



Official Information Health Care  
Professionals Can Trust

# Reading a Professional Remittance Advice (RA)

ICN908328/ October 2015

## 1.0 Reading a Professional RA: Overview

This is one of a series of booklets about Remittance Advice (RA). This booklet informs physicians, providers, and suppliers (hereafter referred to as “providers”) how to read a Health Insurance Portability and Accountability Act of 1996 (HIPAA)-compliant Professional Electronic RA (ERA), also known as Transaction 835 or “the 835”, using Medicare Remit Easy Print (MREP) software. It also explains how to read the Standard Paper RA (SPR). There are three major sections:

- **Reading a Professional Electronic RA (ERA or 835):** The first section provides guidance for reading a Professional ERA;
- **Reading a Professional Standard Paper RA (SPR):** The second section provides guidance for reading an SPR; and
- **Balancing a Professional RA:** The last section presents guidance and examples for balancing the ERA or the SPR so that the providers’ records are consistent with Medicare’s records.

## 1.1 INTRODUCTION

Physicians, providers, and suppliers submit claims to Medicare contractors, known as Medicare Administrative Contractors (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 that submit professional claims to MACs receive a Professional RA.

### 1.1.1 What Are the 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 the 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, the 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.

### **1.1.2 Is The RA Standardized?**

Yes. Medicare has standardized the Professional SPR to ensure you receive the necessary information. The SPR mirrors the information provided in an ERA.

## **1.2 Reading a Professional Electronic Remittance Advice (ERA)**

### **1.2.1 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.

### **1.2.2 How Is the ERA Generated?**

The MACs produce the ERA in the HIPAA-compliant ASC X12N 835 format, often referred to as Transaction 835 ("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 has been adopted under HIPAA as the 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, financial institution). It is possible that the entity receiving the 835 may not regularly send the Remittance Advice Remark Codes (RARCs) that explain adjustments in reimbursement.

### **1.2.3 How Can I View the Information in an ERA?**

Since the ASC X12N 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.

Professional providers can get free translator software for viewing HIPAA 835 files from their MAC. This software is called Medicare Remit Easy Print (MREP). 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 should 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 an SPR, or view them directly in the MREP software.

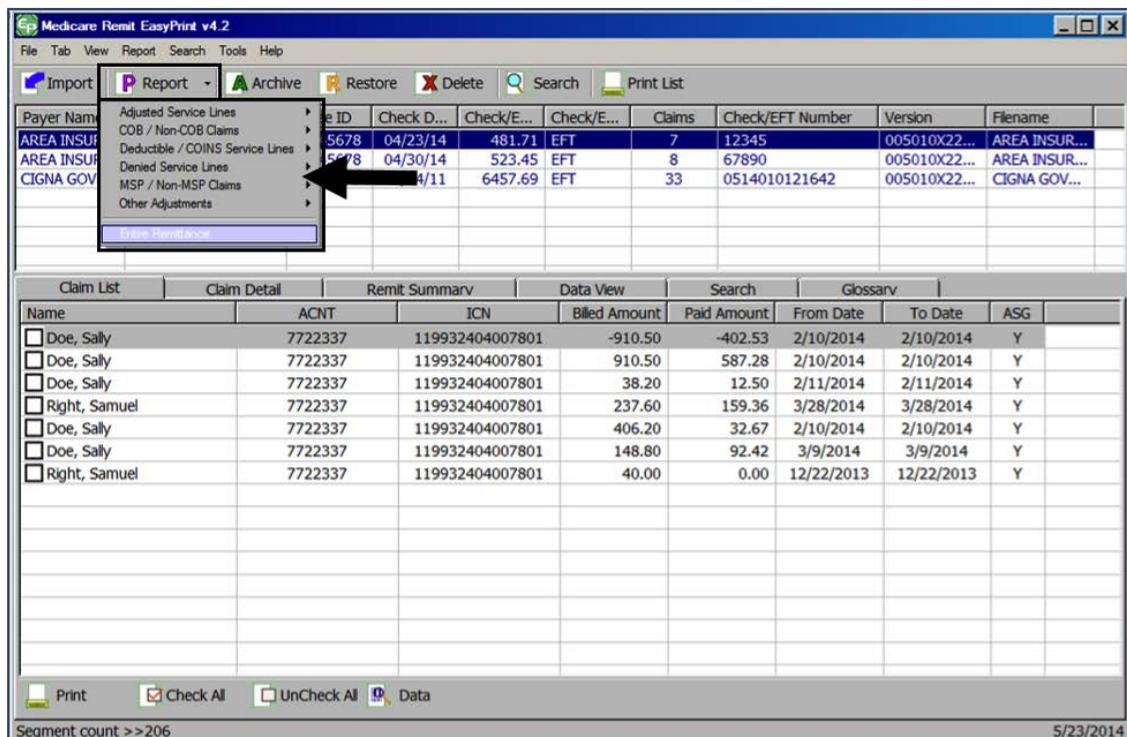
### 1.2.3.1 How Does the MREP Software Present the ERA Information?

