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

Click Here to Print a Text-Only Version

Official Information Health Care Professionals Can Trust

Reading a Professional Remittance Advice (RA)

ICN 908328/ October 2015

Contents

1.0 Reading a Professional RA Fact Sheet: Overview 1

1.1 INTRODUCTION 1
1.1.1 What Are the Data Elements in the RA? 1
1.1.2 Is The RA Standardized? 1

1.2 Reading a Professional Electronic Remittance Advice (ERA) 1
1.2.1 How Is the ERA available? 1
1.2.2 How Is the ERA Generated? 2
1.2.3 How Can I View the Information in an ERA? 2
1.2.3.1 How Does the MREP Software Present the ERA Information? 2
1.2.4 Using the MREP Software to Print an RA 3
1.2.5 Viewing Remittance Information Using the MREP Software 4
1.2.5.1 The Claim List Tab (Professional ERA) 4
1.2.5.2 The Claim Detail Tab (Professional ERA) 5
1.2.5.3 The Remit Summary Tab (Professional ERA) 6
1.2.5.4 The Data View Tab (Professional ERA) 6
1.2.5.5 The Search Tab (Professional ERA) 7
1.2.5.6 The Glossary Tab (Professional ERA) 8
1.2.6 Generating Special Reports Using the MREP Software 9
1.2.6.1 The Adjusted Service Lines Report 9
1.2.6.2 COB Claims and Non-COB Claims Reports 9
1.2.6.3 Deductible and Coinsurance Service Lines Reports 9
1.2.6.4 The Denied Service Lines Report 9
1.2.6.5 The Other Adjustments Report 9
1.2.6.6 Fields Appearing on MREP Special Reports 9

1.3 Reading a Professional Standard Paper Remittance Advice (SPR) 10
1.3.1 How is the SPR Available? 10
1.3.1.1 What Types of SPRs are Available? 10

1.4 What are the Components of the Professional SPR? 10
1.4.1 Header Information (Professional SPR) 12
1.4.2 Assigned Claims (Professional SPR) 12
1.4.2.1 Assigned Claims - Claim-Level Information (Professional SPR) 13
1.4.2.2 Assigned Claims - Service-Line-Level Information (Professional SPR) 13
1.4.2.3 Assigned Claims - Totals (Professional SPR) 13
1.4.2.4 Assigned Claims - Adjustments Line (Professional SPR) 13
1.4.2.5 Assigned Claims - Totals for All Assigned Claims (Professional SPR) 13
1.4.2.6 Assigned Claims - Provider-Level Adjustment Detail (Professional SPR) 14
1.4.3 Unassigned Claims (Professional SPR) 14
1.4.3.1 Unassigned Claims - Adjustments Line (Professional SPR) 14
1.4.4 The Glossary Section (Professional SPR) 14

1.5 Balancing a Professional RA 15
1.5.1 What Are the General Rules for Remittance Balancing? 15
1.5.2 Transaction-Level Balancing a Professional RA 15
1.5.2.1 On a Professional ERA 15
1.5.2.2 On a Professional SPR 15
1.5.3 Claim-Level Balancing a Professional RA 16
1.5.3.1 On a Professional ERA 16
1.5.3.2 On a Professional SPR 16
1.5.4 Service-Line-Level Balancing a Professional RA 17
1.5.4.1 On a Professional ERA 17
1.5.4.2 On a Professional SPR 17

Resources 18
Other Booklets Included in This Series 18

Disclaimer 19

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.

