

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



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Remittance Advice Information: An Overview

Fact Sheet



The Remittance Advice (RA) is a notice of payment sent as a companion to claim payments by Medicare Administrative Contractors (MACs), including Durable Medical Equipment Medicare Administrative Contractors (DME MACs), to providers, physicians, and suppliers.

What Is an RA?

When you submit a claim to a MAC, you will receive an RA that explains the payment and any adjustment(s) made to a payment during Medicare's adjudication of claims. RAs provide itemized claims processing decision information regarding:

- Payments;
- Deductibles and co-pays;
- Adjustments;
- Denials;
- Missing or incorrect data;
- Refunds; and/or
- Claims withholding due to Medicare Secondary Payer (MSP) or penalty situations.



The RA provides justification for the payment, as well as input to your accounting system/accounts receivable and general ledger applications. The codes in the RA will help you identify any additional action you may need to take. For example, some RA codes may indicate that you need to resubmit the claim with corrected information, while others may indicate that you can appeal a payment decision.

For more information about RAs visit the [Health Care Payment and Remittance Advice](#) web page on the Centers for Medicare & Medicaid Services (CMS) website.

What Types of RAs Are Available?

MACs send RAs in either an electronic format (Electronic Remittance Advice [ERA]), or a paper format (Standard Paper Remittance Advice [SPR]). Although the information that the two formats provide is similar, the ERA offers some data and administrative efficiencies not available in an SPR. For example, ERAs can be manipulated electronically into a variety of report formats. Further advantages of the ERA are listed on page 3.

To obtain ERAs, or to switch from receiving SPRs to ERAs, you need to contact your MAC to establish Electronic Data Interchange (EDI) capabilities with that MAC.

ERAs are only available electronically to providers for a specified period of time after claims adjudication. Your MAC determines the timeframe for RA availability. Therefore, you should confirm the timeline and establish processes to download and save ERA data files on a regular basis.

MACs do not distribute SPRs if a provider also receives ERAs for more than 31 days (institutional providers) and 45 days (professional providers/suppliers). If you submit through a billing service or clearinghouse, or a submitter/sender ID that is currently receiving ERAs, you will no longer receive SPRs effective with the completion of the ERA setup date.

Providers Must Use EFT

All providers enrolling in the Medicare Program for the first time, changing existing enrollment data or revalidating enrollment, must use Electronic Funds Transfer (EFT) to receive payments. [EFT information](#) is available on the CMS website.

What Are the Benefits of ERA?

Using the ERA saves time and increases productivity by providing electronic payment adjustment information that is portable, reusable, retrievable, and storable. Trading partners can exchange the ERA with much greater ease than an SPR. ERA advantages include:

- Faster communication and payment notification;
- Faster account reconciliation through electronic posting;
- Automation of follow-up action;
- Generation of less paper;
- Lower operating costs;
- Ability to create various reports;
- Ability to search for information on claims;
- Ability to export data to other applications;
- More detailed information; and
- Access to data in a variety of formats through free software supported by Medicare.



In addition, an ERA can contain more information than an SPR. For example, an SPR contains two basic page layouts: the Claims Page and the Summary Page. However, an ERA contains four page layouts: the All Claims Screen, Single Claim Screen, Bill Type Summary Screen, and Provider Payment Screen.

Who Receives an RA?

MACs send RAs to providers, billers, and sometimes to a provider's designated financial institution (if the provider enrolled in EDI).

Medicare categorizes providers as either accepting or not accepting assignment.

Providers that accept assignment receive payment from a MAC for the claims they submitted, as well as an RA.

Providers that do not accept assignment must still submit claims to a MAC for services, procedures, or supplies they furnish to Medicare beneficiaries. The MAC sends payment for those claims to the beneficiary. The provider receives an informational RA to report the amount of payment and the adjustments the MAC made to those claims during adjudication. Providers who do not accept assignment must bill the beneficiary to obtain payment.

NOTE: An informational RA is mostly identical to other RAs. However, an informational RA contains a Remittance Advice Remark Code (RARC) indicating that the provider does not have appeal rights.

NOTE: MACs allow only one receiver of an ERA per National Provider Identifier. Your MAC will contact you if you are set up on its files for multiple receivers of the ERA.

How Do I View an RA?

Viewing the ERA

The MAC produces the ERA in the Health Insurance Portability and Accountability Act (HIPAA)-compliant Accredited Standards Committee (ASC) X12N 835 format, often referred to as the ASC X12 835 transaction. The ASC X12 835 transaction is for electronic transfers only and the data is not easily readable without a translator

Providers can view and print the information in an ERA using special translator software. For more information on the Medicare standardized data requirement companion guides for the ASC X12N 835, visit <http://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/index.html> on the CMS website.

