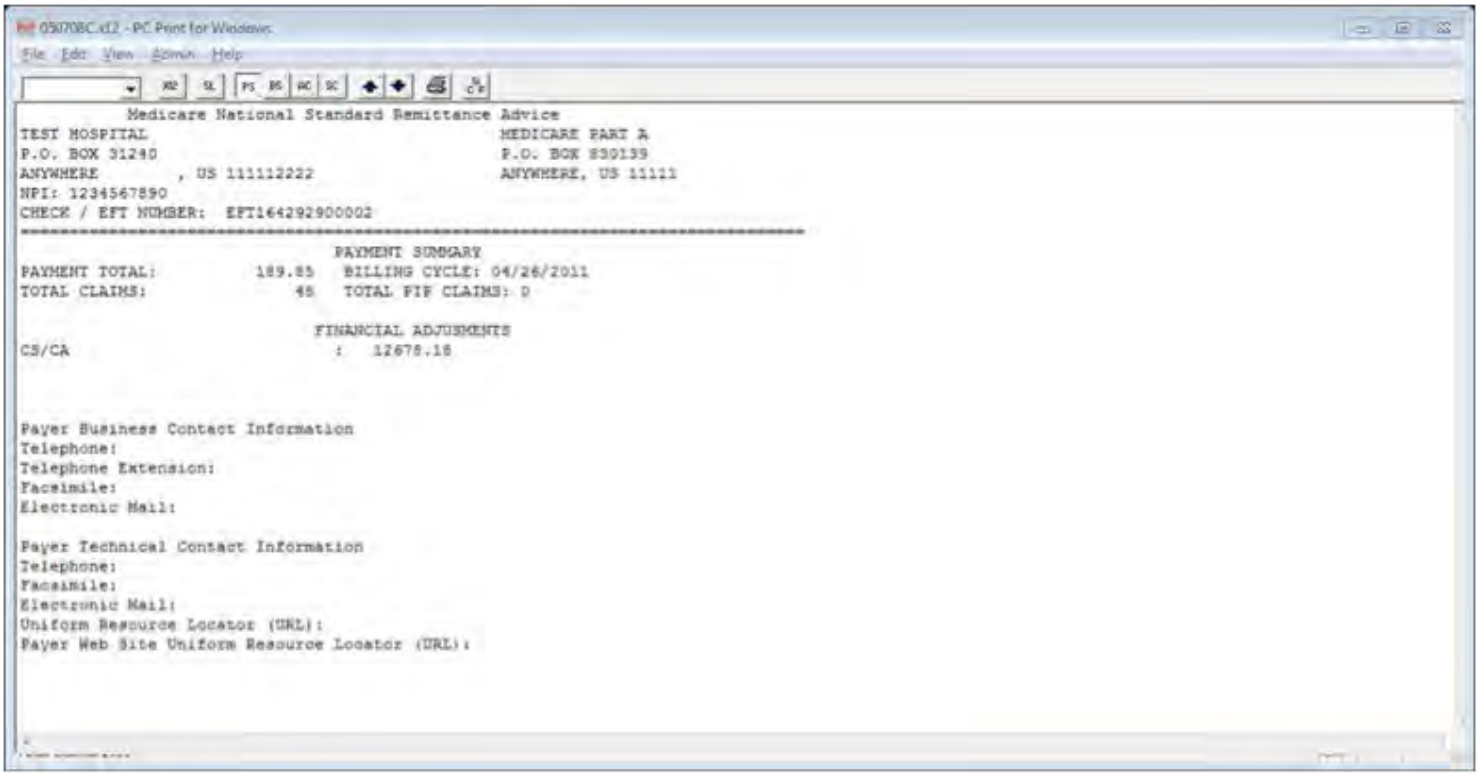
Section 2 shows a summary of the charges.

Section 3 contains a summary of the DAYS/VISITS.

Section 4 contains a summary of the PAYMENT DATA.