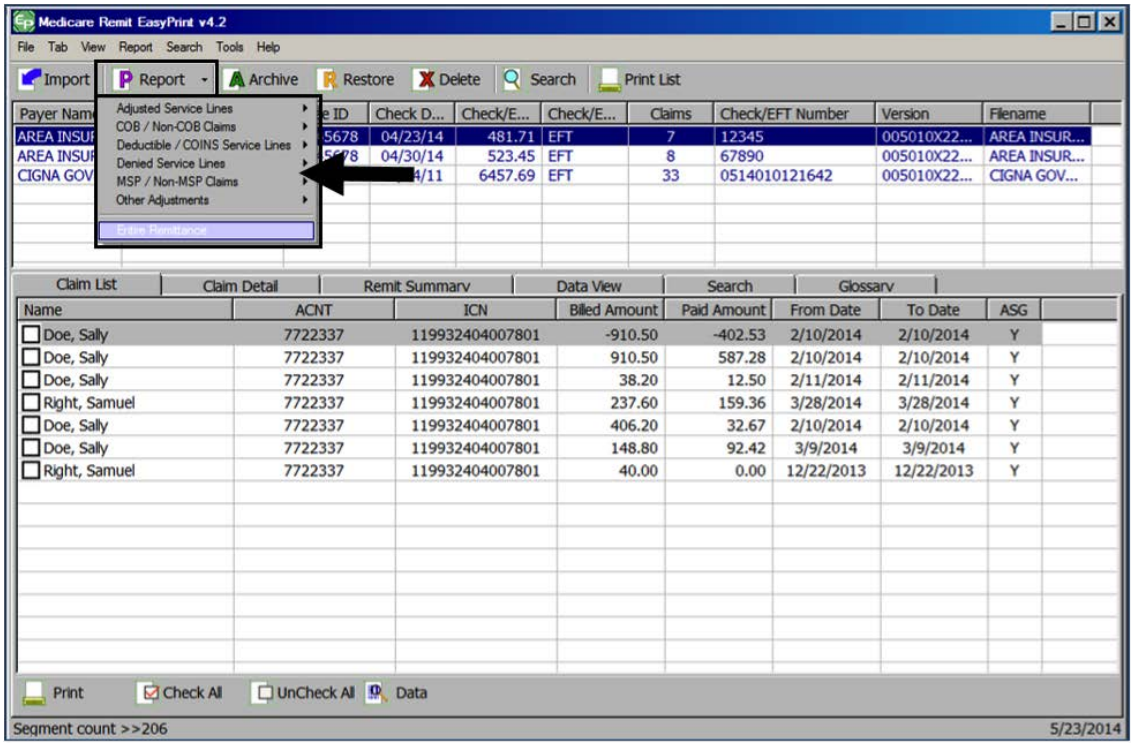


Figure 1. Using the Entire Remittance Report in the MREP Software to Print an SPR

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.