Helpful Software for Institutional RAs

PC Print software enables institutional providers to print remittance data transmitted by Medicare. MACs are required to make PC Print software available to providers for downloading at no charge, although MACs may charge up to \$25 per mailing to recoup costs if the software is sent to *providers* on a CD/DVD or any other means at *the provider's* request when the software is available for downloading. This software includes self-explanatory loading and use information for providers. It should not be necessary for you to receive formal provider training to use the PC Print software. MACs must supply providers with PC Print software within 3 weeks of request.

MACs are required to supply the PC Print software upon request. [Contact](#) information for MACs is available on the CMS website.

Helpful Software for Professional RAs

CMS has developed software that gives professional providers/suppliers a tool to view and print an ERA in a user-friendly format. This software is called Medicare Remit Easy Print (MREP). This software is available to providers through their respective MACs and/or Common Electronic Data Interchange (CEDI) contractor. The software is updated three times a year to accommodate the Claim Adjustment Reason Code (CARC) and Remittance Advice Remark Code (RARC) tri-annual updates, and any applicable enhancements. In addition to these three regular updates, there is also an annual enhancement update, if needed.

The MREP software enables providers to:

- View and print remittance information on all claims included in the ASC X12 835;
- View and print remittance information for a single claim;
- View and print a summary page; and
- View, print, and export special reports.

MREP software has been updated to accommodate ASC X12 835 version 5010.

The MREP software is available for [download](#) from, the CMS website. Further information on the [MREP software](#) is also available on the CMS website.

What Information Does the RA Include?

The RA provides detailed payment information about a health care claim(s) and, if applicable, describes why Medicare has not paid the total original charges in full. The RA codes help the provider understand the actions the MACs took while processing the claim(s), and to identify any additional action that may be necessary.

For example, some RA codes may indicate a need to resubmit a claim with corrected information, while others may indicate whether the provider may appeal the payment decision.

The RA also features valid codes and specific values that make up the claim payment. Some of these codes may identify adjustments. An adjustment refers to any change that relates to how a MAC paid a claim differently than the original billing.

There are seven general types of adjustments:

1. Denied claim;
2. Zero payment;
3. Partial payment;
4. Reduced payment;
5. Penalty applied;
6. Additional payment; and
7. Supplemental payment.



The RA uses fields to identify areas of a claim and codes to categorize details of the claim. A field may indicate specific data about the beneficiary, or specific supplies or services the provider rendered. A code represents a standardized reason or condition that relates to the claim or service.

The basic elements of the RA can be alphabetic, numeric, or alphanumeric. The HIPAA format standards define these elements as “Required” or “Situational”. The required fields are mandatory and MACs must include them in every RA. Situational fields depend on data content and context (for example, Medicare requirements for a particular service).

NOTE: The field names may vary depending on the translator software used by the provider.

Although several codes may appear on an RA, not all of these codes may appear at the same time. The codes are either medical or non-medical code sets, as defined below.

Medical Code Sets

Medical code sets are clinical codes MACs use to identify what procedures, services, supplies, drugs, and diagnoses pertain to a beneficiary encounter. Professional societies and public health organizations maintain medical codes that characterize a medical condition or treatment. Some medical code sets are specific to a particular provider type.

The RA includes medical code sets such as:

- Healthcare Common Procedure Coding System (HCPCS) Level I and Level II Codes;
- International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM);
- Current Dental Terminology (CDT) Codes; and
- National Drug Codes (NDCs).

Additional information on the [medical codes sets](#) used in RAs is available on the CMS website.

Non-Medical Code Sets

Non-medical code sets are code sets that characterize a general administrative situation rather than a medical condition or service. The non-medical code set descriptions appear below.

Group Codes

A group code is a code identifying the general category of payment adjustment. A group code is always used in conjunction with a CARC to show liability for amounts not covered by Medicare for a claim or service. For more information on group codes, visit the “Medicare Claims Processing Manual,” [Chapter 22](#) (Remittance Advice), Section 60.1 (Group Codes) on the CMS website.

Claim Adjustment Reason Codes (CARCs)

CARCs provide financial information about claim decisions. CARCs communicate adjustments the MAC made and offer explanation when the MAC pays a particular claim or service line differently than what was on the original claim. If there is no adjustment to a claim or service line, then there is no need to use a CARC.

CARCs are located in the ADJ REASON CODES field on the ERA and the RC field on the SPR.

A national health care code committee maintains and updates CARCs three times per year.

For a listing of all CARCs and their descriptions, visit <http://www.wpc-edi.com/reference/> on the Internet.

Remittance Advice Remark Codes (RARCs)

RARCs further explain an adjustment or relay informational messages that CARCs cannot express. Additionally, there are some informational RARCs, starting with the word “Alert” that MACs use to provide general adjudication information. These RARCs are not always associated with a CARC when there is no adjustment.

MACs can use RARCs at the service-line level or the claim level.

