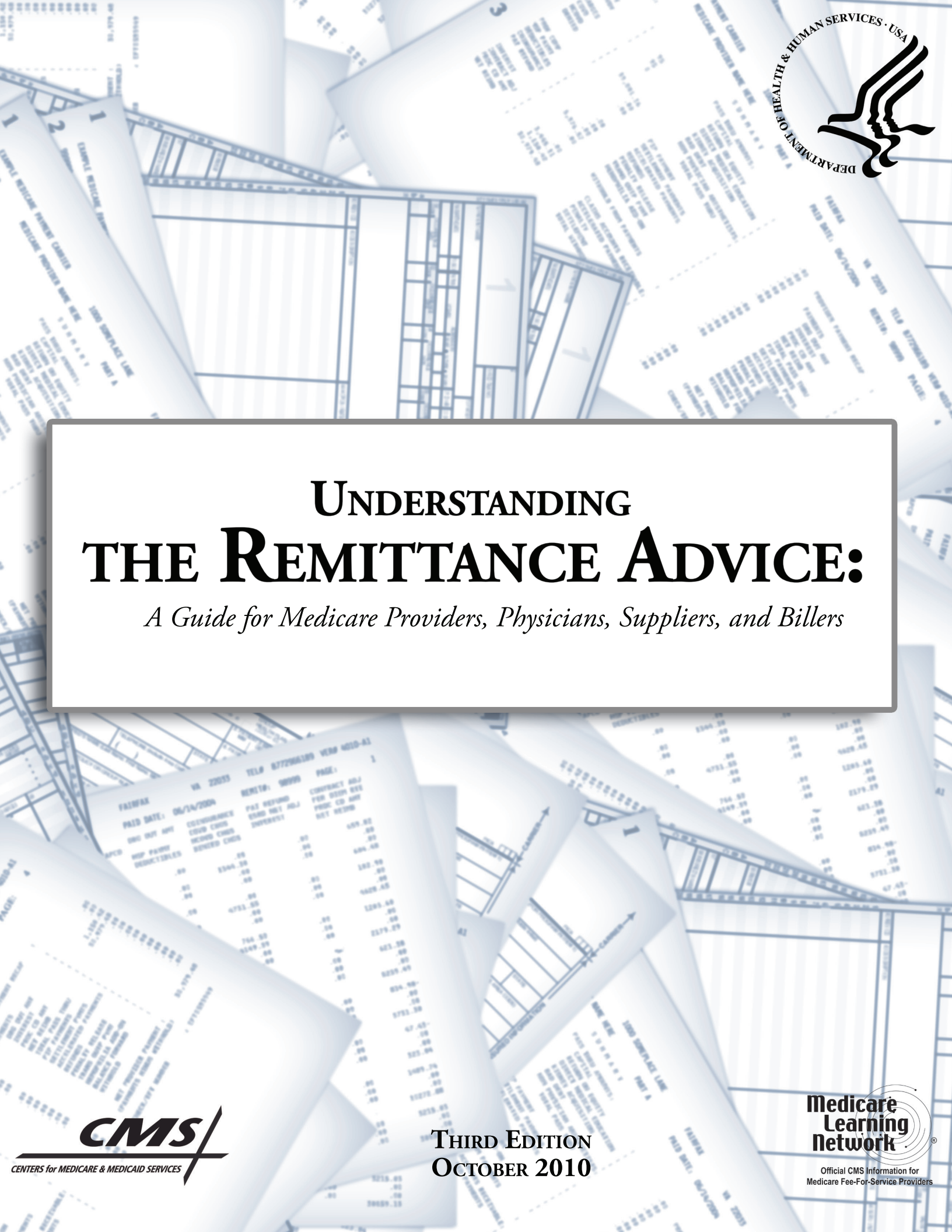

UNDERSTANDING THE REMITTANCE ADVICE:

A Guide for Medicare Providers, Physicians, Suppliers, and Billers

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

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Medicare Learning Network®
Official CMS Information for Medicare Fee-For-Service Providers

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Understanding the Remittance Advice: A Guide for Medicare Providers, Physicians, Suppliers, and Billers

Third Edition, October 2010

DISCLAIMER

This Guide 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 Guide is a general summary that explains certain aspects of the Medicare Program; however, this is not a legal document and does not grant rights or impose obligations. The Centers for Medicare & Medicaid Services (CMS) will not bear any responsibility or liability for the results or consequences of using this summary guide. This document was current as of the date of publication; nevertheless, we encourage readers to review the specific laws, regulations and rulings for up-to-date information. Providers are responsible for the correct submission of claims and response to any remittance advice in accordance with current laws, regulations and standards.

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An Updated Remittance Advice Resource for Medicare Fee-For-Service Providers

The Medicare Fee-For-Service (FFS) Program serves 85 percent of the more than 53 million Medicare beneficiaries enrolled in the program. Medicare processes more than 1.2 billion Medicare claims annually, submitted by approximately 1.5 million health care providers, including hospitals, skilled nursing facilities, home health agencies, physicians, non-physician practitioners, clinical laboratories, and durable medical equipment suppliers. Medicare FFS claims are processed by non-government organizations or agencies that contract to serve as the fiscal agent between providers and the Federal government. These claims processors are known as Fiscal Intermediaries (FI), Carriers, Part A/B Medicare Administrative Contractors (A/B MACs), and Durable Medical Equipment Medicare Administrative Contractors (DME MACs). They apply the Medicare coverage rules to determine the appropriateness of claims and are responsible for a variety of activities that support the business relationship between Medicare participating FFS providers and the Medicare Program. Medicare FFS Contractors use notices called the remittance advice (RA) as a means to communicate to providers claim processing decisions such as payments, adjustments, and denials.

Everyday, Medicare FFS Contractors send thousands of RAs to providers. Each RA contains information that may affect a provider's Medicare business. Because of the importance of RA notices to a provider's business, the Centers for Medicare & Medicaid Services (CMS) wants to make sure that every provider that receives RAs from Medicare sufficiently understands how to read and interpret these notices. ***Understanding the Remittance Advice: A Guide for Medicare Providers, Physicians, Suppliers, and Billers*** is one resource that CMS has developed to help FFS providers gain a better understanding of the RA.

This publication, designed as a self-help resource for health care professionals and their staff, provides information on topics such as types of RAs, the purpose of the RA, and types of codes that appear on the RA. Use of this guide offers the user the following benefits:

- Easy access to general information about the RA;
- Increased ability to understand and interpret the reasons for denials and adjustments;
- Reduction in the resubmission of claims;
- Rapid follow-up action, resulting in quicker payment; and
- A useful tool for training new staff or a refresher for experienced staff.

With the release of the Third Edition of ***Understanding the Remittance Advice: A Guide for Medicare Providers, Physicians, Suppliers, and Billers,*** CMS continues its commitment to actively work to be more supportive and responsive to Medicare providers by providing timely, accurate educational materials that help to keep you informed and up-to-date about the various changes to the Medicare Program. We hope that you and your staff will continue to find this publication a useful resource that you can rely on time and again.

Preface

DISCLAIMER

This Guide serves as a resource on how to read a Remittance Advice (RA). The information contained in this publication was current at the time of publishing, and is intended for instructional purposes only. Chapter 3 contains information specifically for providers who receive Institutional RAs and Chapter 4 contains information specifically for providers who receive Professional RAs. Refer to the appropriate chapter for detailed information on how to read your specific type of RA. You may also contact your Medicare Contractor's call center or visit their website for the most up-to-date information.

The Third Edition of the *RA Guide* has been developed by the Centers for Medicare & Medicaid Services (CMS) as a resource to help Medicare FFS providers to understand the RA, its applicable uses, and how to interpret fields and codes communicated by Medicare Contractors: Medicare Carriers, Medicare Fiscal Intermediaries (FIs), Part A/B Medicare Administrative Contractors (A/B MACs), and Durable Medical Equipment Medicare Administrative Contractors (DME MACs). The *RA Guide* offers information in a practical, easy to use, readily accessible format that describes the types and uses of the RA and then walks the reader through the process of reading a professional and institutional RA. The publication is divided into the following four chapters and four reference sections.

Chapter 1.0 - Introduction to the Remittance Advice (RA)

Provides an overview of the RA; includes the definition, types, uses, and descriptions of its senders and recipients.

Chapter 2.0 - Components of a Remittance Advice (RA)

Provides an introduction to the different RA formats, explains the RA components, and details information on RA codes.

Chapter 3.0 - Reading an Institutional Remittance Advice (RA)

Provides detailed information on how to read an Electronic Remittance Advice (ERA) (using PC-Print software) and a Standard Paper Remittance Advice (SPR), and includes specific information regarding each level involved in remittance balancing. It also includes an overview of the individual field descriptions and screens of an ERA, and the individual pages and field descriptions of an SPR.

Chapter 4.0 - Reading a Professional Remittance Advice (RA)

Provides detailed information on how to read an Electronic Remittance Advice (ERA) (using Medicare Remit Easy Print software) and an SPR, and includes each level involved in remittance balancing. It also includes an overview of the individual field descriptions and screens of an ERA, and the individual pages and field descriptions of an SPR.

Reference A - Acronyms

Contains a list of acronyms used throughout this Guide.

Reference B - Glossary

Contains a list of terms used throughout this Guide.

Reference C - Websites and Phone Numbers

Contains a list of websites and phone numbers that are referenced throughout this Guide.

Reference D - Resources

Contains a list of resources used to create this Guide.

Index

Provides page references for key terms and subjects found in this Guide. This index does not include page references for individual fields found on the ERA or the SPR.

Field Index for Institutional RAs

Provides Chapter 3 page references for fields found on an Institutional ERA and an SPR.

Field Index for Professional RAs

Provides Chapter 4 page references for fields found on a Professional ERA and an SPR.

Web-Based Training is Available for the RA!

As a companion to this Guide, CMS has developed two Web-Based Training (WBT) courses on the RA; one for institutional providers and one for professional providers. To register, free of charge, for these WBT courses, please visit the Medicare Learning Network® (MLN) Web-Based Training page at http://www.cms.gov/MLNProducts/03_WebBasedTraining.asp on the CMS website.

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Chapter 1: Introduction to the Remittance Advice (RA)

1.1 WHAT IS AN RA?

A **Remittance Advice (RA)** is a notice of payments and adjustments sent to providers, billers, and suppliers. After a claim has been received and processed, a Medicare Contractor produces the RA, which may serve as a companion to a claim payment(s) or as an explanation when there is no payment. The RA explains the reimbursement decisions including the reasons for payments and adjustments of processed claims.

1.2 WHAT ARE THE USES FOR THE RA?

Providers use the RA to post payments and to review claim adjustments. The RA also contains detailed and specific claim decision information. An adjustment may be made for any number of reasons. These reasons are identified on the RA through standardized code sets which include Group Codes, Claim Adjustment Reason Codes, and RA Remark Codes. Refer to Chapter 2 of this Guide: *Components of a Remittance Advice (RA)*, for more information on adjustments and codes.

1.3 WHAT ARE THE DIFFERENT TYPES OF RAs?

A provider may receive an RA from Medicare transmitted in an electronic format, called the **Electronic Remittance Advice (ERA)**, or in a paper format, called the **Standard Paper Remittance Advice (SPR)**. Although the information featured on the ERA and SPR is similar, the two formats are arranged differently, and the ERA offers some data and administrative efficiencies not available in an SPR. Chapters 3 and 4 of this Guide provide more specific detailed information on the ERA and SPR formats.

1.3.1 The Importance of the ERA

The ERA must be produced in the current Health Insurance Portability and Accountability Act of 1996 (HIPAA)-compliant Accredited Standards Committee (ASC) X12N 835 004010A1 format. The Secretary of the Department of Health & Human Services (HHS) adopted ASC X12N 835 version 004010 as the standard for ERA in August 2000. In February 2003, an addendum was added and version 004010A1 became the standard.

The *ASC X12N 835 Implementation Guide: Health Care Claim Payment/Advice* defines the requirements for the form and content of ERAs. The Implementation Guide provides standardized data requirements and content for all producers of the ASC X12N 835. It provides a detailed explanation of the transaction set by defining data content, identifying valid code sets, and specifying values that are applicable for electronic reporting of claims payment, either via a paper check or Electronic Funds Transfer (EFT). The version 004010A1

More 835 Information

For more information on the Medicare standardized data requirement companion guides for the ASC X12N 835, visit http://www.cms.gov/ElectronicBillingEDITrans/11_Remittance.asp on the CMS website.