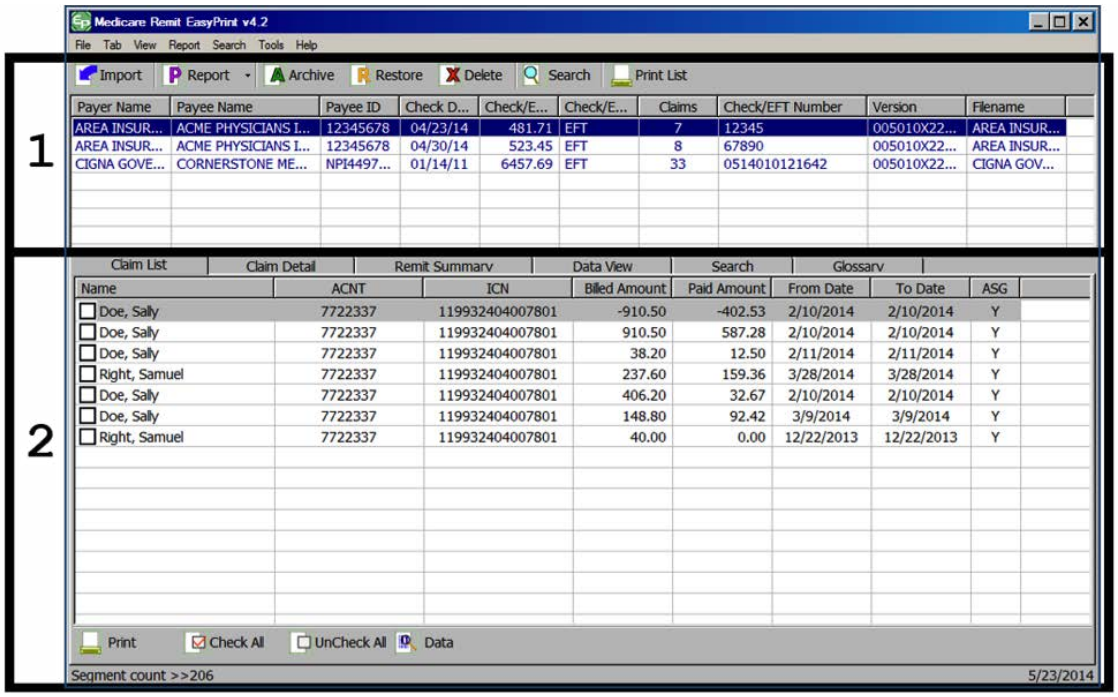


Figure 2. The MREP Software with Multiple 835s Ready for Viewing

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.

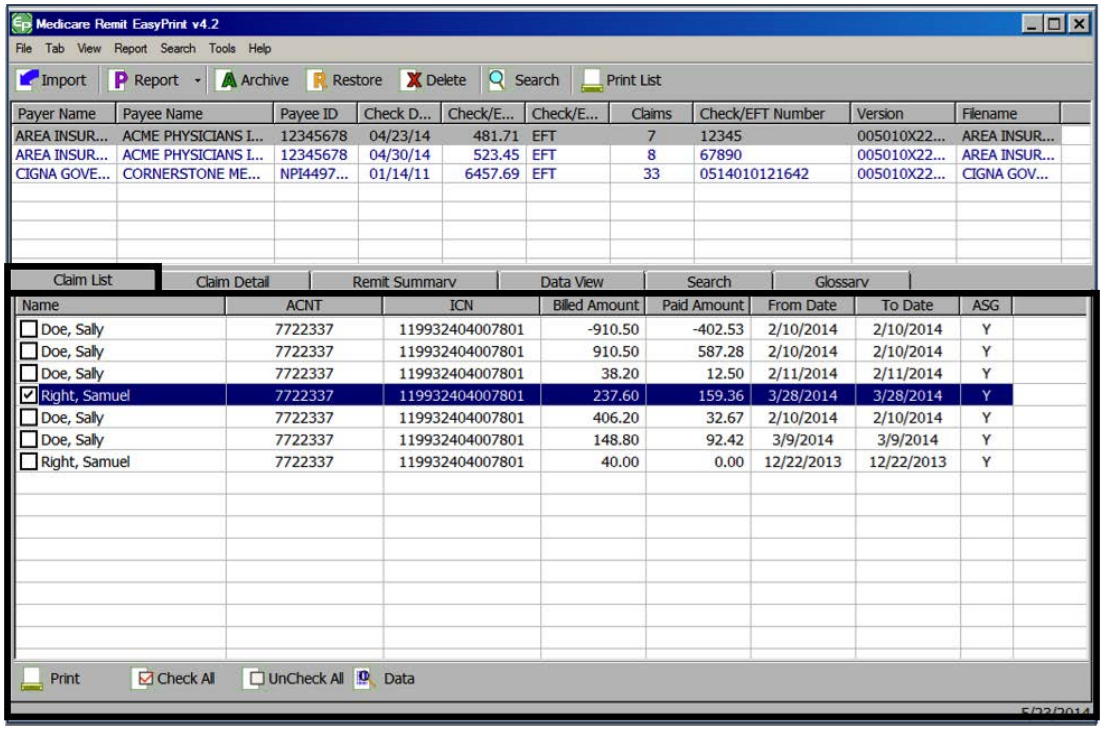


Figure 3. The Claim List Tab

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.