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 provider number, a PS screen displays for each provider number.



```
          Medicare National Standard Remittance Advice
TEST HOSPITAL                                  MEDICARE PART A
P.O. BOX 31240                                 P.O. BOX 830139
ANYWHERE        , US 111112222                 ANYWHERE, US 11111
NPI: 1234567890
CHECK / EFT NUMBER:  EFT164292900002
==============================================================================
                              PAYMENT SUMMARY
PAYMENT TOTAL:          189.85   BILLING CYCLE: 04/26/2011
TOTAL CLAIMS:                45   TOTAL PIP CLAIMS: 0

                           FINANCIAL ADJUSTMENTS
CS/CA                        :   12678.18


Payer Business Contact Information
Telephone:
Telephone Extension:
Facsimile:
Electronic Mail:

Payer Technical Contact Information
Telephone:
Facsimile:
Electronic Mail:
Uniform Resource Locator (URL):
Payer Web Site Uniform Resource Locator (URL):
```

Figure 4. The Institutional ERA Provider PS Screen

For a complete listing of Provider-Level Adjustment Reason Codes, refer to the **ASC X12N 835 Implementation Guide: Health Care Claim Payment/Advice** on the internet.

Reading an Institutional Standard Paper Remittance Advice (SPR)

What are the SPR Basics?

If you elect to receive a paper RA, you will receive an SPR. You will 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. SPR formats may vary by the MAC that provides the SPR.

Medicare does not send you an SPR if you receive an ERA. If you are submitting a new request to receive ERAs, you will be allowed to receive the SPR in addition to the ERA for a limited 31-day period.

CMS has instructed MACs to terminate issuance of SPRs to those entities (such as a provider, billing agent, clearinghouse, or other entity representing a provider) currently receiving or who begin to receive ERAs, effective the 31st day after initial issuance of the ERA in production. If you use a billing agent, clearinghouse, or other entity to obtain the ERA, the same guidelines will apply. If you are set up to generate an ERA, MACs will not generate a Paper Remit.

How Can I Change from an SPR to an ERA?

If you currently receive SPRs and want to change to ERAs, you should contact the Electronic Data Interchange (EDI) department of your MAC.

What Are 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 Skilled Nursing Facilities (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 is an example page from the AC section of an SPR.