In January 2009, HHS approved the replacement of the 4010A1 versions of electronic transactions, including the 835, with the ASC X12 Version 5010. Medicare providers must be fully compliant with ASC X12 Version 5010 by January 1, 2012. Information and the latest news for the 5010 may be found at http://www.cms.gov/Versions5010andD0/01_overview.asp on the Centers for Medicare & Medicaid Services (CMS) website.

Implementation Guide adopted as the HIPAA standard can be obtained at http://www.wpc-edi.com/hipaa on the Internet.

1.4 WHY RECEIVE THE ERA?

Using the ERA saves time and increases productivity by providing electronic payment adjustment information that is portable, reusable, retrievable, and storable. The ERA can be exchanged between partners with much greater ease than a paper remittance. Advantages to using the ERA include:

- Faster communication and payment notification;
- Faster account reconciliation through electronic posting;
- Less paper generated;
- Lower operating costs;
- More detailed information; and
- Access to data in a variety of formats through free, Medicare-supported software.

1.5 WHERE DOES THE RA FIT INTO THE CLAIMS PROCESSING CYCLE?

Once a claim has been received and accepted, it is processed and the appropriate payment is determined. The Medicare Contractor generates the RA and sends it to the provider. If a claim does not meet coverage, medical necessity, or policy requirements, providers may have the right to appeal the claim with additional information for redetermination based on RA guidance.

1.6 WHO RECEIVES AN RA?

Medicare Contractors send RAs to institutional and professional providers, their billers, and sometimes to a provider's designated financial institution (if enrolled in Electronic Data Interchange [EDI]). Providers may be categorized as either accepting or not accepting assignment. Providers that accept assignment receive payment from a Medicare Contractor for the claims they submitted. Providers that do not accept assignment are required to submit claims to a Medicare Contractor for services, procedures, or supplies furnished for Medicare beneficiaries. The payment for those claims is sent to the beneficiaries and those providers are sent informational RAs* to report the amount of payment and the adjustments made to those claims during adjudication. Providers that do not accept assignment must bill the beneficiaries to obtain payment.

NOTE: Institutional providers that participate in Medicare and submit claims to Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), and Part A Medicare Administrative Contractors (MACs) must accept assignment. Some professional providers that bill Carriers, Part B MACs, or Durable Medical Equipment Medicare Administrative Contractors (DME MACs) have the option to accept assignment.

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

1.6.1 Types of Medicare Providers and Contractors

Institutional Providers Serviced by Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), and/or Part A Medicare Administrative Contractors (MACs)

These contractors process claims for:

- Hospitals (inpatient and outpatient services),
- Critical Access Hospitals (CAHs),
- Long Term Care Hospitals (LTCHs) and units,
- Community Mental Health Centers (CMHCs),
- Federally Qualified Health Centers (FQHCs [for FQHC services only]),
- Rural Health Clinics (RHCs [for RHC services only]),
- Skilled Nursing Facilities (SNFs),
- Psychiatric units (of a hospital),
- Indian Health Service (IHS) facilities,
- Rehabilitation facilities,
- Rehabilitation units (of a hospital),
- Other institutional providers, and
- Home Health Agencies (HHAs) and hospice agencies.

Medicare refers to these providers as institutional providers.

Professional Providers Serviced by Carriers, Durable Medical Equipment Medicare Administrative Contractors (DME MACs), and/or Part B MACs

These contractors process claims for individual (and groups of) physicians and other recognized health care practitioners. Medicare refers to these providers as professional providers. Professional providers include the following:

- Physicians,
- Nurse practitioners,
- Clinical psychologists,
- Physical therapists in private practice,
- Occupational therapists in private practice,
- Ambulance service suppliers,
- Ambulatory Surgical Centers (ASCs),
- Independent clinical laboratories,
- Independent diagnostic testing facilities,
- Medical faculty practice plans,
- Multi-specialty clinics or group practices,
- Registered dietitians,
- Limited licensed practitioners, and
- Other qualified non-physician providers.

DME MACs process claims for suppliers of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS), parenteral and enteral nutrition suppliers, and pharmacies.

1.7 WHAT TO DO WITH THE RA ONCE IT IS RECEIVED

When an ERA is received, providers may:

- Post decision and payment information automatically, for individual claims included in an RA to the appropriate beneficiary accounts when a compatible provider accounts receivable software application is being used;
- Identify the reasons for any 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 being issued;
- Submit a secondary electronic claim that incorporates Medicare adjustment and payment 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 to which is attached a print-out of the Medicare ERA information for that claim;
- Print for specific payment information, as needed, by using translation software (e.g., PC-Print for institutional providers and Medicare Remit Easy Print [MREP] for professional providers and suppliers); and
- Use it to quickly identify potential problems with the way the original claim was submitted, so as to avoid the same errors with similar claims in the future.

When an SPR is received, providers may:

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

1.7.1 Electronic Funds Transfer (EFT)

All providers entering the Medicare Program for the first time must use EFT in order to receive payments. Any provider not currently on EFT that submits any change to its existing enrollment data must also submit a CMS-588 form to convert to EFT. Eventually, all existing providers/entities will be required to make the transition to EFT.

Notes

Notes

Chapter 2: Components of a Remittance Advice (RA)

2.1 WHAT IS THE PURPOSE OF AN RA?

The purpose of an RA is to provide detailed payment information relative to a health care claim(s) and, if applicable, to describe why the total original charges have not been paid in full. This remittance information is provided as "justification" for the payment, as well as input to the payee's patient accounting system/accounts receivable (A/R) and general ledger applications. The codes listed on the RA help the provider 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 payment decision can be appealed.

The RA 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 claim is paid differently from the original billing. There are seven general types of adjustments:

- Denied Claim,
- Zero Payment,
- Partial Payment,
- Reduced Payment,
- Penalty Applied,
- Additional Payment, and
- Supplemental Payment.

Although RAs are furnished in either electronic or paper formats, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandates that a standard format be used if transactions are performed electronically. The Accredited Standards Committee (ASC) X12N 835 version 004010A1 is the standard Electronic Remittance Advice (ERA) that complies with HIPAA requirements. The HIPAA-compliant fields and codes apply universally to all entities that transmit health care information. In addition, Medicare requires that the same codes be included in both the ERA and the Standard Paper Remittance Advice (SPR) formats. This chapter provides a general overview of RA components for all institutional and professional providers. Chapter 3 contains information on reading RAs specific to institutional providers, while Chapter 4 contains information on reading RAs specific to professional providers.

2.1.1 What Purpose Do Fields and Codes Serve on an RA?

Fields are used to identify areas of a claim; codes are used to categorize details of the claim. A **field** may indicate specific data about the beneficiary, or specific supplies and/or services rendered. A **code** represents a standardized reason or condition that relates to the claim or service.

NOTE: The field names may vary depending on the translator software used by the provider/receiver. **Translator software** converts the electronic format of an RA into a user-friendly format on the provider's computer screen. PC-Print (used by institutional providers) and Medicare Remit Easy Print (MREP) (used by professional providers and suppliers) are examples of translator software.

2.2 WHICH CODES APPEAR ON AN RA?

Although several codes may appear on an RA, all of these codes may not appear at the same time. The codes are classified as medical or non-medical code sets. The medical codes contained on an 835 are generally the same codes submitted on the claims reported on the 837. In some cases, however, incoming codes might be modified during adjudication. For instance, separately billed laboratory Healthcare Common Procedure Coding System (HCPCS) codes might be bundled and paid under a single HCPCS code. When this happens, information is reported on the RA to identify both the codes that the provider submitted on the claim, as well as the bundled code so the provider will be able to associate that information on the RA with the original claim. If an examination was ever down coded, both the paid on and the submitted Current Procedural Terminology (CPT-4) codes would be reported on the RA.

2.2.1 Use of Non-Medical Code Sets on the RA

Under HIPAA, code sets that characterize a general administrative situation, rather than a medical condition or service, are referred to as **non-clinical** or **non-medical code sets**. State abbreviations, Zip codes, telephone area codes, and race and ethnicity codes are examples of general administrative non-medical code sets. Other non-medical code sets are more comprehensive. For example, non-medical codes may describe provider areas of specialization, payment policies, the status of claims, and why claims were denied or adjusted. The following four non-medical code sets are used extensively to provide claim and reimbursement information on the RA:

- Group Codes,
- Claim Adjustment Reason Codes (CARCs),
- Remittance Advice Remark Codes (RARCs), and
- Provider-Level Adjustment Reason Codes.

Group Codes identify the financially responsible party or the general category of payment adjustment (see Table 2-1). A Group Code must always be used in conjunction with a Claim Adjustment Reason Code (CARC).

For a Current List of CARCs and RARCs

View the latest Claim Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs) at http://www.wpc-edi.com/codes on the Internet.

Table 2-1. Group Codes for Use on an RA

Code	Payment Adjustment Category Description
CO	Contractual Obligation - used when a contractual agreement between Medicare and the provider, or a regulatory requirement, resulted in an adjustment. When CO is used to describe an adjustment, a provider is not permitted to bill the beneficiary for the amount of that adjustment.
CR	Correction and Reversal - used for correcting a prior claim. It applies when there is a change to a previously adjudicated claim.
OA	Other Adjustment - used when no other Group Code applies to the adjustment.
PR	Patient Responsibility - represents an adjustment amount that is billed to the beneficiary or insured. This Group Code is typically used for deductible and coinsurance adjustments.

Claim Adjustment Reason Codes (CARCs) provide financial information about claim decisions. CARCs communicate an adjustment, or why a claim (or service line) was paid differently than it was billed (see Table 2-2). If there is no adjustment to a claim/service line, then there is no need to use a CARC. These codes can be found in the ADJ REASON CODES field on the ERA and the RC field on the SPR.

Table 2-2. Examples of Claim Adjustment Reason Codes (CARCs)

Code	Financial Information
1	Deductible amount
2	Coinsurance amount
3	Co-payment amount
4	The procedure code is inconsistent with the modifier used or a required modifier is missing. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
5	The procedure code/bill type is inconsistent with the place of service. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
40	Charges do not meet qualifications for emergent/urgent care. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT). Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

CARCs were designed to replace the large number of proprietary coding systems unique to each payer used by non-Medicare health payers in the United States (U.S.) prior to HIPAA, and to relieve the burden on medical providers to interpret each of the different coding systems. These codes were developed for use by all U.S. health payers. To ensure usability by all providers and Insurers, the codes are intentionally generic.

Medicare Contractors use only codes that are valid when the RA is generated. This code set is maintained and updated three times per year by a national health care code committee. Visit http://www.wpc-edi.com/codes for a listing of all CARCs and their descriptions.

Remittance Advice Remark Codes (RARCs) are used in conjunction with CARCs on an RA to further explain an adjustment (see Table 2-3). Additionally, there are some informational RARCs, starting with the word "Alert", that are used to provide general adjudication information (e.g., appeal rights). These RARCs can be used without any associated CARC and/or when there is no adjustment. RARCs are maintained by the Centers for Medicare & Medicaid Services (CMS), but may be used by any health care payer when appropriate. Any RARC may be reported at the service-line level or the claim level, as applicable, on any ERA or SPR. Visit http://www.wpc-edi.com/codes for a listing of RARCs and their descriptions.

Table 2-3. Examples of Remittance Advice Remark Codes (RARCs)

Code	Informational Message
M1	X-ray not taken within the past 12 months or near enough to the start of treatment.
M2	Not paid separately when the patient is an inpatient.
M3	Equipment is the same or similar to equipment already being used.
M4	Alert: This is the last monthly installment payment for this durable medical equipment.
M125	Missing/incomplete/invalid information on the period of time for which the service/supply/equipment will be needed.
N1	Alert: You may appeal this decision in writing within the required time limits following receipt of this notice by following the instructions included in your contract or plan benefit documents.
N24	Missing/incomplete/invalid Electronic Funds Transfer (EFT) banking information.

Provider-Level Adjustment Reason Codes - Some adjustments that are made on an RA are not related to a specific claim or service. These adjustments are made at the provider level, and are described by codes called Provider-Level Adjustment Reason Codes (see Table 2-4). Lists of Provider-Level Adjustment Reason Codes for institutional and professional providers are available in Tables 3-9 and 4-1 of this Guide, respectively.