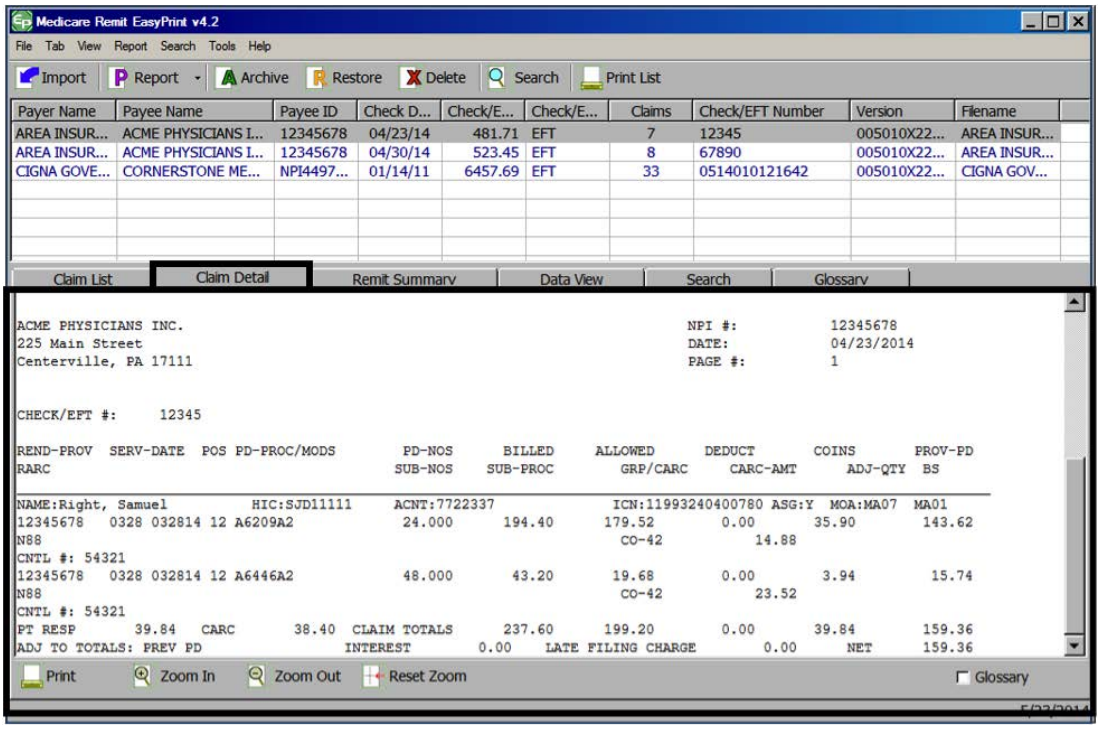


Figure 4. The Claim Detail Tab

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      BILLED   ALLOWED    DEDUCT     COINS     TOTAL      PROV PD      PROV     CHECK
         CLAIMS        AMT       AMT       AMT       AMT    RC 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 5. Totals as Shown on an SPR