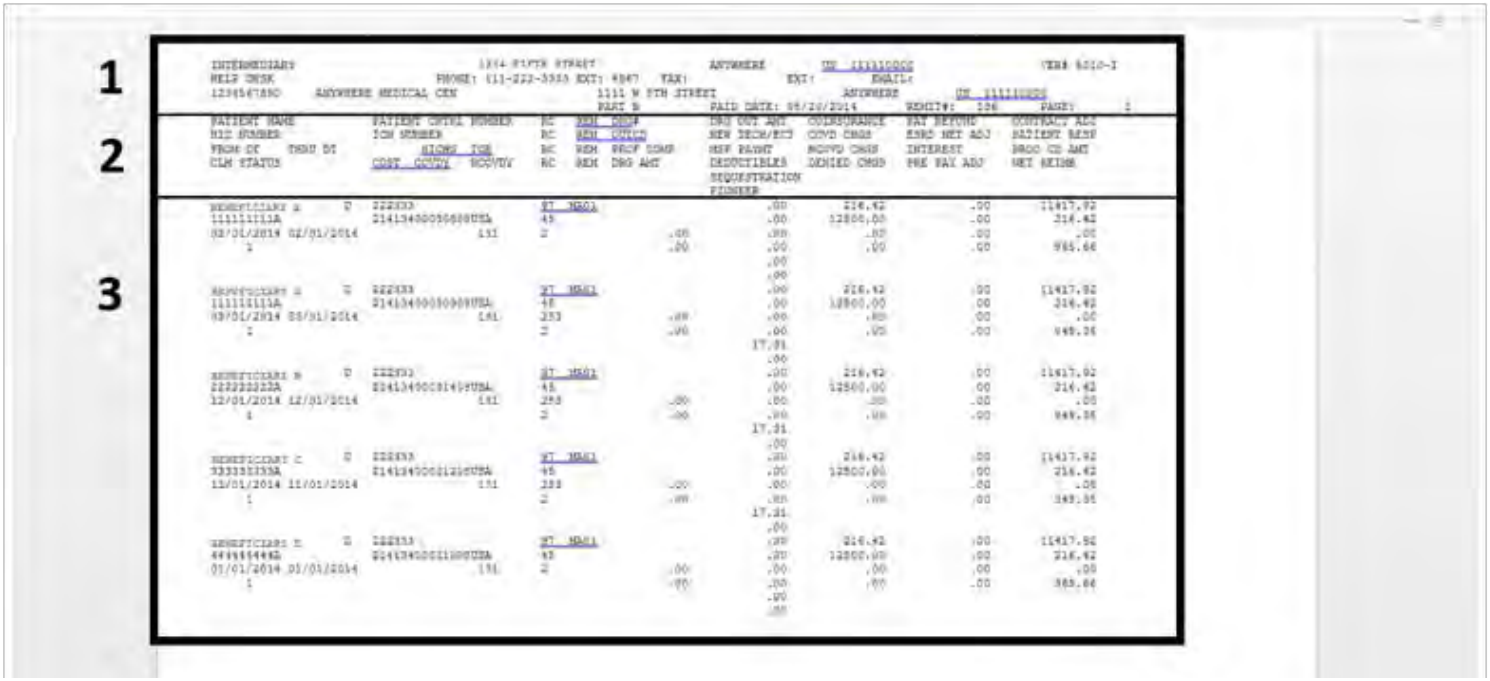


Figure 5. An Example Page from the AC Page of an Institutional SPR

Section 1 of Figure 5 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.

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 is an example of a summary page from an Institutional SPR. We have 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.