The MREP software presents remittance information in several ways. They include:

- The Entire Remittance Report - This report allows you to view or print your remittance information quickly in a format similar to an SPR.
- A Tabbed Information View - This tabbed view allows you to view **only the information you select** from a particular ERA. Six tabs give you the ability to:
  - Select specific claims;
  - View and print claim information for the selected claims;
  - View and print summary information for the entire ERA;
  - View ERA data in loops and segments;
  - Search claims for specific information; and
  - View a glossary of all Claim Adjustment Reason Codes (CARCs) and RARCs that appear on the ERA.
- Special Reports - Special reports give you information specific to:
  - Claims containing adjusted service lines;
  - Coordination of Benefits (COB) and Non-COB claims;
  - Deductible and coinsurance service lines;
  - Denied service lines; and
  - Other adjustments.

### 1.2.4 Using the MREP Software to Print an RA

To print quickly from an 835, you can use the “Report” function, as shown in **Figure 1**. 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.** 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. You should refer to the “Medicare Claims Processing Manual,” [Chapter 22](#) (Remittance Advice), on the CMS website, 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:

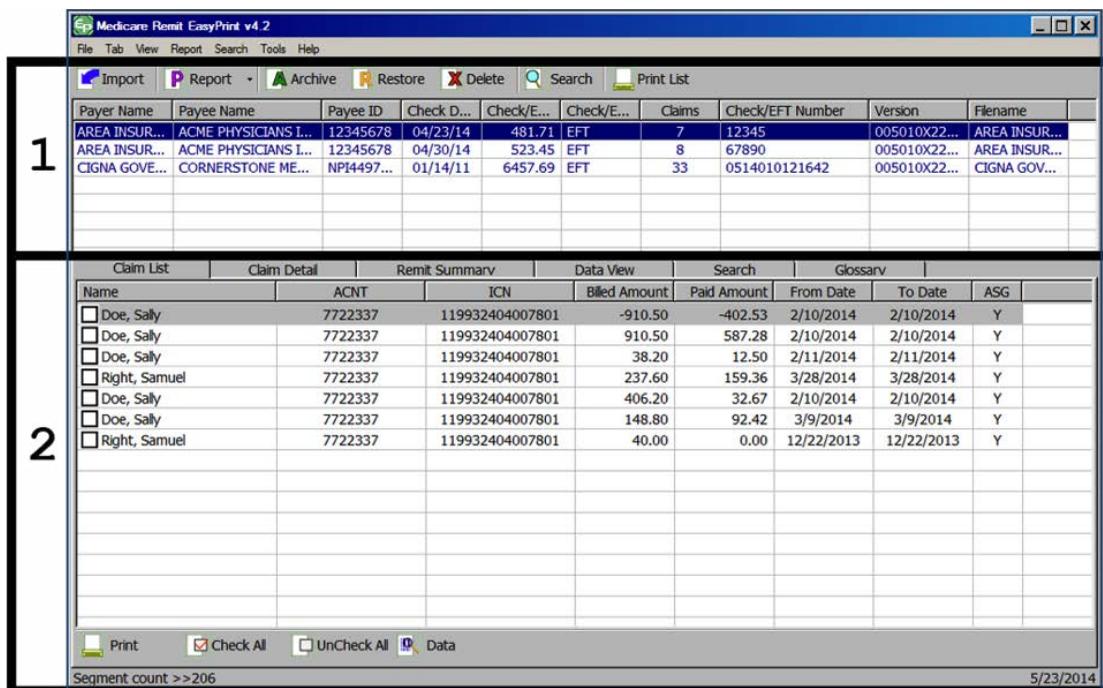
- The totals section - The paper remittance from MREP software includes totals for all claims, assigned and unassigned.
- The handling of adjusted claims - The paper remittance from MREP software mirrors the 835 by showing the adjusted and the replacement claim.
- The bulletin board section - The MREP 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.

### 1.2.5 Viewing Remittance Information Using the MREP Software

In addition to printing a remittance, the MREP software provides several valuable ways to view and print remittance information as follows:

1. **Figure 2** shows the MREP software after the provider has imported several 835s.
2. **Figure 2** - Section 1 provides a list of imported 835s. .
3. When you select an 835 from this list, information about that 835 appears in Section 2. The six tabs that you use to view remittance information are discussed on the following pages.