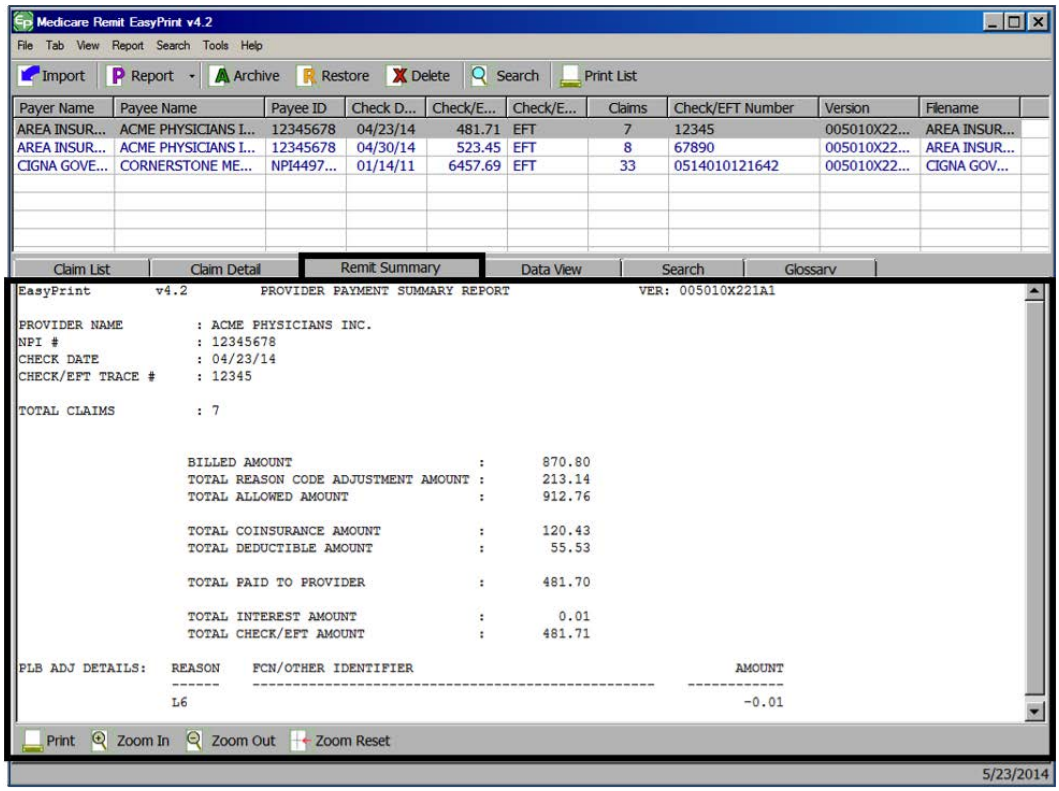


Figure 6. The Remit Summary Tab

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.