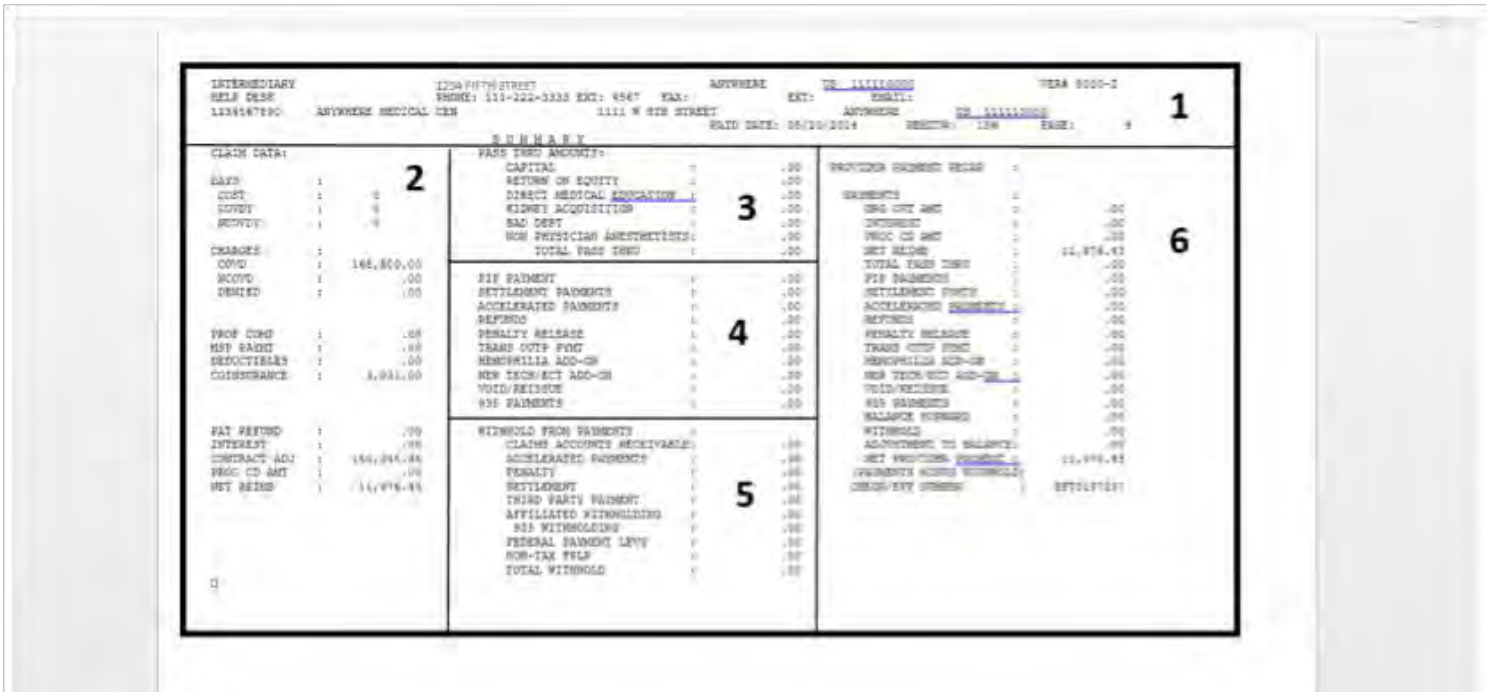


Figure 6. Summary Page from an Institutional SPR

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 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.

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.

What Are The 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; and
- 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. You should 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
– Prodvider-level adjustment(s) made to the claim payments

Total Payment Amount
(This should match the check of EFT amount)

On An Institutional ERA

You can 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). This screen may also include a FINANCIAL ADJUSTMENTS field that appears only if financial adjustments have been made. You should use the amount in the FINANCIAL ADJUSTMENTS field to determine total provider adjustments. If claims are billed using more than one provider number, there is a separate PS screen for each provider number.