Table 2-4. Examples of Provider-Level Adjustment Reason Codes

Code	Definition	Use
50	Late Charge	Used to identify Late Claim Filing Penalty or Medicare Late Cost Report Penalty. Code "LR" appears on an Institutional RA for a late cost report penalty (e.g., 50/LR).
51	Interest Penalty Charge	Used to identify the interest assessment for late filing. Code "IP" appears on an Institutional RA (e.g., 51/IP).
72	Authorized Return	Used to identify a refund adjustment to an institutional provider (from a previous overpayment). Code "PR" appears on an Institutional RA (e.g., 72/PR). This adjustment should be a negative value and always be offset by some other provider-level adjustment referring to the original refund request or reason.
90	Early Payment Allowance	Used to identify an early payment allowance.

Additional Non-Medical Code Sets Used on the RA

Place of Service (POS) codes indicate the location where the billed service was provided. These codes often determine payment amounts for particular services and provider specialties (see Table 2-5). These codes only apply to professional providers who submit claims to Carriers, Part B Medicare Administrative Contractors (MACs), or Durable Medical Equipment Medicare Administrative Contractors (DME MACs).

POS codes are maintained by the CMS Place of Service Workgroup, comprised of representatives of several components of CMS. A list of POS codes is available at http://www.cms.gov/manuals/downloads/clm104c26.pdf on the CMS website.

Table 2-5. Example POS Codes

POS Code	POS Name	POS Description
11	Office	Location, other than a hospital, Skilled Nursing Facility (SNF), military treatment facility, community health center, State or local public health clinic, or Intermediate Care Facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.
21	Inpatient Hospital	A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions.
32	Nursing Facility	A facility which primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick persons, or, on a regular basis, health-related care services above the level of custodial care to other than mentally retarded individuals.

2.2.2 How Often Are Claim Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs) Updated?

CARCs and RARCs are updated three times a year. The latest codes may be viewed at http://www.wpc-edi.com/codes on the Internet.

For RARCs, CMS has developed a website that allows users to search the RARC code database for specific codes or categories of codes. This tool may be found at http://www.wpc-edi.com/content/view/739/1 on the Internet. Additionally, providers can sign up for a broadcast service to receive RARC list update announcements via e-mail by visiting http://mailman.wpc-edi.com/mailman/listinfo/remarkcodesnotification on the Internet. This service notifies the provider of two events in the RARC maintenance process:

- When a new version of the list is published; and
- When decisions about pending requests are posted to the RARC List On-line Conference for public review and comment.

Medicare Contractors may also alert providers of updated codes through bulletins, appropriate listservs, and/or on their websites. Medicare Contractors must use only RARCs and CARCs that are valid when the RA is generated. Providers must be compliant with electronic transactions and code requirements as set by HIPAA and use the latest software provided by either Medicare or their billing software company. Updates to the CARC and RARC sets may include modifications to existing codes, addition of new codes, and/or deactivation of existing codes.

2.2.3 Requests for Additional Codes

The maintenance committee that manages the CARC set meets 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/content/view/700/1 to submit a request.

CMS has national responsibility for maintenance of RARCs. Requests for a new code or modification of an existing code should be submitted to CMS via the Washington Publishing Company RARCs request function at http://www.wpc-edi.com/content/view/743/1 on the Internet. Requests for codes must include the name, phone number, company name, and e-mail address of the requestor; the existing code number (if requesting a revision to a code); the suggested wording for the new or revised message; an explanation of how the message will be used and why it is needed; and the associated CARC. A fax number or mailing address is acceptable in the absence of an e-mail address.

A requester can also request to have a CARC or a RARC deactivated. CARC deactivation and most modifications do not become effective immediately, but new codes become effective when published. RARC modifications and new codes become effective when published, but deactivations are effective after a certain period of time. The lead time for deactivation is provided for payers, providers, and vendors to update their systems.

2.2.4 Use of Medical Code Sets on the RA

Medical code sets are clinical codes used in transactions to identify what procedures, services, supplies, drugs, and diagnoses pertain to a beneficiary encounter. The codes characterize a medical condition or treatment and are usually maintained by professional societies and public health organizations. Some medical code sets are specific to a particular provider type.

Medical code sets that may be used on the RA include:

- Healthcare Common Procedure Coding System (HCPCS) Level I and Level II Codes;
- International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) Codes - Volume 3 only;
- Current Dental Terminology (CDT-4) Codes; and
- National Drug Codes (NDCs).

The **Healthcare Common Procedure Coding System (HCPCS)** is divided into two principal subsystems, referred to as Level I and Level II.

Level I of the HCPCS is also referred to as Current Procedural Terminology (CPT-4) Codes. The CPT-4 is a uniform coding system consisting of descriptive terms and identifying codes that are used primarily to identify medical services and procedures furnished by physicians (see Table 2-6) (e.g., physician services, physical and occupational therapy services, radiologic procedures, clinical laboratory procedures, etc.). CPT-4 codes are maintained by the American Medical Association (AMA).

Level II of the HCPCS is a standardized coding system that is used primarily to identify products, supplies, and services not included in the CPT-4 codes (e.g., ambulance services and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies [DMEPOS] when used outside a physician's office). HCPCS Level II permanent codes are maintained jointly by America's Health Insurance Plans (AHIPs), the Blue Cross and Blue Shield Association (BCBSA), and CMS (see Table 2-7). HCPCS codes appear on a Professional ERA and SPR. However, for Medicare Contractors processing outpatient services, HCPCS codes do not appear on an SPR but may appear on an ERA.

For a Current List of Level II HCPCS Codes

For the most current Level II Healthcare Common Procedure Coding System (HCPCS) code list, visit http://www.cms.gov/HCPCSReleaseCodeSets on the CMS website.

Table 2-6. Example CPT-4 Codes (also known as HCPCS Level I)

Code	Description
29405	Application of short leg cast (below knee to toes)
30465	Surgical repair of vestibular stenosis (bilateral)
69000	Drainage external ear, abscess or hematoma; simple
77401	Radiation treatment delivery, superficial

Table 2-7. HCPCS Level II Codes

Code	Description
A4357	Bedside drainage bag, day or night, with or without anti-reflux device, with or without tube, each
B4150	Enteral formula, nutritionally complete with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit
E0130	Walker, rigid (pickup), adjustable or fixed height
G0402	Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first 12 months of Medicare enrollment.
J1566	Injection, immune globulin, intravenous, lyophilized (e.g. powder), not otherwise specified, 500mg

International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) codes do not normally appear on an RA. However, there are some cases that do require that they be included on an ERA. Medicare only uses Volume 3 of the ICD-9-CM code set.

ICD-9-CM Volume 3 (including the Official ICD-9-CM Guidelines for Coding and Reporting) indicate the following procedures or other actions taken for diseases, injuries, and impairments for hospitals:

- Prevention,
- Diagnosis,
- Treatment, and
- Management.

See Table 2-8 for institutional provider ICD-9-CM procedure code examples.

Table 2-8. Example Institutional Provider ICD-9-CM Procedure Codes

Code	Description
V43.65	Knee joint replacement
V53.31	Fitting/adjustment cardiac pacemaker
V58.81	Fitting/adjustment of vascular catheter

Current Dental Terminology (CDT-4) codes are used to describe dental services, and are maintained by the American Dental Association (ADA).

National Drug Codes are used to describe drugs and biologics on retail pharmacy drug transactions. NDCs are maintained and distributed by HHS, in collaboration with drug manufacturers.

For more information on HIPAA medical code sets, visit http://www.cms.gov/EducationMaterials/Downloads/Whateelectronictransactionsandcodesets-4.pdf on the CMS website. For general information about HIPAA, visit http://www.cms.gov/HIPAAGenInfo on the CMS website.

Notes

Notes

Chapter 3: Reading an Institutional Remittance Advice (RA)

3.1 INTRODUCTION

Chapter 1 of this Guide introduced the uses for the Remittance Advice (RA) and the advantages of the Electronic Remittance Advice (ERA) format for providers and their billers. Chapter 2 introduced the purpose and basic components of both the electronic and paper versions of the RA.

This chapter specifically targets providers that submit claims to Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), and Part A Medicare Administrative Contractors (MACs) and is organized in three major sections. The sections provide more detailed information on how to read the Institutional RA. Professional providers that submit claims to Carriers, Durable Medical Equipment (DME) MACs, or Part B MACs should refer to Chapter 4 of this Guide. Since most institutional providers elect to receive claims information electronically, the first section provides specific guidance for reading an Institutional ERA. For providers that elect to receive this information on paper, the next section provides similar guidance for reading an Institutional Standard Paper Remittance Advice (SPR). 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.

After claims are processed by Medicare Contractors, an RA is generated as a companion to the payment or as an explanation of no payment. Providers that submit claims to FIs, RHHIs, or Part A MACs receive an Institutional RA.

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

The required fields are mandatory for Medicare Contractors to include in the RA. The use of situational fields depends on data content and business context (Medicare requirements), and is used if the situation applies. For example, if the payment is based on a procedure code (Healthcare Common Procedure Coding System/Current Procedural Terminology Code [HCPCS/CPT-4]) that is different from the procedure code submitted on the claim (e.g., the Medicare Contractor revised the HCPCS/CPT-4 code during processing), both procedure code fields appear in the 835. If there is no difference between the adjudicated procedure code (required field) and the submitted procedure code (situational field), only the adjudicated procedure code field appears in the 835. The submitted procedure code field does not appear because the situation does not apply.

The Institutional SPR and ERA (when viewed using the free Medicare provided PC-Print software) are standardized to ensure that the provider receives the necessary information. Institutional providers using proprietary software to receive an ERA should confirm that the software meets HIPAA-compliant ASC X12N 835 format standards and includes required and situational data elements that comply with the Medicare business context. The SPR mirrors the information provided in an ERA.

3.2 READING AN INSTITUTIONAL ELECTRONIC REMITTANCE ADVICE (ERA)

3.2.1 ERA Basics

Electronic Remittance Advices (ERAs) are available electronically to providers for a specified period of time determined by the Medicare Contractor. For institutional providers, ERAs provide additional information that is not available on the Standard Paper Remittance Advice (SPR). This includes more detailed claim-level information, a summary based on Type of Bill (TOB), and additional summary information. Some fields may or may not be populated depending on the claim.

NOTE: In the remainder of this section, Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), and Part A Medicare Administrative Contractors (MACs) are referred to as "Medicare Contractors".

3.2.2 How Is an ERA Generated?

The ERA is produced in the Health Insurance Portability and Accountability Act of 1996 (HIPAA)-compliant Accredited Standards Committee (ASC) X12N 835 format. In this Guide, this is often referred to as Transaction 835 ("the 835").

The 835, sent to providers by Medicare Contractors, is a variable-length record designed for wire (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 Guide refers to the 004010A1 version of the ASC X12N 835, which has been adopted under HIPAA as the standard.

More 835 Information

In January 2009, HHS approved the replacement of the 4010A1 versions of electronic transactions, including the 835, with the ASC X12 Version 5010. Medicare providers must be fully compliant with ASC X12 Version 5010 by January 1, 2012. Information and the latest news for the 5010 may be found at http://www.cms.gov/Versions5010andD0/01_overview.asp on the Centers for Medicare & Medicaid Services (CMS) website.

NOTE: 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 (i.e., financial institution). For example, Remittance Advice Remark Codes (RARCs) explaining any adjustment in reimbursement may not be sent regularly by the entity receiving the 835.

3.2.3 How Can the Information in an ERA Be Viewed?

Since the ASC X12N 835 format is meant for electronic transfers only, the data are not easily readable. Provider personnel can view and print the information in an ERA using special translator software. Medicare provides the PC-Print software for this purpose. However, providers may decide to purchase their own software. Availability of the PC-Print software varies depending on the type of provider. Medicare Contractors are required to supply the PC-Print software upon request. Contact information for Medicare Contractors may be found at http://www.cms.gov/MLNProducts/Downloads/CallCenterTollNumDirectory.zip on the CMS website.

PC-Print is designed to produce one of four print versions of data contained in an 835. Since PC-Print allows a provider to choose how much or how little 835 data to print, it offers a number of advantages over the SPR. The number of institutional claims submitted in batches, as well as the number of service lines can be very large. Medicare does not include service-line level data in the SPRs sent to the institutional providers that still prefer to receive SPRs since such large paper files would be very bulky and expensive to ship. Providers that want access to service-line level information must accept an 835.