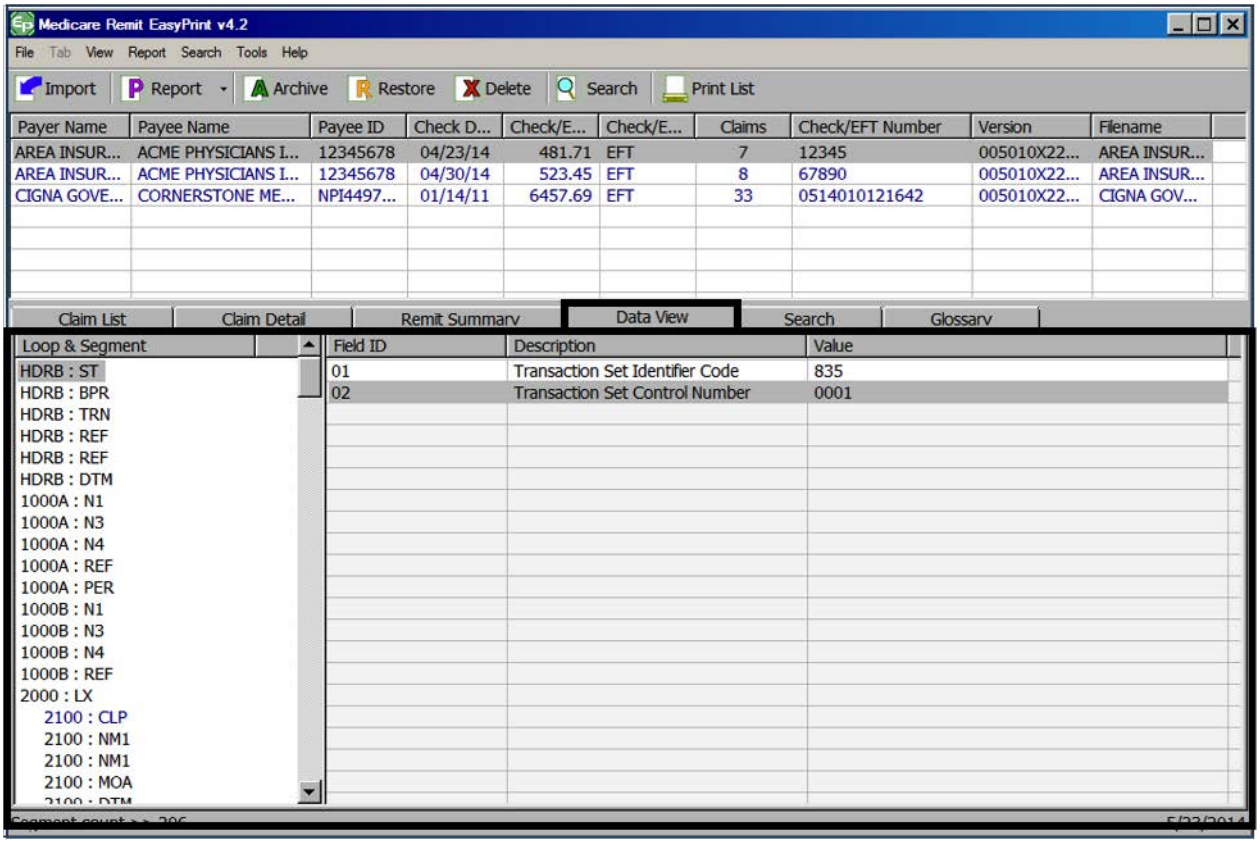


Figure 7. The Data View Tab

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.