CMS maintains and updates RARCs three times per year. For a listing of RARCs and their descriptions, visit <http://www.wpc-edi.com/reference/> on the Internet. For more Medicare specifics see the “Medicare Claims Processing Manual” ([Chapter 22](#), section 60.3) on the CMS website.

Provider-Level Balance (PLB) ReasonCodes

Provider Level Balance (PLB) reason codes describe adjustments the MACs make at the provider level, instead of a specific claim or service line. Some examples of provider-level adjustments would be:

- An increase in payment for interest due as a result of late payment of a claim by Medicare;
- A deduction from payment as a result of prior overpayment; and
- An increase in payment for any provider incentive plan.

The PLB code list is an internal code list. For more information on PLB codes, see MLN Matters® article, [MM7068](#), on the CMS website.

CARC and RARC Update Schedule

The Council on Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE) mandated operating rules require the usage of a standardized CARC and RARC combinations when used on the ASC X12 835 transactions. These combinations are maintained in a list updated three times a year by CAQH CORE. The complete CARC/RARC code combination list is available at: <http://www.caqh.org/CORECodeCombinations.php> on the Internet. This website notifies the provider of the following events in the RARC maintenance process:

- The Start (or effective date) and Last Modified date of **‘current’** codes;
- The Start, Last Modified, and planned Stop Date of **‘to be deactivated’** codes; and
- The Start, Last Modified, and Stop Date of **‘deactivated’** codes.

The updated list of CARCs is published three times a year after the committee meets before the ASC X12 trimester meeting in the months of January/February, June, and September/October. MACs use the latest approved CARCs in ERA, SPR, and COB transactions.

The RARC list is also updated three times a year, and the list is posted at the WPC website and gets updated at the same time when the reason code list is updated. Both code lists are updated on or around March 1, July 1, and November 1. MACs use the latest approved remark codes. CMS publishes MLN Matters articles whenever CARC/RARC updates are made. [Subscribe](#) to the MLN Matters mailing list so you will receive email notice of all new MLN Matters articles, including those announcing CARC/RARC changes.

MACs may also alert providers of updated codes through bulletins, appropriate listserv messages, and/or their websites.

Requests for Adding, Modifying, or Deactivating CARC and RARC Codes

The maintenance committees that manage the CARC and RARC sets meet three times a year to review all new requests. To request additional CARCs, or to modify an existing code, visit <http://www.wpc-edi.com/reference/codelists/healthcare/claim-adjustment-reason-codes/> to submit a request. Requests for a new code or modification of an existing RARC code should be submitted via <http://www.wpc-edi.com/reference/codelists/healthcare/remittance-advice-remark-codes/> on the Internet.

Once I Receive an RA, What Do I Do?

When you receive an ERA, you may:

Post decision and payment information automatically, for individual claims in the RA, to the appropriate beneficiary accounts when you are using a compatible provider accounts receivable software application;

Identify the reasons for adjustments (denials or payment reductions);

Note when an EFT payment issued with the ERA is scheduled for deposit in the provider’s bank account, or arrange for a deposit of a paper check;

Submit a secondary electronic claim that incorporates Medicare adjustment and payment for data from the ERA to other health care plans that cover the beneficiary if the ERA does not indicate that Medicare has issued a Coordination of Benefits (COB) transaction;

Submit a paper secondary claim when appropriate to other health care plans, with an attached print out of the Medicare ERA information;

Print for specific payment information, as needed, by using translation software; and

Avoid future errors by identifying potential problems with the way original claims were submitted.

When you receive an SPR, you may:

- Post manually to accounts receivable;
- Use it to correct any errors that you may have encountered during claims processing; and
- Bill secondary health care plans that cover the beneficiary.

There are other educational resources available from the Medicare Learning Network®. The other products are:

- [Medicare Remit Easy Print Software](#) - This fact sheet is designed to provide education detailing the Medicare Remit Easy Print (MREP) software that enables physicians and suppliers to view and print their remittance information. It includes a basic software overview, the benefits of using electronic remittance information, minimum system requirements, and additional resources available on the Internet.
- [Reading a Professional Remittance Advice](#) - This booklet is designed to provide information outlining professional Remittance Advice (RA). It includes screenshots of the RA with an explanation of how to read it.
- [Reading the Institutional Remittance Advice](#) - This booklet is designed to provide education outlining the institutional Remittance Advice (RA). It includes screen shots of an institutional RA with an explanation of what you will find on each screen.

Payment Recoupment Process

RAs display information on overpayments Medicare has identified and recouped. MACs begin recoupment of an overpayment on Day 41 from the date of the initial demand letter. Interest accrues and assesses on an overpayment if you have not paid in full by Day 30. Providers may request that recoupment begin prior to Day 41. Providers who elect this option may avoid paying interest if the overpayment is recouped in full prior to Day 31. For more information, see the “Medicare Financial Management Manual,” ([Chapter 4](#), Sections 10.1 & 80.2).



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