A number of commercial software vendors also include software in their HIPAA suite that customers can use to print a paper version of the 835. Providers that have such software are encouraged to test its capabilities to format and report 835 data.

3.2.3.1 How Does PC-Print Present the ERA Information?

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

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

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

Option 3: The Bill Type Summary (BS) screen - The BS screen provides a summary of claims billed for each Type of Bill (TOB), for each provider number, and for each Fiscal Year (FY). For example, if a Home Health Agency (HHA) billed 32X and 33X claims, for FY 09 and FY 10, it would receive the following FOUR billing summaries:

- TOB 32X for FY 09
- TOB 32X for FY 10
- TOB 33X for FY 09
- TOB 33X for FY 10

The provider only receives a bill summary for those TOBs that were processed on this ERA. Therefore, if only 32X claims for FY 09 were processed on this ERA, the HHA only receives one bill summary.

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

DISCLAIMER

In this portion of the Guide, ERA examples are shown as they would be displayed using PC-Print. The format may appear differently depending on the type of software used to view the ERA.

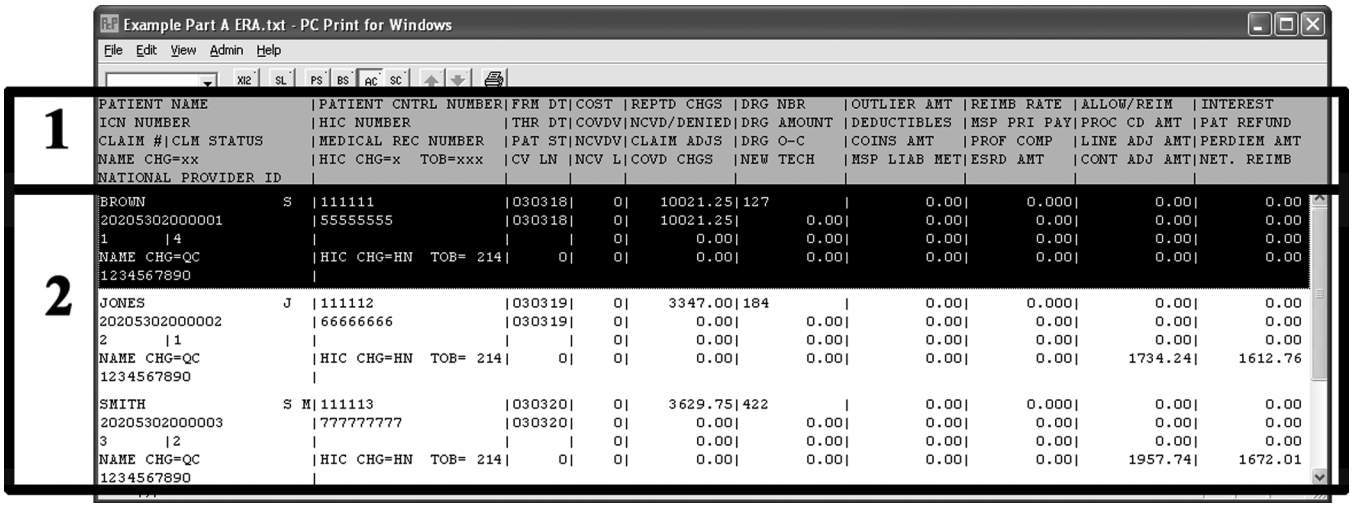
The data field names and definitions presented in the screen-by-screen breakdown of this section are the same among Medicare Contractors. Some data fields in this section are situational and may not apply to every provider type. This Guide is based on the 004010A1 ERA format.

The PC-Print software and HIPAA code sets (medical and non-medical) are subject to periodic revision. Therefore, providers should update their software and reliance on this Guide when required.

3.2.4 The All Claims (AC) Screen (Institutional ERA)

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

The example AC screen shown in Figure 3-1 contains RA information for three separate claims. The lines and bold numbers on the left were added to designate particular sections of the ERA that are discussed on the following pages. Section 1 contains the field names of each position in each AC record. Section 2 contains the data for each of the three claims. The 10 columns of data for each claim correspond to the 10 columns of header information in Section 1. The following pages contain information regarding the header fields that are divided into 10 columns.




```
PATIENT NAME              |PATIENT CNTRL NUMBER|FRM DT|COST |REPTD CHGS |DRG NBR    |OUTLIER AMT |REIMB RATE |ALLOW/REIM  |INTEREST
ICN NUMBER                |HIC NUMBER          |THR DT|COVDV|NCVD/DENIED|DRG AMOUNT |DEDUCTIBLES |MSP PRI PAY|PROC CD AMT |PAT REFUND
CLAIM #|CLM STATUS        |MEDICAL REC NUMBER  |PAT ST|NCVDV|CLAIM ADJS |DRG O-C    |COINS AMT   |PROF COMP  |LINE ADJ AMT|PERDIEM AMT
NAME CHG=xx               |HIC CHG=x  TOB=xxx  |CV LN |NCV L|COVD CHGS  |NEW TECH   |MSP LIAB MET|ESRD AMT   |CONT ADJ AMT|NET. REIMB
NATIONAL PROVIDER ID      |                    |      |     |           |           |            |           |            |
BROWN                 S   |111111              |030318|    0|   10021.25|127        |        0.00|      0.000|        0.00|        0.00
20205302000001            |55555555            |030318|    0|   10021.25|       0.00|        0.00|       0.00|        0.00|        0.00
1       |4                |                    |      |    0|       0.00|       0.00|        0.00|       0.00|        0.00|        0.00
NAME CHG=QC               |HIC CHG=HN  TOB= 214|     0|    0|       0.00|       0.00|        0.00|       0.00|        0.00|        0.00
1234567890                |
JONES                 J   |111112              |030319|    0|    3347.00|184        |        0.00|      0.000|        0.00|        0.00
20205302000002            |66666666            |030319|    0|       0.00|       0.00|        0.00|       0.00|        0.00|        0.00
2       |1                |                    |      |    0|       0.00|       0.00|        0.00|       0.00|        0.00|        0.00
NAME CHG=QC               |HIC CHG=HN  TOB= 214|     0|    0|       0.00|       0.00|        0.00|       0.00|     1734.24|     1612.76
1234567890                |
SMITH                 S M|111113              |030320|    0|    3629.75|422        |        0.00|      0.000|        0.00|        0.00
20205302000003            |777777777           |030320|    0|       0.00|       0.00|        0.00|       0.00|        0.00|        0.00
3       |2                |                    |      |    0|       0.00|       0.00|        0.00|       0.00|        0.00|        0.00
NAME CHG=QC               |HIC CHG=HN  TOB= 214|     0|    0|       0.00|       0.00|        0.00|       0.00|     1957.74|     1672.01
1234567890                |
```

Figure 3-1. The Institutional ERA All Claims (AC) Screen

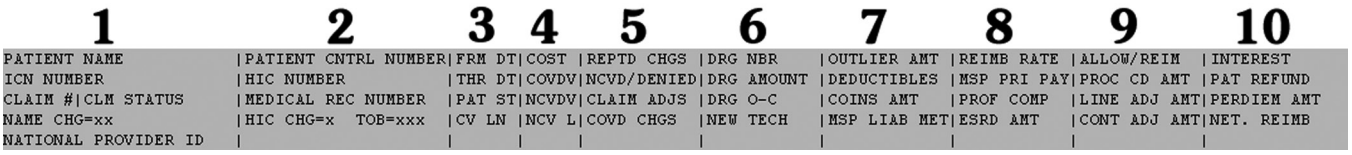


Figure 3-2. Header Information for Claims Listed on the AC Screen

3.2.4.1 Column 1 of the AC Screen (Institutional ERA)

PATIENT NAME - This field displays the last name, first name (may be first initial only), and middle initial (if known/available) of the beneficiary under which the claim was processed. If a claim was submitted by the provider using the name Jane Smith, but during processing Medicare records indicate the name of record for that beneficiary is listed as Jane Jones on the Common Working File (CWF), then the RA shows the name "Jones Jane" in this field. See the NAME CHG=xx field description that follows.

ICN NUMBER - This field displays the Internal Control Number (ICN). The 14-digit ICN is a unique number assigned to the claim at the time it is received by the Medicare Contractor. It is used to track and monitor the claim. The first six digits reflect when the claim was received. The first digit is a century code ("1" indicates 1900-1999 and "2" indicates 2000 and after). The second two digits indicate the last two digits of the year that the claim was received. The next three digits indicate the day of the year the claim was submitted, out of 365 days (366 in a leap year). The last eight digits are a unique set of numbers assigned by Medicare Contractors.

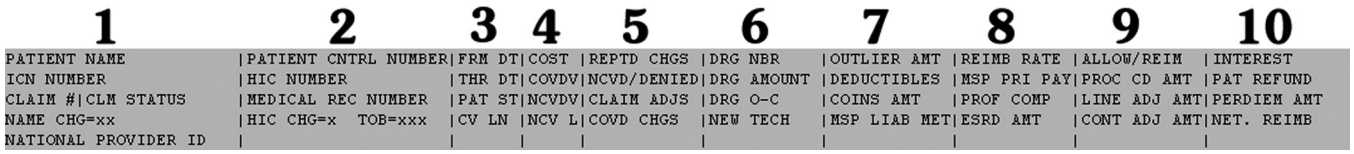
> **EXAMPLE:** A claim with ICN number 20905302000001 would have been received on February 22, 2009.

CLAIM # - This field reflects the claim number assigned by PC-Print to each claim. For Home Health Agencies (HHAs), this can be a Request for Anticipated Payment (RAP) printed from the ERA.

CLM STATUS - This field indicates the status of the claim (i.e., the payment result when the claim completed processing). These codes are consistent on both ERAs and SPRs. See Table 3-1 for codes used by Medicare to indicate the status of a processed claim.

Table 3-1. Claim Status Codes Used by Medicare

Code	Description
1	Paid as primary.
2	Paid as secondary.
3	Paid as tertiary.
4	Denied (this claim status shows when a claim is denied or rejected).
19	Medicare paid primary and the Intermediary sent the claim to another insurer.
20	Medicare paid secondary and the Intermediary sent the claim to another insurer.
21	Medicare paid tertiary and sent the claim to another insurer.
22	Adjustment to prior claim, reversal to previous payment [this claim status also shows when a claim is cancelled (TOB XX8), including RAPs that have auto cancelled or been cancelled by the provider].
23	Not a Medicare claim and the Intermediary sent claim to another insurer.



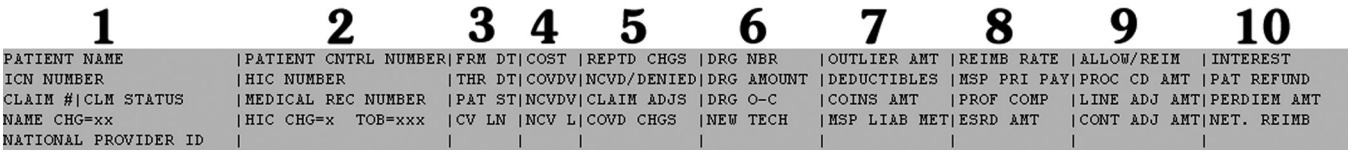
1	2	3	4	5	6	7	8	9	10
PATIENT NAME	PATIENT CNTRL NUMBER	FRM DT	COST	REPTD CHGS	DRG NBR	OUTLIER AMT	REIMB RATE	ALLOW/REIM	INTEREST
ICN NUMBER	HIC NUMBER	THR DT	COVDV	NCVD/DENIED	DRG AMOUNT	DEDUCTIBLES	MSP PRI PAY	PROC CD AMT	PAT REFUND
CLAIM # CLM STATUS	MEDICAL REC NUMBER	PAT ST	NCVDV	CLAIM ADJS	DRG O-C	COINS AMT	PROF COMP	LINE ADJ AMT	PERDIEM AMT
NAME CHG=xx	HIC CHG=x TOB=xxx	CV LN	NCV L	COVD CHGS	NEW TECH	MSP LIAB MET	ESRD AMT	CONT ADJ AMT	NET. REIMB
NATIONAL PROVIDER ID									

NAME CHG=xx - This field indicates whether the beneficiary's name was changed during the processing of the claim. See Table 3-2 for the qualifiers associated with a beneficiary name change.