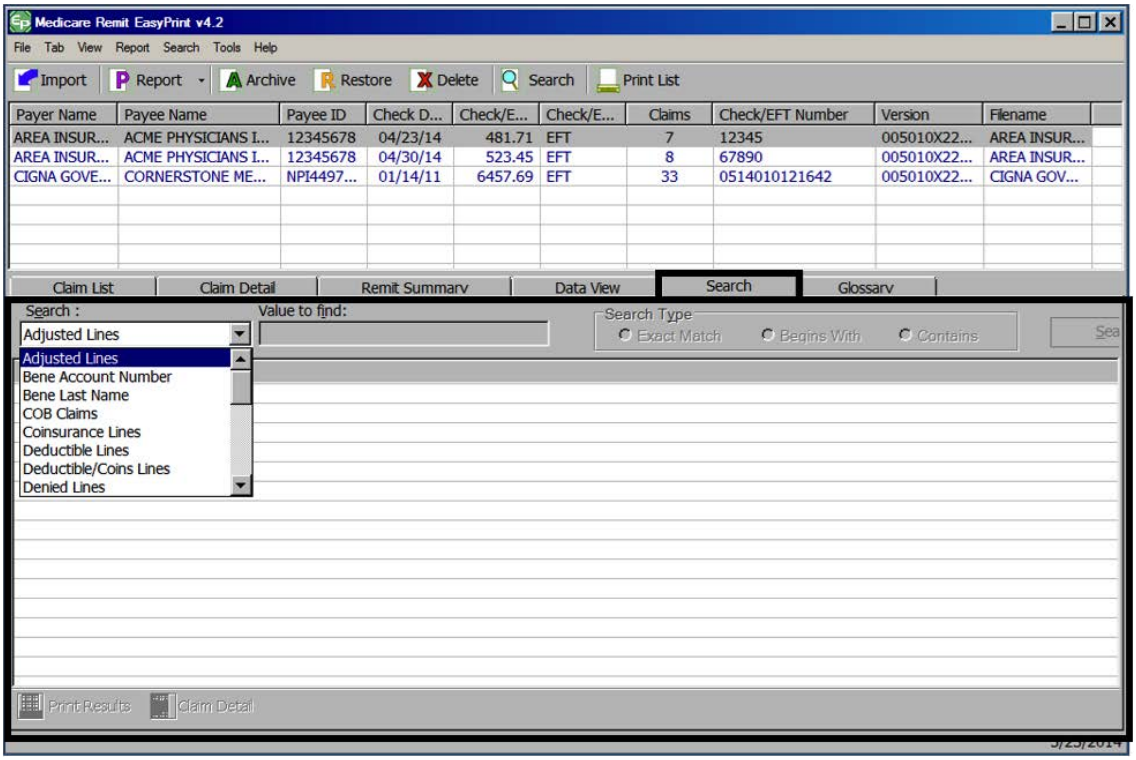


Figure 8. The Search Tab

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.

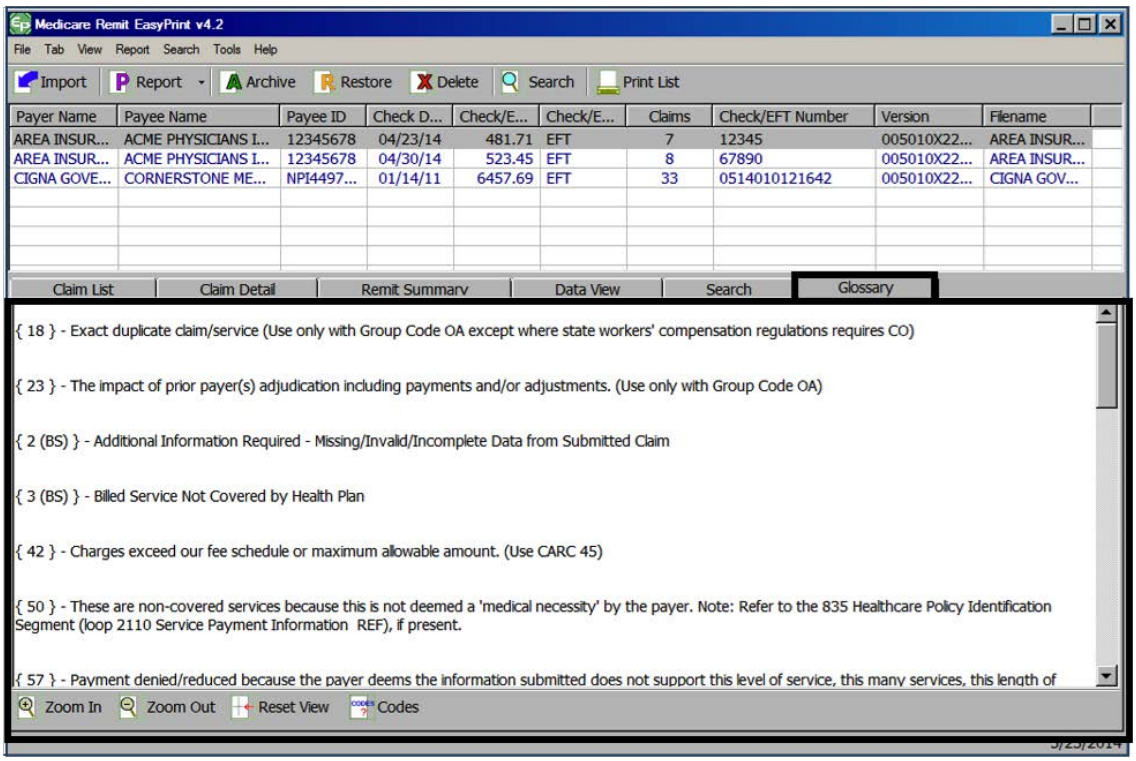


Figure 9. The Glossary Tab

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.

Print preview

Close

Page 1

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	119932404007801	01	12/22/13-12/22/13	A6261	40.00	0.00	0.00	0.00	0.00
		Right Samuel	SJD11111			A1	Reason Code: CO-18		Remark Codes: N111		
							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.