**Figure 2.** The MREP Software with Multiple 835s Ready for Viewing

#### 1.2.5.1 The Claim List Tab (Professional ERA)

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

Payer Name	Payee Name	Payee ID	Check D...	Check/E...	Check/E...	Claims	Check/EFT Number	Version	Filename
AREA INSUR...	ACME PHYSICIANS I...	12345678	04/23/14	481.71	EFT	7	12345	005010X22...	AREA INSUR...
AREA INSUR...	ACME PHYSICIANS I...	12345678	04/30/14	523.45	EFT	8	67890	005010X22...	AREA INSUR...
CIGNA GOVE...	CORNERSTONE ME...	NPI4497...	01/14/11	6457.69	EFT	33	0514010121642	005010X22...	CIGNA GOV...

Name	ACNT	ICN	Billed Amount	Paid Amount	From Date	To Date	ASG
<input type="checkbox"/> Doe, Sally	7722337	119932404007801	-910.50	-402.53	2/10/2014	2/10/2014	Y
<input type="checkbox"/> Doe, Sally	7722337	119932404007801	910.50	587.28	2/10/2014	2/10/2014	Y
<input type="checkbox"/> Doe, Sally	7722337	119932404007801	38.20	12.50	2/11/2014	2/11/2014	Y
<input checked="" type="checkbox"/> Right, Samuel	7722337	119932404007801	237.60	159.36	3/28/2014	3/28/2014	Y
<input type="checkbox"/> Doe, Sally	7722337	119932404007801	406.20	32.67	2/10/2014	2/10/2014	Y
<input type="checkbox"/> Doe, Sally	7722337	119932404007801	148.80	92.42	3/9/2014	3/9/2014	Y
<input type="checkbox"/> Right, Samuel	7722337	119932404007801	40.00	0.00	12/22/2013	12/22/2013	Y

Figure 3. The Claim List Tab

### 1.2.5.2 The Claim Detail Tab (Professional ERA)

The Claim Detail tab (see Figure 4) 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.

RARC	SERV-DATE	POS	PD-PROC/MODS	PD-NOS	SUB-NOS	BILLED	SUB-PROC	ALLOWED	GRP/CARC	DEDUCT	CARC-AMT	COINS	ADJ-QTY	PROV-PD	BS
NAME: Right, Samuel			HIC: SJD11111		ACNT: 7722337		ICN: 119932404007801	ASG: Y	MOA: MA07	MA01					
12345678	0328	032814	12 A6209A2	24.000	194.40	179.52	0.00	35.90	143.62						
N88						CO-42	14.88								
CNTL #: 54321															
12345678	0328	032814	12 A6446A2	48.000	43.20	19.68	0.00	3.94	15.74						
N88						CO-42	23.52								
CNTL #: 54321															
FT RESP	39.84	CARC		38.40	CLAIM TOTALS	237.60	199.20	0.00	39.84	159.36					
ADJ TO TOTALS: PREV PD				INTEREST	0.00	LATE FILING CHARGE	0.00	NET	159.36						

Figure 4. The Claim Detail Tab

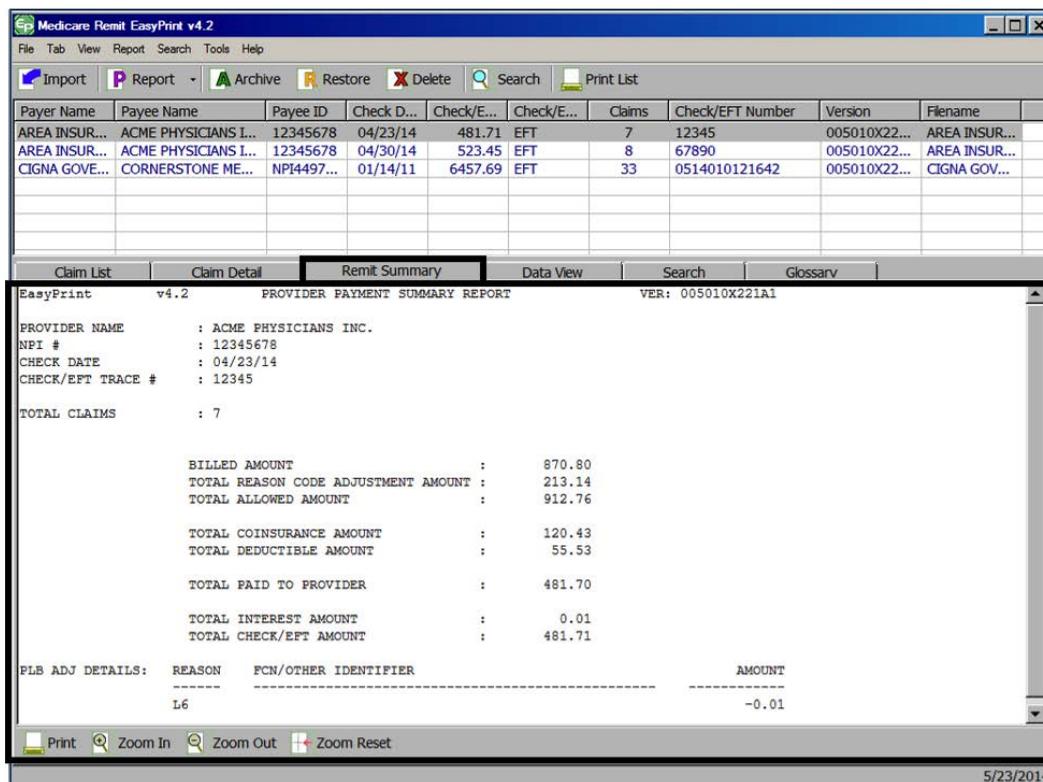
The information in the Claim Detail tab appears in a format similar to an SPR. However, total information across all selected claims does not appear the way it does at the end of an SPR. For a description of how to read the detailed claim information in this tab, refer to sections titled “Header Information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