Table 3-2. Qualifiers Associated with Beneficiary Name Change

Qualifier	Description
QC	**No name change:** the name used to process the claim is the same as the name that was submitted on the claim.
74	**Name change:** the beneficiary's name was changed during the processing of the claim. The name the claim was processed with shows in the PATIENT NAME field.

NATIONAL PROVIDER ID - This field displays the National Provider Identifier (NPI) of the facility receiving the ERA. The NPI is the number assigned to the provider for billing and identification purposes. For more information about the NPI, visit http://www.cms.gov/NationalProvIdentStand on the CMS website.



3.2.4.2 Column 2 of the AC Screen (Institutional ERA)

PATIENT CNTRL NUMBER - This field displays the Patient Control Number (PCN) that was submitted on the claim. The PCN is usually assigned by providers to each admission and provides an easy method for applying receipt of payment for a particular beneficiary.

HIC NUMBER - This field displays the Health Insurance Claim (HIC) number of the beneficiary for whom the claim was processed. For example, a claim was submitted by the provider using the HIC number 123456789A. If the beneficiary's HIC number was changed to 987654321B on the CWF, then the RA shows the HIC number 987654321B in this field. See the HIC CHG=x field description below.

MEDICAL REC NUMBER - This field displays the Medical Record Number (MRN) that was submitted on the claim. The MRN can be used by providers as part of their own internal record keeping.

HIC CHG=x - This field indicates whether the beneficiary's HIC number was changed during claim processing. See Table 3-3 for the qualifiers associated with a beneficiary HIC number change.

Table 3-3. Qualifiers Associated with Beneficiary HIC Number Change

Qualifier	Description
HN	**No HIC change:** the beneficiary's HIC number used to process the claim is the same as the HIC number that was submitted on the claim.
C	**HIC change:** the beneficiary's HIC number was changed during the processing of the claim. The HIC number the claim was processed with shows in the HIC NUMBER field. If the HIC number has changed, it is important to note the change for future reference.

TOB=xxx - This field indicates the TOB that the claim data reflects. The TOB is a 3-digit[1] alphanumeric code that identifies what type of provider is billing and in what sequence. If the claim was fully denied, the TOB changes to XX0. See Tables 3-4 through 3-8 for details regarding the TOB code structure. Codes used for Medicare claims are available from Medicare Contractors. Codes are also available from the National Uniform Billing Committee (NUBC) in its official *UB-04 Data Specifications Manual* available at http://www.nubc.org on the Internet.

[1] The Type of Bill (TOB) is technically a 4-digit code. For Medicare purposes, the leading zero is ignored, and the three pieces of information addressed by Tables 3-4 through 3-8 are used.

Table 3-4. Type of Bill Code Structure – 1st Digit, Type of Facility[1]

Digit	Description
1	Hospital[2]
2	Skilled Nursing Facility (SNF)
3	Home Health
4	Religious Non-Medical (Hospital)
5	Reserved for National Assignment (Discontinued)
6	Intermediate Care
7	Clinic or Hospital Based Renal Dialysis Facility (Requires special information in second digit below)
8	Special Facility (Requires special information in second digit below)
9	Reserved for National Assignment

Table 3-5. Type of Bill Code Structure – 2nd Digit, Bill Classification (if first digit is 1-5)[1]

Digit	Description
1	Inpatient Part A
2	Inpatient (Part B) (Includes HHA visits under a Part B plan of treatment)
3	Outpatient or Free-Standing or Provider-based (Includes HHA visits under Part A plan of treatment and use of HHA DME under a Part A plan of treatment)
4	Other (Part B) (Includes HHA medical and other health services not under a plan of treatment, hospital and SNF for laboratory services for "non-patients")
5	Intermediate Care - Level I
6	Intermediate Care - Level II
7	Reserved for National Assignment (Discontinued)
8	Swing bed (Used to indicate billing for SNF level of care in a hospital with an approved swing bed agreement)
9	Reserved for National Assignment

Table 3-6. Type of Bill Code Structure – 2nd Digit, Bill Classification (if first digit is 7)[1]

Digit	Description
1	Rural Health Clinic (RHC)
2	Hospital Based or Independent Renal Dialysis Facility
3	Clinic - Free-Standing (effective April 1, 2010)
4	Clinic Outpatient Physical Therapy (OPT)
5	Comprehensive Outpatient Rehabilitation Facility (CORF)
6	Community Mental Health Center (CMHC)
7	Freestanding and Provider-Based Federally Qualified Health Center (FQHC) (effective April 1, 2010)
8	Reserved for National Assignment
9	Other

[1] The Type of Bill (TOB) is technically a 4-digit code. For Medicare purposes, the leading zero is ignored, and the three pieces of information addressed by Tables 3-4 through 3-8 are used.

[2] Hospital-based multi-unit complexes may also have use for the first digits 2-9 when billing non-hospital services: (e.g., hospital-based SNF).

Table 3-7. Type of Bill Code Structure – 2nd Digit, Bill Classification (if first digit is 8)[1]

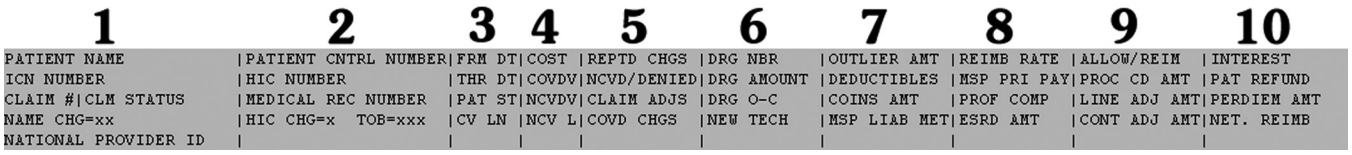
Digit	Description
1	Hospice (Non-Hospital Based)
2	Hospice (Hospital Based)
3	Ambulatory Surgical Center (ASC) Services to Hospital Outpatients
4	Free Standing Birthing Center
5	Critical Access Hospital (CAH)
6-8	Reserved for National Assignment
9	Other

Table 3-8. Type of Bill Code Structure – 3rd Digit, Frequency[1]

Digit	Description
A	Admission/Election Notice
B	Hospice/Medicare Coordinated Care Demonstration/Religious Non-Medical Health Care Institution – Termination/Revocation Notice
C	Hospice Change of Provider
D	Hospice/Medicare Coordinated Care Demonstration/Religious Non-Medical Health Care Institution – Void/Cancel
E	Hospice Change of Ownership
F-P	Adjustment Claims (Not initiated by Provider)
0	Non-Payment/Zero Claim
1	Admit Through Discharge Claim
2	Interim - First Claim (Also used for Home Health Prospective Payment System (HHPPS) Request for Anticipated Payment [RAP])
3	Interim - Second and Continuing Claim(s) (Not valid for PPS bills. Exception: SNF PPS bills)
4	Interim - Last Claim (Not valid for PPS bills. Exception: SNF PPS bills)
5	Late Charge(s) Only
7	Replacement of Prior Claim (Initiated by Provider)
8	Void/Cancel of Prior Claim
9	Home Health Prospective Payment System (HHPPS) Episode Final Claim

EXAMPLE: In a 214 TOB, the "2" indicates a Skilled Nursing Facility (SNF); the "1" indicates an inpatient stay; and the "4" indicates that the beneficiary was discharged.

[1] The Type of Bill (TOB) is technically a 4-digit code. For Medicare purposes, the leading zero is ignored, and the three pieces of information addressed by Tables 3-4 through 3-8 are used.



1	2	3	4	5	6	7	8	9	10
PATIENT NAME	PATIENT CNTRL NUMBER	FRM DT	COST	REPTD CHGS	DRG NBR	OUTLIER AMT	REIMB RATE	ALLOW/REIM	INTEREST
ICN NUMBER	HIC NUMBER	THR DT	COVDV	NCVD/DENIED	DRG AMOUNT	DEDUCTIBLES	MSP PRI PAY	PROC CD AMT	PAT REFUND
CLAIM # CLM STATUS	MEDICAL REC NUMBER	PAT ST	NCVDV	CLAIM ADJS	DRG O-C	COINS AMT	PROF COMP	LINE ADJ AMT	PERDIEM AMT
NAME CHG=xx	HIC CHG=x TOB=xxx	CV LN	NCV L	COVD CHGS	NEW TECH	MSP LIAB MET	ESRD AMT	CONT ADJ AMT	NET. REIMB
NATIONAL PROVIDER ID									

3.2.4.3 Column 3 of the AC Screen (Institutional ERA)

FRM DT - This field indicates the start date of services on the processed claim.

THR DT - This field indicates the last date of services on the processed claim.

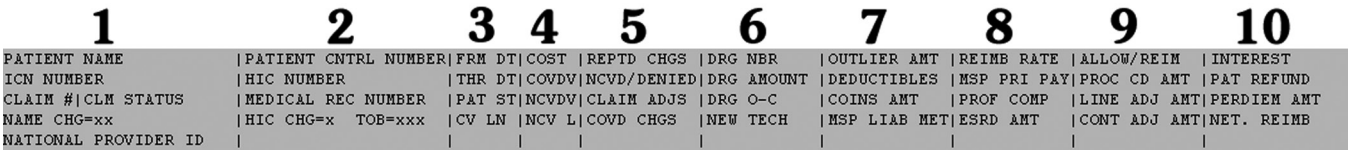
PAT ST - This field indicates the patient status code that was billed on the claim. Patient status codes appear only on ERAs for institutional inpatients, and indicate the beneficiary's status as of the through date of the billing period. For example, 01 indicates that the beneficiary was discharged to home.

For a Current List of Patient Status Codes

Patient status codes are available from Medicare Contractors. The most current list of patient status codes can also be found from the National Uniform Billing Committee (NUBC) in its official *UB-04 Data Specifications Manual* available at http://www.nubc.org on the Internet.

CV LN - This field indicates the number of covered lines billed on the claim.

- **For claims that are denied or rejected**, this field shows a zero. The field also shows a zero when no payment can be made by Medicare. For example, if the beneficiary's primary insurance paid more than Medicare would have paid, no payment is made by Medicare.
- **For cancel claims**, this field is negative.
- **For home health RAPs**, this field shows a zero, but for home health final claims, it shows the number of covered visits.
- **For an inpatient hospital, SNF, and swing bed**, this value shows the number of covered days in the inpatient stay.
- **For outpatient services at a hospital, Community Mental Health Center (CMHC), SNF, Rural Health Clinic (RHC), Renal Dialysis Facility (RDF), Comprehensive Outpatient Rehabilitation Facility (CORF), and other outpatient providers**, this field shows a zero.



1	2	3	4	5	6	7	8	9	10
PATIENT NAME	PATIENT CNTRL NUMBER	FRM DT	COST	REPTD CHGS	DRG NBR	OUTLIER AMT	REIMB RATE	ALLOW/REIM	INTEREST
ICN NUMBER	HIC NUMBER	THR DT	COVDV	NCVD/DENIED	DRG AMOUNT	DEDUCTIBLES	MSP PRI PAY	PROC CD AMT	PAT REFUND
CLAIM # CLM STATUS	MEDICAL REC NUMBER	PAT ST	NCVDV	CLAIM ADJS	DRG O-C	COINS AMT	PROF COMP	LINE ADJ AMT	PERDIEM AMT
NAME CHG=xx	HIC CHG=x TOB=xxx	CV LN	NCV L	COVD CHGS	NEW TECH	MSP LIAB MET	ESRD AMT	CONT ADJ AMT	NET. REIMB
NATIONAL PROVIDER ID									

3.2.4.4 Column 4 of the AC Screen (Institutional ERA)

COST - This field indicates the number of days used and applied to the Medicare Cost Report (MCR).

- A value displays in this field for **inpatient hospital, SNF, swing bed, and home health final claims**.
- This field does not apply to and shows a zero for **RHC, home health RAPs, hospice, outpatient hospital, outpatient SNF, CMHC, CORF, Outpatient Physical Therapy (OPT), FQHC, and RDF claims**.
- For **cancel claims**, this field is negative.
- For **claims that are denied or rejected**, this field shows a zero.