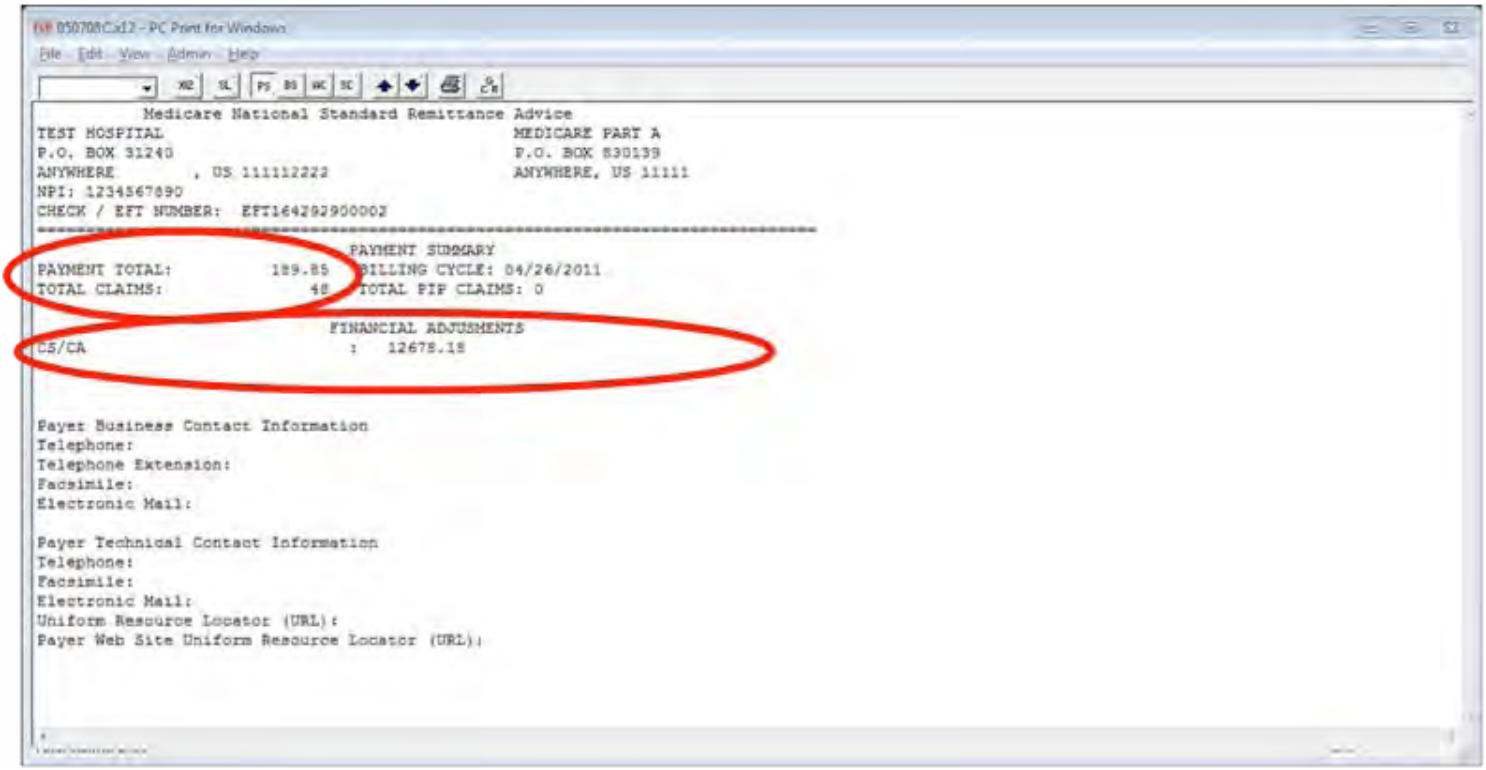


Figure 7. The PS Screen of an Institutional ERA Used For Transaction-Level Balancing

On An Institutional SPR

You can use the PROVIDER PAYMENT RECAP section on the Summary Page to locate fields involved in transaction-level balancing (see Figure 8). 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 Section 5 of Figure 8). This should result in the amount of the provider's reimbursement check (NET PROVIDER PAYMENT in Section 6 of Figure 8).

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

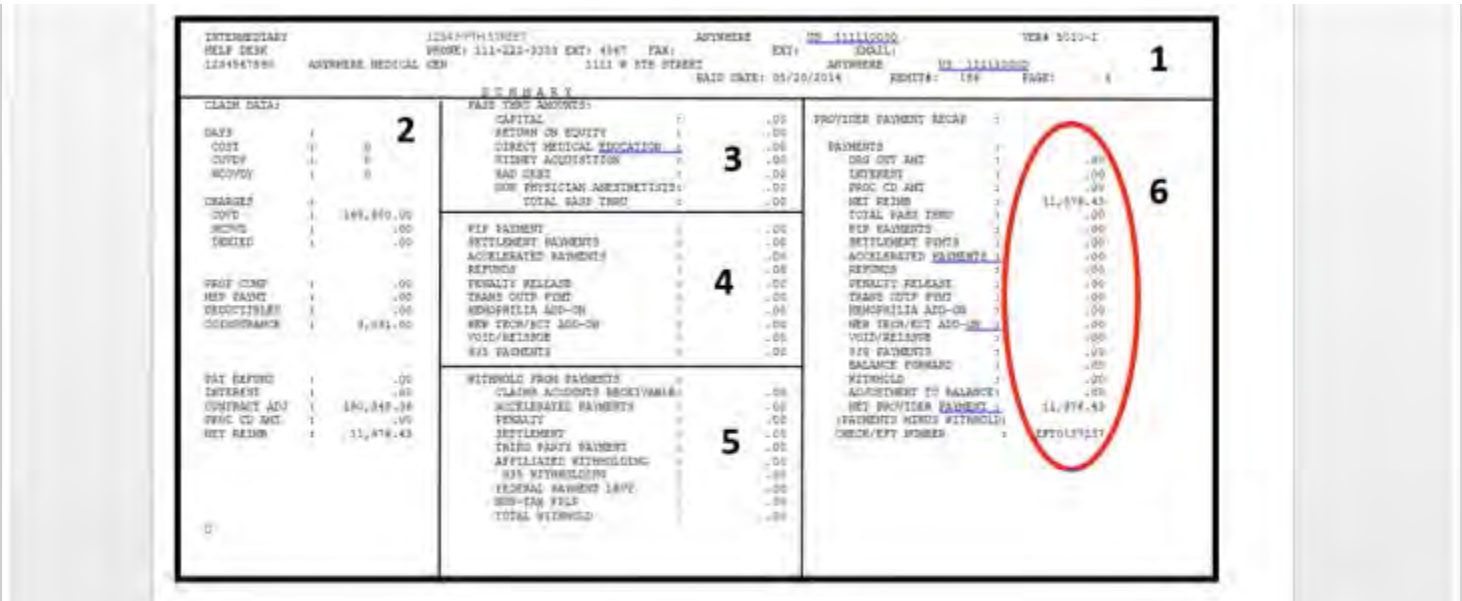


Figure 8. The Summary Page of an Institutional SPR Used For Transaction-Level Balancing

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

Dollar Amount	Field used for balancing this SPR	Description
11,976.43	NET REIMB	Total of claim payment amounts.
-0.00	None	Total Provider-Level Adjustments[1]
11,976.43	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.