### 1.2.5.3 The Remit Summary Tab (Professional ERA)

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. You may notice a difference in the way totals for the entire RA appear on an SPR (see **Figure 5**) and on the Remit Summary tab (see **Figure 6**) 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.

TOTALS:	# of CLAIMS	BILLED AMT	ALLOWED AMT	DEDUCT AMT	COINS AMT	TOTAL RC AMT	PROV PD AMT	PROV ADJ AMT	CHECK AMT
	5	321.00	211.47	0.34	39.88	109.53	161.25	25.44	135.81
PROVIDER ADJ DETAILS:			PLB REASON CODE	FCN	HIC	AMOUNT			
			50			15.44			
			FB		0202199306770	9999999999	10.00		

**Figure 5.** Totals as Shown on an SPR



**Figure 6.** The Remit Summary Tab

### 1.2.5.4 The Data View Tab (Professional ERA)

The Data View tab (**Figure 7**) 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 at <http://www.wpc-edi.com/> on the Internet.

Payer Name	Payee Name	Payee ID	Check D...	Check/E...	Check/E...	Claims	Check/EFT Number	Version	Filename
AREA INSUR...	ACME PHYSICIANS I...	12345678	04/23/14	481.71	EFT	7	12345	005010X22...	AREA INSUR...
AREA INSUR...	ACME PHYSICIANS I...	12345678	04/30/14	523.45	EFT	8	67890	005010X22...	AREA INSUR...
CIGNA GOVE...	CORNERSTONE ME...	NPI4497...	01/14/11	6457.69	EFT	33	0514010121642	005010X22...	CIGNA GOV...

Loop & Segment	Field ID	Description	Value
HDRB : ST	01	Transaction Set Identifier Code	835
HDRB : BPR	02	Transaction Set Control Number	0001
HDRB : TRN			
HDRB : REF			
HDRB : REF			
HDRB : DTM			
1000A : N1			
1000A : N3			
1000A : N4			
1000A : REF			
1000A : PER			
1000B : N1			
1000B : N3			
1000B : N4			
1000B : REF			
2000 : LX			
2100 : CLP			
2100 : NM1			
2100 : NM1			
2100 : MOA			
2100 : DTM			

Figure 7. The Data View Tab

### 1.2.5.5 The Search Tab (Professional ERA)

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

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

Once the search is complete, the software provides a list of claims that matched the search criteria. You can 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.