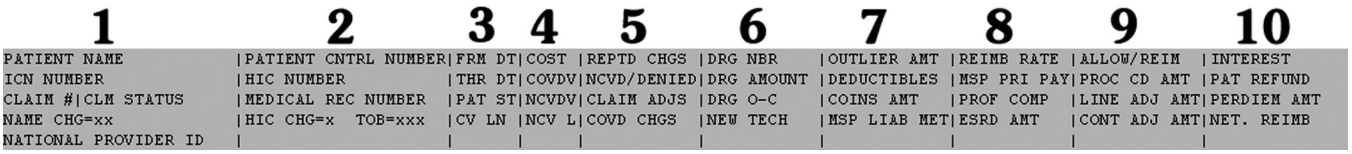
COVDV - This field indicates the number of covered days or visits.

- No value is displayed in this field in Figure 3-1; however, a value appears in this field for **inpatient hospital, SNF, swing bed, and home health final claims**.
- This field does not apply to and shows a zero for **RHC, hospice, outpatient hospital, outpatient SNF, CMHC, CORF, OPT, FQHC, RDF, and home health RAPs**.
- **For cancel claims**, this field is negative.
- **For claims that are denied or rejected**, this field shows a zero.

NCVDV - This field shows the number of non-covered days or visits. Non-covered days or visits are submitted by the provider when it is known that the days or visits are not covered by Medicare. Providers do not anticipate payment on non-covered days or visits they submit. A value shows in this field when the provider has submitted non-covered days or visits, or the day(s) or visit(s) was/were partially denied through Medical Review (MR). A value shows in this field **for an inpatient hospital and SNF**. A value also shows in this field **for home health final claims** in cases where partially denied services result in a Low Utilization Payment Adjustment (LUPA).

NCV L - This field identifies non-covered lines. Non-covered lines are submitted by the provider when it is known that the lines are not covered by Medicare. Providers do not anticipate payment on submitted non-covered lines.

- **For home health providers**, this field displays a value (that corresponds to the number of visits denied on the claim) when a visit has been denied by MR.
- **For an inpatient hospital and SNF**, this field displays a value when leave of absence days (revenue code 180) are billed and when a non-covered level of care (occurrence span code 74) is billed.
- **For an outpatient hospital**, this field shows a zero when the non-covered line is submitted by the provider.
- This field also displays a value when the beneficiary's primary insurer paid more than what Medicare would have paid (and thus, the lines/days are non-covered).



1	2	3	4	5	6	7	8	9	10
PATIENT NAME	PATIENT CNTRL NUMBER	FRM DT	COST	REPTD CHGS	DRG NBR	OUTLIER AMT	REIMB RATE	ALLOW/REIM	INTEREST
ICN NUMBER	HIC NUMBER	THR DT	COVDV	NCVD/DENIED	DRG AMOUNT	DEDUCTIBLES	MSP PRI PAY	PROC CD AMT	PAT REFUND
CLAIM # CLM STATUS	MEDICAL REC NUMBER	PAT ST	NCVDV	CLAIM ADJS	DRG O-C	COINS AMT	PROF COMP	LINE ADJ AMT	PERDIEM AMT
NAME CHG=xx	HIC CHG=x TOB=xxx	CV LN	NCV L	COVD CHGS	NEW TECH	MSP LIAB MET	ESRD AMT	CONT ADJ AMT	NET. REIMB
NATIONAL PROVIDER ID									

3.2.4.5 Column 5 of the AC Screen (Institutional ERA)

REPTD CHGS - This field shows the dollar amount of charges submitted by the provider. This amount does not necessarily impact the provider's reimbursement amount. **For cancel claims and RAPs (TOB XX8)**, this amount is negative.

NCVD/DENIED - This field identifies the dollar amount of non-covered or denied charges.

- **For all institutional provider types**, a dollar amount shows in this field when a claim has non-covered and/or denied charges at the line or claim level (except for Reason Codes A2, 1, 2, 23, 45, 66, 70, 89, 94, 118, and 122).
- **For providers subject to the Outpatient Prospective Payment System (OPPS)**, an amount also shows in this field when a service is bundled and not separately reimbursable.
- **For Critical Access Hospitals (CAHs)**, an amount also shows in this field when the payment for this service is included in the allowance for the basic service/procedure.
- **For RDF providers**, services paid under the per diem/composite rate or under the End Stage Renal Disease Prospective Payment System (ESRD PPS), effective on January 1, 2011, are not separately reimbursable.

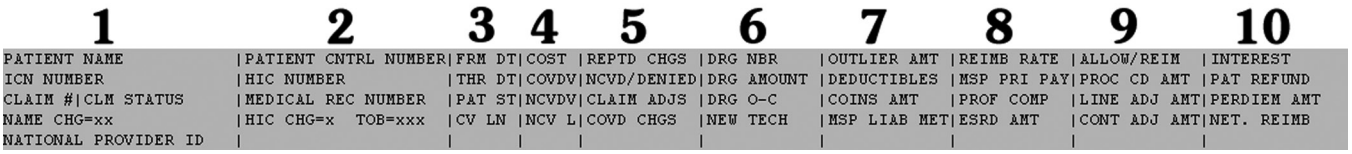
To determine why the charges were non-covered/denied, see the ADJ REASON CODES and REMARK CODES fields on the SC screen in Section 3.2.5.5. The current codes may be found at http://www.wpc-edi.com/codes on the Internet.

CLAIM ADJS - This field reflects the claim-level adjustments.

- **For an inpatient hospital or SNF**, this amount is typically the difference between the COVD CHGS amount and the DRG AMOUNT. If the amount of the COVD CHGS is less than the DRG AMOUNT, this amount is negative.
- **For an outpatient hospital or home health provider**, the amount in this field reflects an outlier payment (see the OUTLIER field on the SC screen in Section 3.2.5.4). The outlier payment equals the difference between the ALLOW/REIM amount and the NET. REIMB amount.
- **For other outpatient services**, this amount is negative.
- **For RHC, CAH, CORF, and swing bed claims**, this field shows a zero.
- **For outpatient SNF, RDF, CMHC, and other outpatient therapy claims**, this field also shows a zero.

COVD CHGS - This field displays the dollar amount of covered charges. If all submitted services/visits are covered, this amount is the same as the amount in the REPTD CHGS field. If any of the services/visits are non-covered/denied or reduced, this amount differs from the amount in the REPTD CHGS field.

- **For cancel claims**, this amount is negative.
- **For denied claims**, this field displays a zero.
- **For RDFs**, the amount in the REPTD CHGS field consistently does not match the amount in the COVD CHGS field.



3.2.4.6 Column 6 of the AC Screen (Institutional ERA)

DRG NBR - This field reflects the Diagnosis Related Group (DRG) number assigned to the claim. The DRG number is determined based on the age, sex, discharge status, principal diagnosis, secondary diagnosis, and procedures performed on the beneficiary.

- A value only displays in this field **for inpatient hospitals**.

DRG AMOUNT - This field displays a dollar amount associated with the DRG number. This amount is calculated by the PRICER software.

- **For inpatient hospitals and SNFs**, this field displays an amount. If the claim is a cancel claim, this amount is negative.
- **For SNFs**, this is the dollar amount associated with the billed Medicare Resource Utilization Group (RUG).
- **For RHC, HHA, outpatient hospital, outpatient SNF, swing bed, CMHC, CORF, OPT, and hospice claims**, this field shows a zero.

DRG O-C - This field indicates the sum of DRG operating payments and capital payments amount. This amount is factored into and is part of a hospital's Prospective Payment System (PPS) payment, and is based on operating costs and capital expenditures.

NEW TECH - This field reflects the dollar amount of the funds Medicare pays for "new technology" drugs and devices. This is in addition to the regular payment.

HHA Claims Only Information

The four fields described below are unique to **HHAs** who have PC-Print version 2.01 or higher. These four fields replace the previous four fields seen by all other provider types and HHAs who do not have PC-Print version 2.01 or higher: DRG NBR, DRG AMOUNT, DRG O-C, and NEW TECH. The following conditions apply to all the fields in this section:

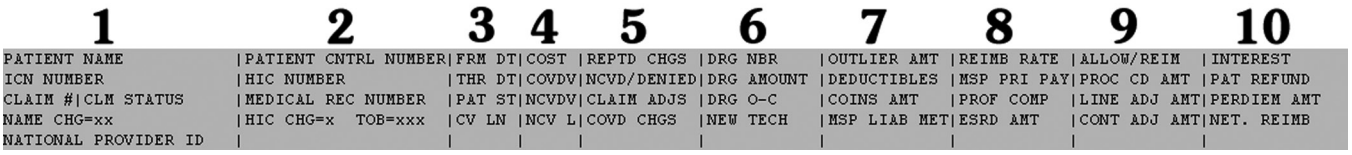
- **For RAPs, rejected claims, and cancelled RAPs**, these fields show a zero.
- **For cancelled final claims**, these fields are negative.

SN DAYS - This field indicates the number of covered Skilled Nursing (SN) units, reflective of the 15-minute increment billing covered on the claim. For example, a claim is processed with six covered skilled nursing visits, each with two units. Under the SN DAYS field, the ERA shows 12 units.

PT DAYS - This field indicates the number of covered Physical Therapy (PT) units, reflective of the 15-minute increment billing covered on the claim.

ST DAYS - This field indicates the number of covered Speech Therapy (ST) (now known as speech-language pathology) units, reflective of the 15-minute increment billing covered on the claim.

OT DAYS - This field indicates the number of covered Occupational Therapy (OT) units, reflective of the 15-minute increment billing covered on the claim.



1	2	3	4	5	6	7	8	9	10
PATIENT NAME	PATIENT CNTRL NUMBER	FRM DT	COST	REPTD CHGS	DRG NBR	OUTLIER AMT	REIMB RATE	ALLOW/REIM	INTEREST
ICN NUMBER	HIC NUMBER	THR DT	COVDV	NCVD/DENIED	DRG AMOUNT	DEDUCTIBLES	MSP PRI PAY	PROC CD AMT	PAT REFUND
CLAIM #	CLM STATUS	MEDICAL REC NUMBER	PAT ST	NCVDV	CLAIM ADJS	DRG O-C	COINS AMT	PROF COMP	LINE ADJ AMT	PERDIEM AMT
NAME CHG=xx	HIC CHG=x TOB=xxx	CV LN	NCV L	COVD CHGS	NEW TECH	MSP LIAB MET	ESRD AMT	CONT ADJ AMT	NET. REIMB
NATIONAL PROVIDER ID									

3.2.4.7 Column 7 of the AC Screen (Institutional ERA)

OUTLIER AMT - This field reflects the dollar amount of an outlier paid for a particular claim. Outliers are cases that, although classifiable into a specific payment group, have exceptionally high costs.

DEDUCTIBLES - This field displays the dollar amount applied to the beneficiary's deductible. The beneficiary (or other insurer if applicable) is responsible for paying the provider the amount shown in this field. Deductibles vary by Medicare benefit (e.g., Part A hospital deductible, Part B deductible, blood deductible).

> **EXAMPLE:** Part A deductibles apply to hospitals. For 2010, there is a deductible of $1,100.00 for days 1-60 for each benefit period.

NOTE: Any services billed by an institutional provider, but paid from the Part B Medicare Trust Fund, may have a Part B deductible amount associated with this field. This is currently a yearly deductible amount of $155 for 2010. This has a Group Code of "PR." See Table 2-1 in Chapter 2 of this Guide for a list of Group Codes.

Deductible amounts are subject to change annually.

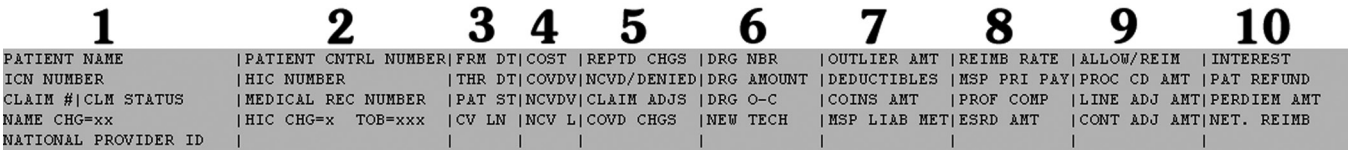
COINS AMT - This field shows the total dollar amount of coinsurance for which the beneficiary is responsible. The beneficiary (or other insurer if applicable) is responsible for paying the provider the amount shown in this field.

- **For cancel claims**, this amount is negative.
- **For outpatient hospital, RDF, OPT, RHC or any other services in which a coinsurance would be applicable**, this field shows an amount.