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

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

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

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

2
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            CLAIM TOTALS     66.00     49.83     0.34     9.97           16.17
                                                                                   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            CLAIM TOTALS     66.00     49.83     0.00     9.97           16.17    39.86
CLAIM INFORMATION FORWARDED TO:  NEW JERSEY MEDICAID                                   NET   39.86
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            CLAIM TOTALS     35.00      7.78     0.00     0.00           27.22     7.78
                                                                                   NET    7.78
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
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

3
TOTALS:    # of      BILLED   ALLOWED    DEDUCT     COINS     TOTAL      PROV PD       PROV      CHECK
        CLAIMS        AMT       AMT       AMT       AMT    RC 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 11. Example of a Professional SPR - Page 1

```
1
EXAMPLE MEDICARE CARRIER                                                        MEDICARE
NPI:  1234567890                        GOODHEALTH GROUP PRACTICE               REMITTANCE
CHECK/EFT:   00234569          01/28/2014          PAGE  2 OF 2                 NOTICE

2
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 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

3
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.
S0      Late Filing Reduction
FB      Forwarding Balance
```

Figure 12. Example of a Professional SPR - Page 2

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                                    MEDICARE
1-877-555-1234                                            REMITTANCE
                                                          NOTICE
EXAMPLE MEDICARE PROVIDER                                 NPI:  1234567890
200 DOCTORS DRIVE                                         PAGE #:  1 OF 2
SUITE 200                                                 DATE: 01/28/14
SOMEWHERE, NJ   16666-0200                                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  <-A
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            CLAIM TOTALS    66.00     49.83     0.34     9.97          16.17
                                                                                   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            CLAIM TOTALS    66.00     49.83     0.00     9.97          16.17    39.86
CLAIM INFORMATION FORWARDED TO:  NEW JERSEY MEDICAID                                   NET   39.86

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  <-B
PT RESP     0.00            CLAIM TOTALS    35.00      7.78     0.00     0.00          27.22     7.78
                                                                                   NET    7.78

NAME  GAMMA, RAYMOND    HIC 9999999999 ACNT  GAMMO861-316    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
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
```

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            CLAIM TOTALS    88.00     54.20     0.00     9.97          33.80    44.23
                                                                                   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 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
```

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 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
```

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    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
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
```

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:

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)

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    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:

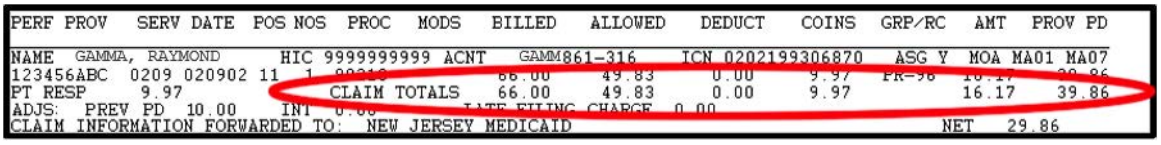
Total submitted charge for this claim
– Monetary adjustment amounts applied to this claim
Paid Amount for this Claim

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  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
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:

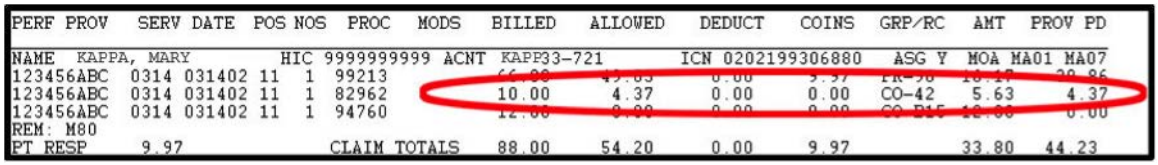
Submitted charge for this service
– Monetary adjustment amount applied to this service
Paid Amount for this Service

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	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

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.”