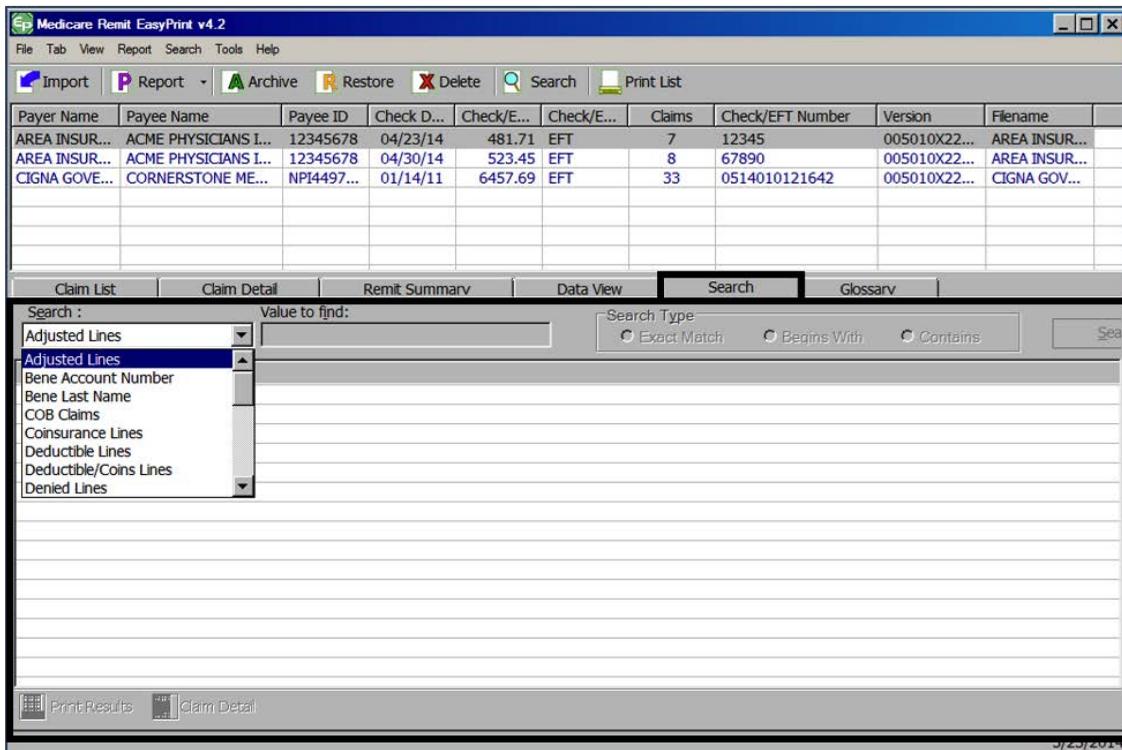


Figure 8. The Search Tab

### 1.2.5.6 The Glossary Tab (Professional ERA)

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

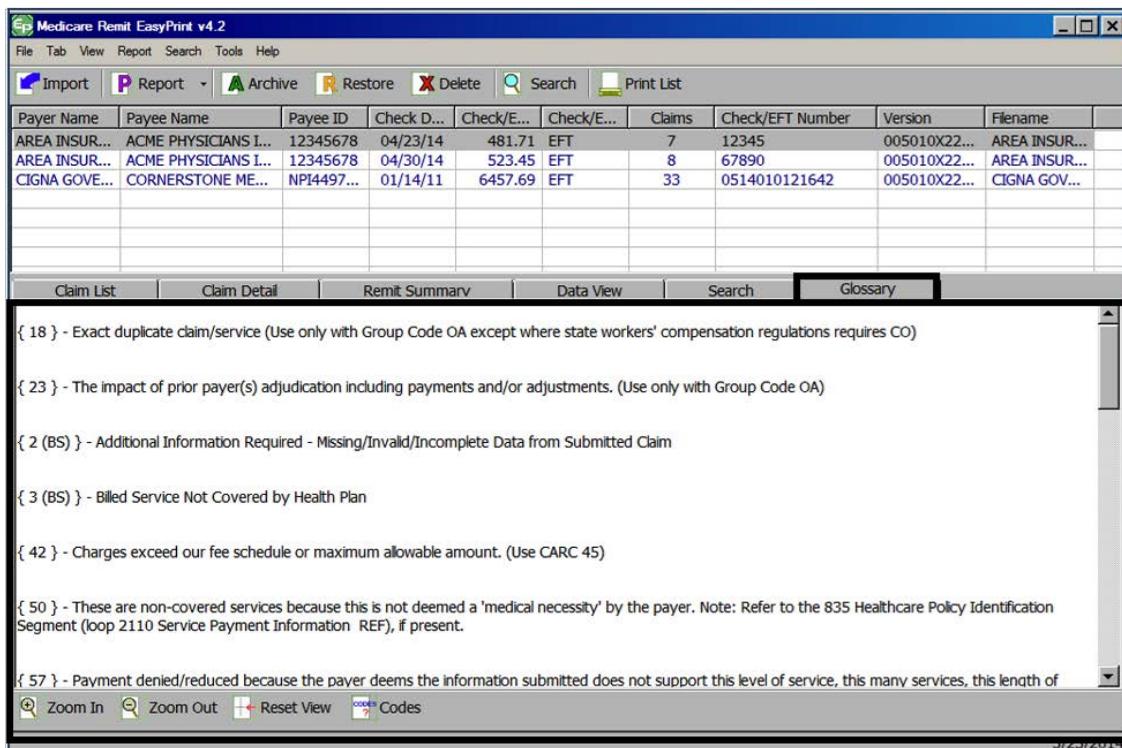


Figure 9. The Glossary Tab

## 1.2.6 Generating Special Reports Using the MREP Software

In addition to the tabbed view that gives you multiple ways in which to view remittance information, the MREP software provides the following automated special reports.

### 1.2.6.1 The Adjusted Service Lines Report

The **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.

### 1.2.6.2 COB Claims and Non-COB Claims Reports

The **COB Claims report** 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.

### 1.2.6.3 Deductible and Coinsurance Service Lines Reports

The MREP software provides the following three reports for viewing deductible and coinsurance services lines:

- The **Deductible Service Lines report** lists all service lines that have a deductible amount.
- The **Coinsurance Service Lines report** lists all service lines that have a coinsurance amount.
- 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.