> **EXAMPLE:** SNF coinsurance under Part A is $137.50 per day for 2010, which must be paid by the beneficiary for days 21-100 in the SNF. Medicare pays in full for days 1-20.

NOTE: Coinsurance amounts are subject to change annually.

MSP LIAB MET - This field indicates that the Medicare Secondary Payer (MSP) liability (beneficiary and/or provider liability) was met by another payer.



1	2	3	4	5	6	7	8	9	10
PATIENT NAME	PATIENT CNTRL NUMBER	FRM DT	COST	REPTD CHGS	DRG NBR	OUTLIER AMT	REIMB RATE	ALLOW/REIM	INTEREST
ICN NUMBER	HIC NUMBER	THR DT	COVDV	NCVD/DENIED	DRG AMOUNT	DEDUCTIBLES	MSP PRI PAY	PROC CD AMT	PAT REFUND
CLAIM # CLM STATUS	MEDICAL REC NUMBER	PAT ST	NCVDV	CLAIM ADJS	DRG O-C	COINS AMT	PROF COMP	LINE ADJ AMT	PERDIEM AMT
NAME CHG=xx	HIC CHG=x TOB=xxx	CV LN	NCV L	COVD CHGS	NEW TECH	MSP LIAB MET	ESRD AMT	CONT ADJ AMT	NET. REIMB
NATIONAL PROVIDER ID									

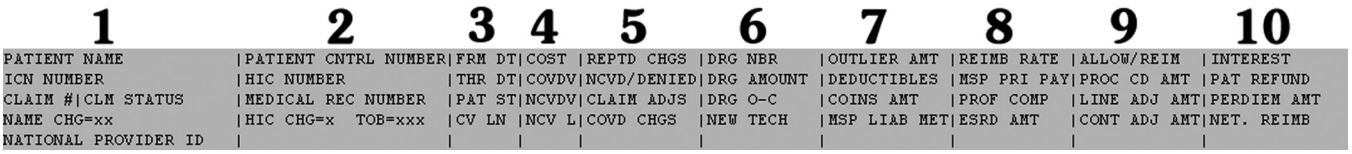
HHA Claims Only Information

The two fields described below are unique to **HHAs** who have PC-Print version 2.01 or higher. These two fields replace the previous two fields seen by all other provider types and HHAs who do not have PC-Print version 2.01 or higher: OUTLIER AMT and DEDUCTIBLES. The following conditions apply to all the fields in this section:

- **For RAPs, rejected claims, and cancelled RAPs**, these fields show a zero.
- **For cancelled final claims**, these fields are negative.

MS DAYS - This field indicates the number of covered Medical Social (MS) worker units, reflective of the 15-minute increment billing covered on the claim.

NA DAYS - This field indicates the number of covered Nurses Aide (NA) (home health aide) units, reflective of the 15-minute increment billing covered on the claim.



1	2	3	4	5	6	7	8	9	10
PATIENT NAME	PATIENT CNTRL NUMBER	FRM DT	COST	REPTD CHGS	DRG NBR	OUTLIER AMT	REIMB RATE	ALLOW/REIM	INTEREST
ICN NUMBER	HIC NUMBER	THR DT	COVDV	NCVD/DENIED	DRG AMOUNT	DEDUCTIBLES	MSP PRI PAY	PROC CD AMT	PAT REFUND
CLAIM # CLM STATUS	MEDICAL REC NUMBER	PAT ST	NCVDV	CLAIM ADJS	DRG O-C	COINS AMT	PROF COMP	LINE ADJ AMT	PERDIEM AMT
NAME CHG=xx	HIC CHG=x TOB=xxx	CV LN	NCV L	COVD CHGS	NEW TECH	MSP LIAB MET	ESRD AMT	CONT ADJ AMT	NET. REIMB
NATIONAL PROVIDER ID									

3.2.4.8 Column 8 of the AC Screen (Institutional ERA)

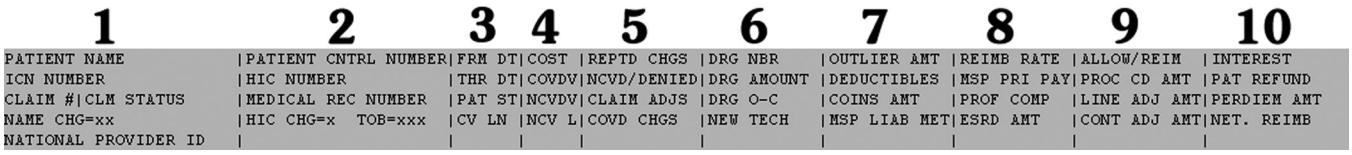
REIMB RATE - This field identifies the per diem amount or percentage of reimbursement paid to a provider, depending on how the provider is reimbursed, for an individual claim. This value only applies to cost reimbursed services.

MSP PRI PAY - This field indicates the MSP Primary Payer amount. An amount shows in this field when the primary insurance has made payment toward the services on this claim. The amount is consistent with the amount reported by the provider on the claim.

PROF COMP - This field indicates whether a physician's professional component was billed on the claim as part of a technical component. This field **applies to CAHs** who have chosen the applicable payment methodology. This field shows the dollar amount of the billed professional component.

ESRD AMT - This field indicates the ESRD Network Reduction amount and **only applies to RDFs**. This is the amount that Medicare's payment is reduced by to help fund the ESRD Network. The current amount is $.50 per covered session.

> **EXAMPLE:** A processed claim with six covered sessions shows an amount of $3.00 in the ESRD AMT field on the ERA.



1	2	3	4	5	6	7	8	9	10
PATIENT NAME	PATIENT CNTRL NUMBER	FRM DT	COST	REPTD CHGS	DRG NBR	OUTLIER AMT	REIMB RATE	ALLOW/REIM	INTEREST
ICN NUMBER	HIC NUMBER	THR DT	COVDV	NCVD/DENIED	DRG AMOUNT	DEDUCTIBLES	MSP PRI PAY	PROC CD AMT	PAT REFUND
CLAIM #|CLM STATUS	MEDICAL REC NUMBER	PAT ST	NCVDV	CLAIM ADJS	DRG O-C	COINS AMT	PROF COMP	LINE ADJ AMT	PERDIEM AMT
NAME CHG=xx	HIC CHG=x TOB=xxx	CV LN	NCV L	COVD CHGS	NEW TECH	MSP LIAB MET	ESRD AMT	CONT ADJ AMT	NET. REIMB
NATIONAL PROVIDER ID									

3.2.4.9 Column 9 of the AC Screen (Institutional ERA)

ALLOW/REIM - This field indicates the allowable reimbursement amount for the covered services, which may include any deductible for which the beneficiary is responsible.

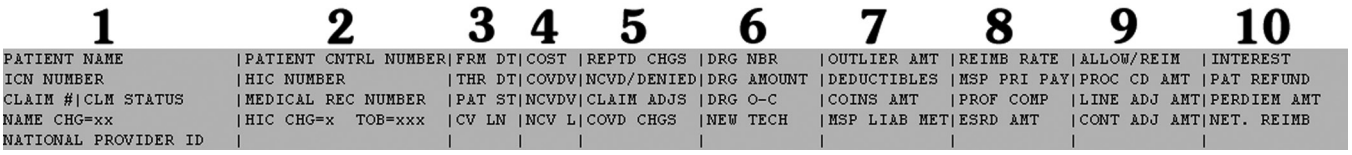
PROC CD AMT - This field indicates the procedure code amount.

- **For OPPS services**, this amount reflects the difference between the REPTD CHGS and the NCVD/DENIED fields.
- **For outpatient services paid under the Medicare Physician Fee Schedule (MPFS)**, this is the total reimbursement amount for all of the covered services under the MFS. For more information about the Medicare Physician Fee Schedule, go to http://www.cms.gov/PhysicianFeeSched on the CMS website.
- **For an RDF** paid under the per diem/composite rate for dates of service prior to January 1, 2011, this amount is the rate multiplied by the number of covered units.
- **For an RHC and an FQHC**, this amount is the covered charge.
- **For inpatient hospital, SNF, swing bed, and CAH claims**, this field shows a zero.

LINE ADJ AMT - This field indicates the total of line item adjusted amounts. For some providers, this is the difference between the provider-billed amount (REPTD CHGS field) and the amount reimbursed by Medicare (NET. REIMB field) for all revenue code lines less the coinsurance amount (COINS AMT field) and the deductible amount (DEDUCTIBLES field).

- **For RDF providers**, in addition to subtracting the coinsurance, the ESRD Network Reduction amount (ESRD AMT field) must also be subtracted.
- **For inpatient hospital and swing bed claims**, this field shows a zero.
- **For home health final claims**, the amount in this field is equal to the amount in the REPTD CHGS field.
- **For paid RAPs and cancelled RAPs and claims**, this field shows a zero.

CONT ADJ AMT - This field indicates an adjustment resulting from a contractual agreement between the payer and payee, or a regulatory requirement. Generally, these adjustments are considered a write-off for the provider and are not billed to the beneficiary. The Group Code “CO” is used for these adjustments.



1	2	3	4	5	6	7	8	9	10
PATIENT NAME	PATIENT CNTRL NUMBER	FRM DT	COST	REPTD CHGS	DRG NBR	OUTLIER AMT	REIMB RATE	ALLOW/REIM	INTEREST
ICN NUMBER	HIC NUMBER	THR DT	COVDV	NCVD/DENIED	DRG AMOUNT	DEDUCTIBLES	MSP PRI PAY	PROC CD AMT	PAT REFUND
CLAIM #	CLM STATUS	MEDICAL REC NUMBER	PAT ST	NCVDV	CLAIM ADJS	DRG O-C	COINS AMT	PROF COMP	LINE ADJ AMT	PERDIEM AMT
NAME CHG=xx	HIC CHG=x TOB=xxx	CV LN	NCV L	COVD CHGS	NEW TECH	MSP LIAB MET	ESRD AMT	CONT ADJ AMT	NET. REIMB
NATIONAL PROVIDER ID									

3.2.4.10 Column 10 of the AC Screen (Institutional ERA)

INTEREST - This field displays an amount when Medicare has paid interest on a claim. Interest is paid by Medicare when a clean claim is not paid in a timely manner.

PAT REFUND - This field indicates the beneficiary refund amount. This is the amount the provider owes the beneficiary for overpaid deductible and coinsurance.

PERDIEM AMT - This field identifies the per diem amount to be paid for an individual claim for providers who are reimbursed on a per diem basis. If the provider is reimbursed based on a percentage of charges, this field identifies the percentage. If per diem payment does not apply, this field shows a zero.

NET. REIMB - This field displays the net reimbursement for the total claim(s).

3.2.5 The Single Claim (SC) Screen (Institutional ERA)

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

Figure 3-3 is an example of an SC screen. While the AC screen shows information for multiple claims at once, the SC screen only shows one claim at a time. Use the arrow buttons in the PC-Print software to move from claim to claim.

In Figure 3-3, the SC screen has been divided into six separate sections for easy reference. The individual fields are described, by section, on the following pages.