Table 1. Example Transaction-Level Balancing an Institutional RA

[1]There were no provider-level adjustments on this example SPR.

Claim-Level Balancing an Institutional RA

Claim-level balancing encompasses the entire claim for one beneficiary. You can 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 cannot 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 Section 4 of Figure 9). 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 Section 6 of Figure 9), the claim-level balancing includes balancing the total claim charge to the sum of the related service charges.

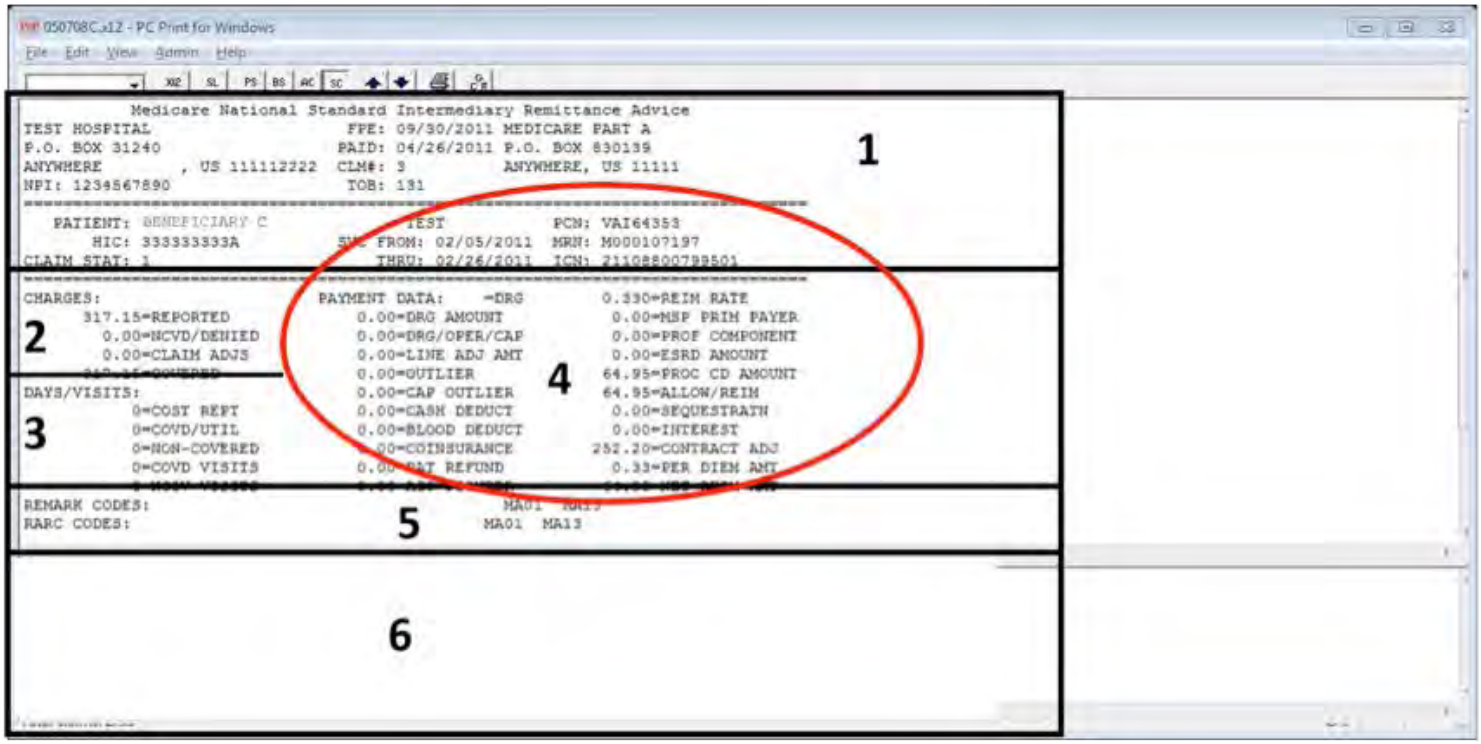


Figure 9. The SC Screen of an Institutional ERA Used For Claim-Level Balancing

On An Institutional SPR

To perform claim-level balancing on an Institutional SPR, subtract all adjustments (found 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). These amounts are found on the AC Page of an SPR (in Section 3 of Figure 10).