### 1.2.6.4 The Denied Service Lines Report

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).

### 1.2.6.5 The Other Adjustments Report

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.

### 1.2.6.6 Fields Appearing on MREP Special Reports

**Figure 10** 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.

**Denied Service Line(s) Report**  
Generated: 5/23/2014 2:55:13 PM

Carrier: AREA INSURANCE  
Payee #: 12345678  
Payee Name: ACME PHYSICIANS INC.  
Chk Date: 04/23/14  
Chk/EFT #: 12345

Seq #	Prov#/NPI	ACNT # / Name	ICN/HICN	Ln#	Service Date(s)	Prod/Serv ID	Billed	Allowed	Deduct	Coins	Pd to Prov
00001	12345678	7722337 Right Samuel	119932404007801 SJD11111	01	12/22/13-12/22/13	A6261 A1	40.00	0.00	0.00	0.00	0.00
							Reason Code: CO-18	Remark Codes: Nil1			
							40.00	0.00	0.00	0.00	0.00

Figure 10. The Denied Service Lines Report

## 1.3 Reading a Professional Standard Paper Remittance Advice (SPR)

### 1.3.1 How is the SPR Available?

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.

#### 1.3.1.1 What Types of SPRs are Available?

You may generate your own SPR by choosing to receive an electronic 835 file and using the new MREP software to view and print the 835 in SPR format. There are slight differences between SPRs you receive from a Medicare contractor 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.

### 1.3.2 How Do I Switch from an SPR to an ERA?

If you currently receive SPRs and are interested in switching to ERAs, you should contact the Electronic Data Interchange (EDI) department of your MAC via their toll free number, which is available at <https://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/Downloads/EDIHelplines.pdf> on the CMS website.

**Note: MACs no longer send the SPR to professional providers who also have been receiving ERAs for 45 days or more.**

## 1.4 What are the Components of the Professional SPR?

Professional SPRs are split into four basic sections:

1. **Header Information (Section 1 of Figure 11 and Figure 12)** - This section contains header information and a bulletin board section.
2. **Assigned Claims (Sections 2 and 3 of Figure 11)** - This section provides detailed information for each individual assigned claim.



### 1.4.1 Header Information (Professional SPR)

Section 1 of **Figure 11** and **Figure 12** 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** shows the header information of page 1 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.

1	EXAMPLE MEDICARE CARRIER 1000 SOMEPLACE LANE FAIRFAX, VA 22033-0000 1-877-555-1234	MEDICARE REMITTANCE NOTICE
	EXAMPLE MEDICARE PROVIDER 200 DOCTORS DRIVE SUITE 200 SOMEWHERE, NJ 16666-0200	NPI: 1234567890 PAGE #: 1 OF 2 DATE: 01/28/14 CHECK/EFT #: 000234569
***** WELCOME TO THE MEDICARE PART B STANDARD PAPER REMITTANCE *****		

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

### 1.4.2 Assigned Claims (Professional SPR)

**Figure 14** 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**) provides a reference for the service-line-level and claim-level data that are displayed for each claim in the assigned claims section.

PERF	PROV	SERV DATE	POS	NOS	PROC	MODS	BILLED	ALLOWED	DEDUCT	COINS	GRP/RC	AMT	PROV PD							
NAME ALPHA, BEN HIC 9999999999 ACNT ALPH6123133-01 ICN 0202199306840 ASG Y MOA MA01																				
123456ABC		0225 022502	11	1	99213		66.00	49.83	0.34	9.97	PR-96	16.17	39.52							
PT RESP		10.31										16.17								
												CLAIM TOTALS	66.00	49.83	0.34	9.97				
												NET			39.52					
NAME ALPHA, BEN HIC 9999999999 ACNT ALPH6123133-01 ICN 0202199306850 ASG Y MOA MA01 MA07																				
123456ABC		0117 011702	11	1	99213		66.00	49.83	0.00	9.97	PR-96	16.17	39.86							
PT RESP		9.97										16.17	39.86							
												CLAIM TOTALS	66.00	49.83	0.00	9.97				
												NET			39.86					
CLAIM INFORMATION FORWARDED TO: NEW JERSEY MEDICAID																				
NAME DELTA, PATI HIC 9999999999 ACNT DELT5-329 ICN 0202199306860 ASG Y MOA MA01																				
123456ABC		0117 011702	11	1	90659		25.00	3.32	0.00	0.00	CO-42	21.68	3.32							
123456ABC		0117 011702	11	1	G0008		10.00	4.46	0.00	0.00	CO-42	5.54	4.46							
PT RESP		0.00										27.22	7.78							
												CLAIM TOTALS	35.00	7.78	0.00	0.00				
												NET			7.78					
NAME GAMMA, RAYMOND HIC 9999999999 ACNT GAMM0861-316 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										16.17	39.86							
												CLAIM TOTALS	66.00	49.83	0.00	9.97				
												NET			39.86					
ADJ TO TOTALS: PREV PD 10.00 INT 0.00 LATE FILING CHARGE 0.00																				
CLAIM INFORMATION FORWARDED TO: NEW JERSEY MEDICAID																				
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										33.80	44.23							
												CLAIM TOTALS	88.00	54.20	0.00	9.97				
												NET			44.23					

**Figure 14.** The Assigned Claims Section of the Professional SPR

After the header row, claims appear individually (shown in Section B of **Figure 14**). 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** shows a single claim from the assigned claims section. The fields displayed for each claim are described in the following sections.

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										33.80	44.23							
												CLAIM TOTALS	88.00	54.20	0.00	9.97				
												NET			44.23					

**Figure 15.** Information for an Individual Claim

### 1.4.2.1 Assigned Claims - Claim-Level Information (Professional SPR)

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

### 1.4.2.2 Assigned Claims - Service-Line-Level Information (Professional SPR)

After this initial line of claim-level information, data is broken out by service lines. In the example shown in **Figure 15**, 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**.

NAME	KAPPA, MARY	HIC	999999999	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

Figure 16. Information for an Individual Claim

### 1.4.2.3 Assigned Claims - Totals (Professional SPR)

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

Some claims, such as that shown in **Figure 17**, 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.

NAME	GAMMA, RAYMOND	HIC	999999999	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

Figure 17. Information for an Individual Claim

### 1.4.2.4 Assigned Claims - Adjustments Line (Professional SPR)

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 an 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.

3	TOTALS:	# of	BILLED	ALLOWED	DEDUCT	COINS	TOTAL	PROV PD	PROV	CHECK
	CLAIMS	AMT	AMT	AMT	AMT	RC AMT	AMT	AMT	ADJ AMT	AMT
	5	321.00	211.47	0.34	39.88	109.53	161.25	25.44	135.81	
	PROVIDER ADJ DETAILS:	PLB REASON CODE			FCN	HIC	AMOUNT			
		50					15.44			
		FB			0202199306770	9999999999	10.00			

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

### 1.4.2.5 Assigned Claims - Totals for All Assigned Claims (Professional SPR)

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

### 1.4.2.6 Assigned Claims - Provider-Level Adjustment Detail (Professional SPR)

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.

### 1.4.3 Unassigned Claims (Professional SPR)

Figure 19 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 an MA28 code.

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	SIGMA4-667	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					

Figure 19. The Unassigned Claims Section of a Professional SPR

#### 1.4.3.1 Unassigned Claims - Adjustments Line (Professional SPR)

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

### 1.4.4 The Glossary Section (Professional SPR)

The glossary section of a Professional SPR (see Figure 20) 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. You should look at this section for an explanation regarding the adjustments the MAC made on the SPR. You may find all RARCs and CARCs at <http://www.wpc-edi.com/reference> on the Internet. For a complete listing of Provider-Level Adjustment Codes, refer to the "ASC X12N 835 Implementation Guide: Health Care Claim Payment/Advice", which is also available at <http://www.wpc-edi.com/reference> on the Internet.

GROUP CODES:	
PR	Patient Responsibility
CO	Contractual Obligation
OA	Other Adjustment
GLOSSARY: Group, Reason, MOA, Remark and Adjustment Codes	
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

Figure 20. The Glossary Section Of A Professional SPR

## 1.5 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.

### 1.5.1 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 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);
- The computed NET field must include PROV PD (the calculated payment to the provider), interest, late filing charges, and previous payments;
- 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 29th day from receipt) increase the amount of the payment from Medicare. Any adjustment with a negative sign reflects an increase in Medicare payment.

### 1.5.2 Transaction-Level Balancing a Professional RA

Within the transaction, the sum of all claim payments minus the sum of all provider-level adjustments equals the total payment amount. You should 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:

$$\begin{array}{l} \text{Total of claim payment amounts included in this RA} \\ - \text{Provider-level adjustment(s) made to the claim payments} \\ \hline \text{Total Payment Amount} \\ \text{(This should match the check or EFT amount)} \end{array}$$

#### 1.5.2.1 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.

#### 1.5.2.2 On a Professional SPR

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

3	TOTALS:	# of	BILLED	ALLOWED	DEDUCT	COINS	TOTAL	PROV PD	PROV	CHECK
	CLAIMS	AMT	AMT	AMT	AMT	RC AMT	AMT	AMT	ADJ AMT	AMT
	5	321.00	211.47	0.34	39.88	109.53	161.25	25.44	135.81	
PROVIDER ADJ DETAILS:		PLB REASON CODE	FCN	HIC	AMOUNT					
		50						15.44		
		FB			0202199306770	9999999999		10.00		

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

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

**Table 1.** 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.

### 1.5.3 Claim-Level Balancing a Professional RA

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:

$$\frac{\text{Total submitted charge for this claim} - \text{Monetary adjustment amounts applied to this claim}}{\text{Paid Amount for this Claim}}$$

#### 1.5.3.1 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.

#### 1.5.3.2 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**). This field horizontally lists the total BILLED, ALLOWED, DEDUCT, COINS, AMT (this is the adjustment amount), and PROV PD amounts for a single claim (see **Figure 22**). Subtracting the DEDUCT, COINS, and AMT amounts in this CLAIM TOTALS from the BILLED amount yields the amount in the PROV PD field.