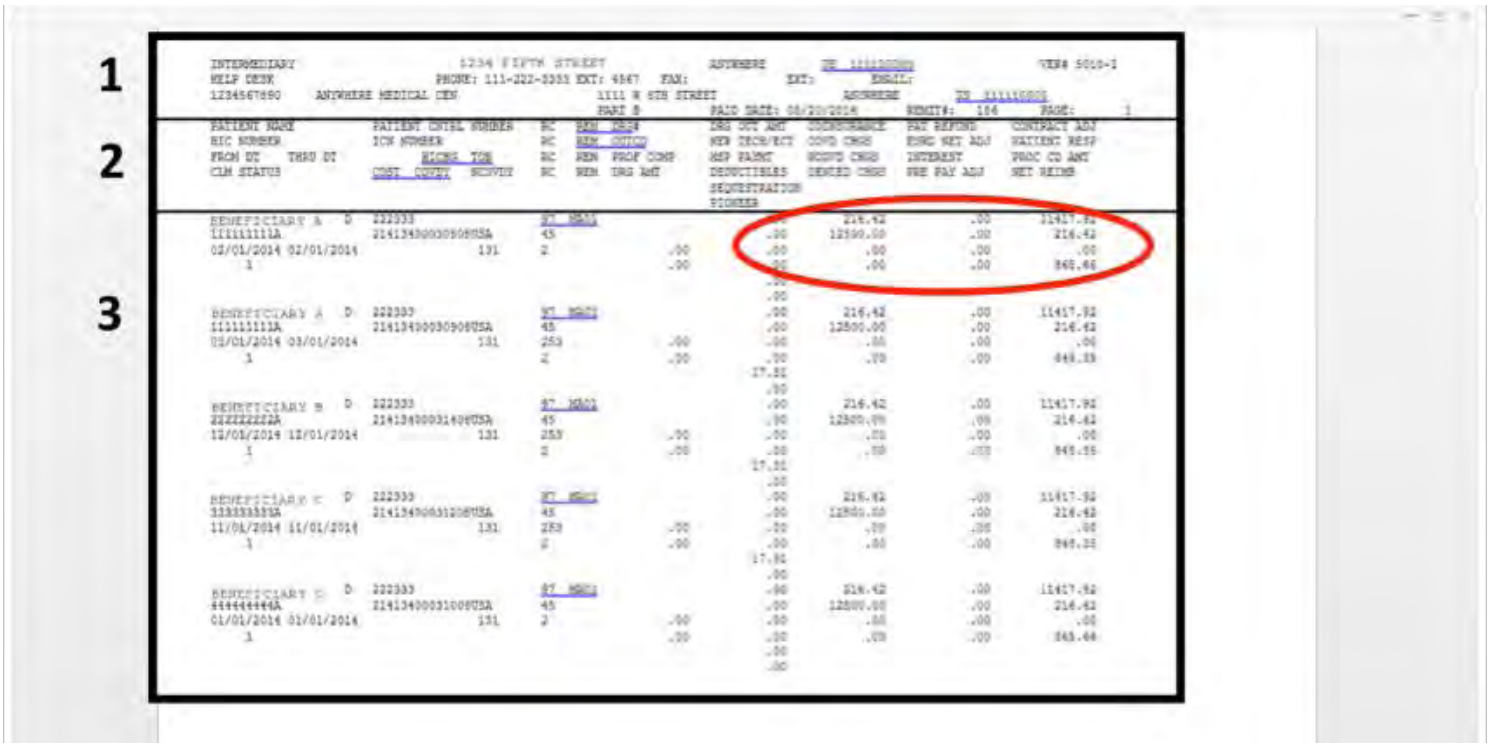


Figure 10. The AC Page of an Institutional SPR Used For Claim-Level Balancing

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

Dollar Amount	Field used for balancing this claim	Description
12,500.00	COVD CHGS	Total submitted charge for this claim.
-11,417.92	CONTRACT ADJ	A claim-level adjustment due to a contractual agreement between the payer and the payee.
865.66	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.