PERF	PROV	SERV DATE	POS NOS	PROC	MODS	BILLED	ALLOWED	DEDUCT	COINS	GRP/RC	AMT	PROV PD
NAME	GAMMA, RAYMOND		HIC	9999999999 ACNT		GAMM861-316	ICN	0202199306870		ASG	Y	MOA MA01 MA07
123456ABC	0209	020902	11	1	00010	66.00	49.83	0.00	9.97	PR-96	16.17	39.86
PT RESP	9.97					66.00	49.83	0.00	9.97		16.17	39.86
ADJS:	PREV PD	10.00	INT	0.00	LATE FILING CHARGE	0.00						
CLAIM INFORMATION FORWARDED TO: NEW JERSEY MEDICAID											NET	29.86

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

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

**Table 2.** 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.

### 1.5.4 Service-Line-Level Balancing a Professional RA

Service-line-level balancing allows you to reconcile totals for service-line entries on individual claims.

The service-line-level balancing formula is:

$$\frac{\text{Submitted charge for this service} - \text{Monetary adjustment amount applied to this service}}{\text{Paid Amount for this Service}}$$

#### 1.5.4.1 On a Professional 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 should contact their vendor for instructions regarding balancing.

#### 1.5.4.2 On a Professional 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). See **Figure 23**.

PERF	PROV	SERV DATE	POS NOS	PROC	MODS	BILLED	ALLOWED	DEDUCT	COINS	GRP/RC	AMT	PROV PD
NAME	KAPPA, MARY		HIC	9999999999	ACNT	KAPF33-721		ICN	0202199306880	ASG	Y	MOA MA01 MA07
123456ABC	0314	031402	11	1	99213	10.00	4.37	0.00	0.00	CO-42	5.63	4.37
123456ABC	0314	031402	11	1	82962	12.00	0.00	0.00	0.00	CO-42	12.00	0.00
123456ABC	0314	031402	11	1	94760							
REM:	M80											
PT RESP	9.97											
CLAIM TOTALS						88.00	54.20	0.00	9.97		33.80	44.23

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

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

**Table 3.** 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.

### Resources:

- “Medicare Claims Processing Manual,” [Chapter 22](#), Remittance Advice, available on the CMS website.
- [Health Care Payment and Remittance Advice](#), also available on the CMS website.

### Other Booklets Included in This Series:

- [Remittance Advice Information: An Overview Booklet](#), ICN 908325, which is available on the CMS website;
- [Remittance Advice Resources Booklet ICN 908329](#), available at on the CMS website; and
- [Medicare Remit Easy Print Software: Free Software Allows Physicians and Suppliers to View and Print Remittance Advice Information](#), ICN 006740, also available on the CMS website.



Check out CMS on:



Twitter, LinkedIn, YouTube, and Flickr

This booklet was current at the time it was published or uploaded onto the web. Medicare policy changes frequently so links to the source documents have been provided within the document for your reference.

This booklet was prepared as a service to the public and is not intended to grant rights or impose obligations. This booklet may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents.

CPT only copyright 2014 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association. Applicable FARS\DFARS Restrictions Apply to Government Use.

Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein.

The American Hospital Association (AHA) allows The Centers for Medicare & Medicaid Services (CMS) permission to reproduce portions of the UB-04 Data Specifications Manual (UB-04 Manual) for training purposes. Please use the following guidance for including the appropriate copyright and disclaimer language regarding National Uniform Billing Codes (NUBC).

Copyright. Any reproduced portion of the UB-04 manual/NUBC codes will include the following copyright notice:  
“Copyright © 2014, the American Hospital Association, Chicago, Illinois. Reproduced with permission. No portion of this publication may be copied without the express written consent of the AHA.”

Disclaimer. Each material containing reprinted information (UB-04 Manual/NUBC codes) will include the following disclaimer in a prominent manner acceptable to the AHA: “The American Hospital Association (the “AHA”) has not reviewed, and is not responsible for, the completeness or accuracy of any information contained in this material, nor was the AHA or any of its affiliates, involved in the preparation of this material, or the analysis of information provided in the material. The views and/or positions presented in the material do not necessarily represent the views of the AHA. CMS and its products and services are not endorsed by the AHA or any of its affiliates.”