Table 2. Example Claim-Level Balancing Fields

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:

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

On An Institutional ERA

To complete service-line-level balancing, you should use the SC screen. The service-line fields are located in Section 6 of the SC screen (see Figure 11). You can 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.

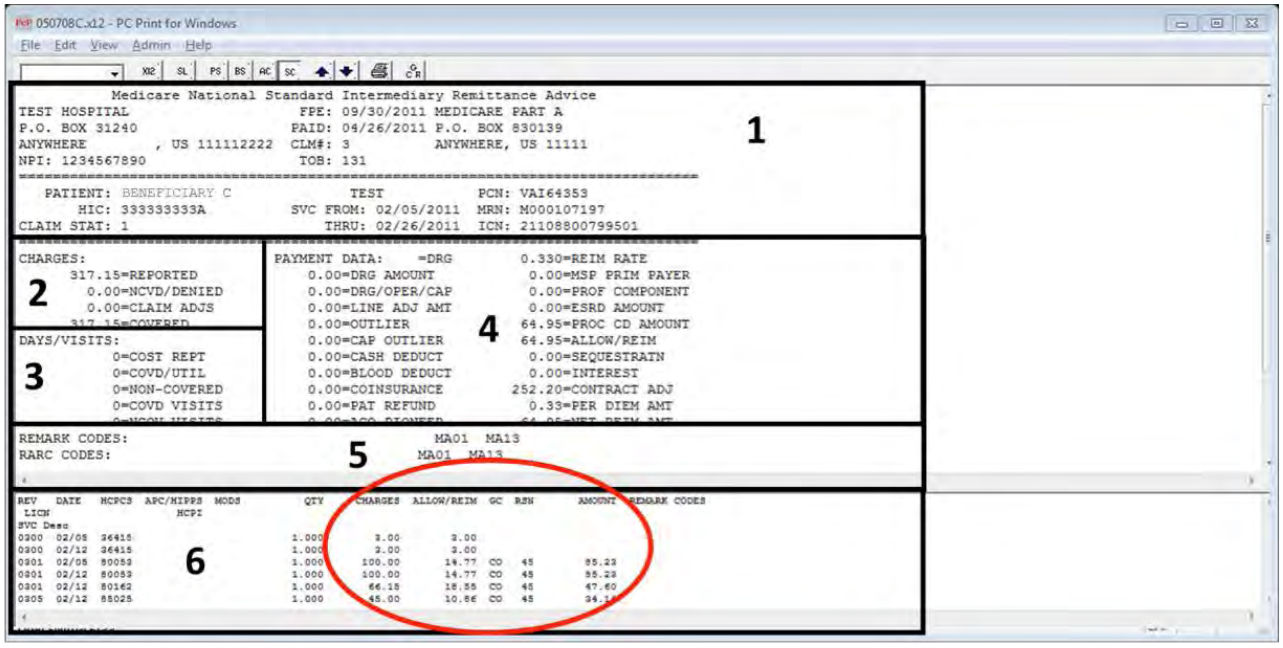


Figure 11. The SC Screen of an Institutional ERA Used For Service-Line-Level Balancing

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.

Additional Resources:

"Medicare Claims Processing Manual," **Chapter 22**, Remittance Advice; and **Health Care Payment and Remittance Advice** web page, both of which are available on the CMS website.

Other booklets in this series include:

Remittance Advice Information: An Overview Booklet, ICN 908325, which is available at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Remit-Advice-Overview-Fact-Sheet-ICN908325.pdf**;

Remittance Advice Resources Booklet ICN 908329, which is available at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Remit-Advice-Resources-Fact-Sheet-ICN908329.pdf**; and

Medicare Remit Easy Print Software: Free Software Allows Physicians and Suppliers to View and Print Remittance Advice Information, ICN 006740, which is available at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MedicareRemit_0408.pdf** on the CMS website.

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