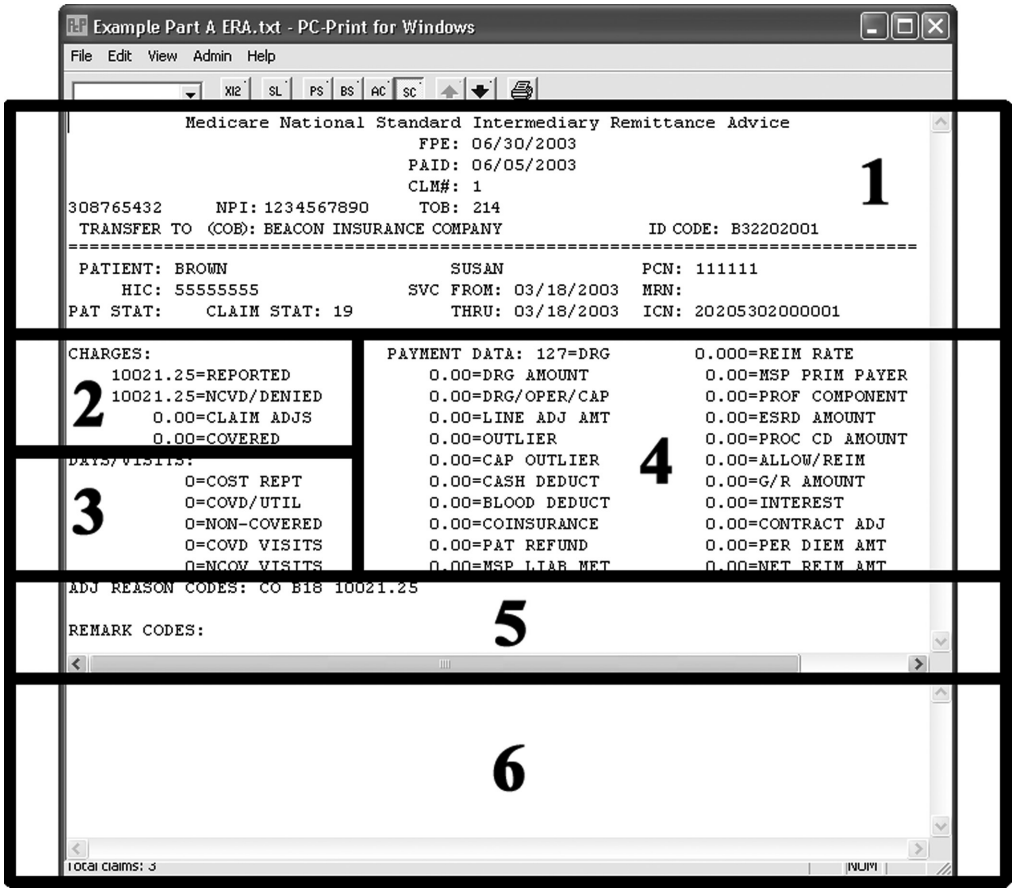


Figure 3-3. The Institutional ERA Single Claim (SC) Screen

NOTE: For an example of when Section 6 is populated, refer to Section 3.2.5.6.

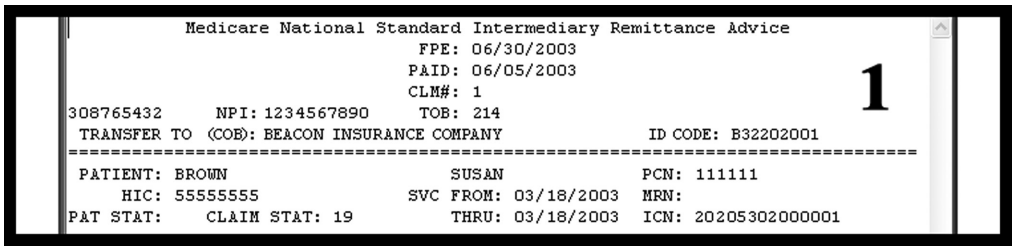


Figure 3-4. Header Information on the SC Screen

3.2.5.1 Section 1 of the SC Screen – Header Information (Institutional ERA)

FPE - This field reflects the provider's Fiscal Period End (FPE).

PAID - This field indicates the date the claim was paid.

CLM# - This field reflects the claim number assigned by PC-Print to each RAP/claim printed on the ERA. This number matches the claim number shown on the AC screen.

Medicare Provider Number - This field indicates the Medicare Provider Number of the provider receiving the ERA. The Medicare Provider Number is the number assigned to the provider for billing and identification purposes. This field is displayed without a field label. In Figure 3-4, the Medicare Provider Number is shown as "308765432".

NPI - This field displays the National Provider Identifier (NPI) of the facility receiving the ERA. The NPI is the number assigned to the provider for billing and identification purposes. For more information about the NPI, visit http://www.cms.gov/NationalProvIdentStand on the CMS website.

TOB - This field indicates the TOB with which the claim was processed. The value in this field is consistent with the value of the TOB=xxx field on the AC screen. See Tables 3-4 through 3-8 in Section 3.2.4.2 for details regarding the TOB code structure. Codes used for Medicare claims are available from Medicare Contractors. Codes are also available from the National Uniform Billing Committee (NUBC) in its official *UB-04 Data Specifications Manual* available at http://www.nubc.org on the Internet.

TRANSFER TO (COB) - Some claims, such as the claim shown in Figures 3-3 and 3-4, show this 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.

ID CODE - This field indicates the identification code of the supplemental Insurer in the TRANSFER TO (COB) field.

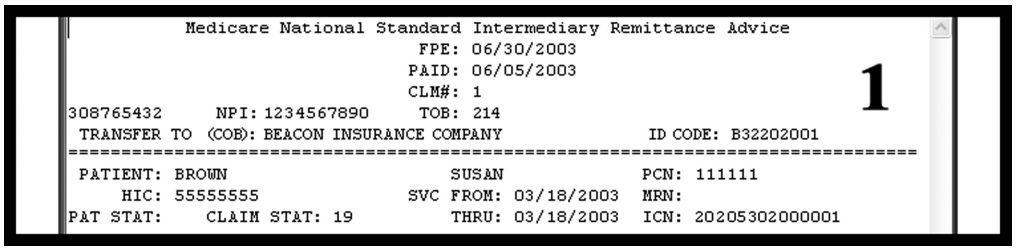
PATIENT - This field provides the beneficiary's last name, first name (may be first initial only), and middle initial (if known/ available) used in the processed claim.

HIC - This field indicates the HIC number with which the claim was processed.

PAT STAT - This field indicates the patient status code that was billed on the claim. Patient status codes appear only on ERAs for institutional inpatients, and indicate the beneficiary's status as of the through date of the billing period. For example, 01 indicates that the beneficiary was discharged to home.

For a Current List of Patient Status Codes

Patient status codes are available from Medicare Contractors. The most current list of patient status codes can also be found from the National Uniform Billing Committee (NUBC) in its official *UB-04 Data Specifications Manual* available at http://www.nubc.org on the Internet.



CLAIM STAT - This field indicates the status of the claim (i.e., the payment result when the claim completed processing). These numbers are consistent on both an ERA and an SPR. See Table 3-1 in Section 3.2.4.1 for codes used by Medicare to indicate the status of a processed claim.

SVC FROM - This field indicates the start date of services on the processed claim.

THRU - This field indicates the last date of services on the processed claim.

PCN - This field displays the Patient Control Number (PCN) that was submitted on the claim. The PCN is usually assigned by providers to each admission and provides an easy method for applying receipt of payment for a particular beneficiary.

MRN - This field displays the Medical Record Number (MRN) that was submitted on the claim. The MRN is used by providers as part of their own internal record keeping.

ICN - This field contains the Internal Control Number (ICN) assigned to the claim. The 14-digit ICN is a unique number assigned to the claim at the time it is received by the Medicare Contractor. It is used to track and monitor the claim. The first six digits reflect when the claim was received. The first digit is a century code ("1" indicates 1900-1999 and "2" indicates 2000 and after). The second two digits indicate the last two digits of the year that the claim was received. The next three digits indicate the day of the year the claim was submitted, out of 365 days (366 in a leap year). The last eight digits are a unique set of numbers assigned by Medicare Contractors.

> **EXAMPLE:** A claim with ICN number 20905302000001 would have been received on February 22, 2009.

3.2.5.2 Section 2 of the SC Screen - CHARGES (Institutional ERA)

REPORTED - This field shows the dollar amount of charges submitted by the provider or that are covered by Medicare. This amount does not necessarily impact the provider's reimbursement amount. **For cancel claims and RAPs (TOB XX8)**, this amount is negative.

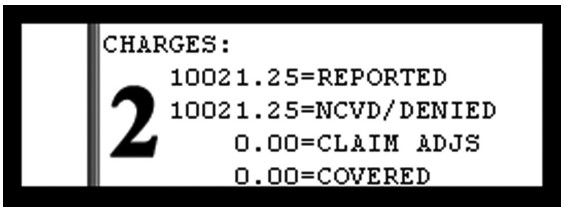


Figure 3-5. Charges Data on the SC Screen

NCVD/DENIED - This field identifies the dollar amount of non-covered or denied charges.

- **For all institutional provider types**, a dollar amount shows in this field when a claim has non-covered and/or denied charges at the line or claim level (except for Reason Codes A2, 1, 2, 23, 45, 66, 70, 89, 94, 118, and 122).
- **For providers subject to the OPPS**, an amount also shows in this field when a service is bundled and not separately reimbursable.
- **For CAHs**, an amount also shows in this field when the payment for this service is included in the allowance for the basic service/procedure.
- **For RDF providers**, services paid under the per diem/composite rate or under the ESRD PPS, effective on January 1, 2011, are not separately reimbursable.

To determine why the charges were non-covered/denied, see the ADJ REASON CODES and REMARK CODES fields on the SC screen in Section 3.2.5.5. The current codes may be found at http://www.wpc-edi.com/codes on the Internet.

CLAIM ADJS - This field reflects the claim-level adjustments.

- **For an inpatient hospital or SNF**, this amount is typically the difference between the COVERED amount and the DRG AMOUNT. If the amount of the COVERED is less than the DRG AMOUNT, this amount is negative.
- **For an outpatient hospital or home health provider**, the amount in this field reflects an outlier payment (see the OUTLIER field on the SC screen in Section 3.2.5.4). The outlier payment equals the difference between the ALLOW/REIM amount and the NET REIM AMT amount.
- **For other outpatient services**, this amount is negative.
- **For RHC, CAH, CORF, and swing bed claims**, this field shows a zero.
- **For outpatient SNF, RDF, CMHC, and other outpatient therapy claims**, this field also shows a zero.

COVERED - This field displays the dollar amount of covered charges. If all submitted services/visits are covered, this amount is the same as the amount in the REPORTED field. If any of the services/visits are non-covered/denied or reduced, this amount differs from the amount in the REPORTED field.

- **For cancel claims**, this amount is negative.
- **For denied claims**, this field displays a zero.
- **For RDFs**, the amount in the REPORTED field consistently does not match the amount in the COVERED field.

3.2.5.3 Section 3 of the SC Screen - DAYS/VISITS (Institutional ERA)

COST REPT - This field indicates the number of days used and applied to the Medicare Cost Report (MCR).

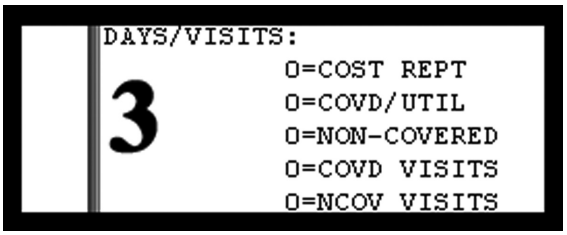


Figure 3-6. Days/Visits Data on the SC Screen

- A value displays in this field for **inpatient hospital, SNF, swing bed, and home health final claims**.
- This field does not apply to and shows a zero for **RHC, home health RAPs, hospice, outpatient hospital, outpatient SNF, CMHC, CORF, OPT, and RDF claims**.
- **For cancel claims**, this field is negative.
- **For claims that are denied or rejected**, this field shows a zero.

COVD/UTIL - This field indicates the number of covered days or visits (visits apply only **for home health providers**).

- **For claims that are denied or rejected**, this field shows a zero. The field also shows a zero when no payment can be made by Medicare. For example, if the beneficiary's primary insurance paid more than Medicare would have paid, no payment is made by Medicare.
- **For cancel claims**, this field is negative.
- **For home health RAPs**, this field shows a zero, but for **home health final claims**, it shows the number of covered visits.
- **For an inpatient hospital, SNF, and swing bed**, this value shows the number of covered days in the inpatient stay.
- **For outpatient services at a hospital, CMHC, SNF, RHC, RDF, CORF, and other outpatient therapies**, this field shows a zero.

NON-COVERED - This field identifies non-covered days/visits.

COVD VISITS - This field indicates the number of covered visits on this claim.

NCOV VISITS - This field indicates the number of non-covered visits or days (for inpatient care). Non-covered lines are submitted by the provider when it is known that the lines are not covered by Medicare. Providers do not anticipate payment on submitted non-covered lines.

- **For home health providers**, this field displays a value (that corresponds to the number of visits denied on the claim) when a visit has been denied by MR.
- **For an inpatient hospital and SNF**, this field displays a value when leave of absence days (revenue code 180) are billed and when a non-covered level of care (occurrence span code 74) is billed.
- **For an outpatient hospital**, this field shows a zero when the non-covered line is submitted by the provider.
- This field also displays a value when the beneficiary's primary insurer paid more than what Medicare would have paid (and thus, the lines/days are non-covered).

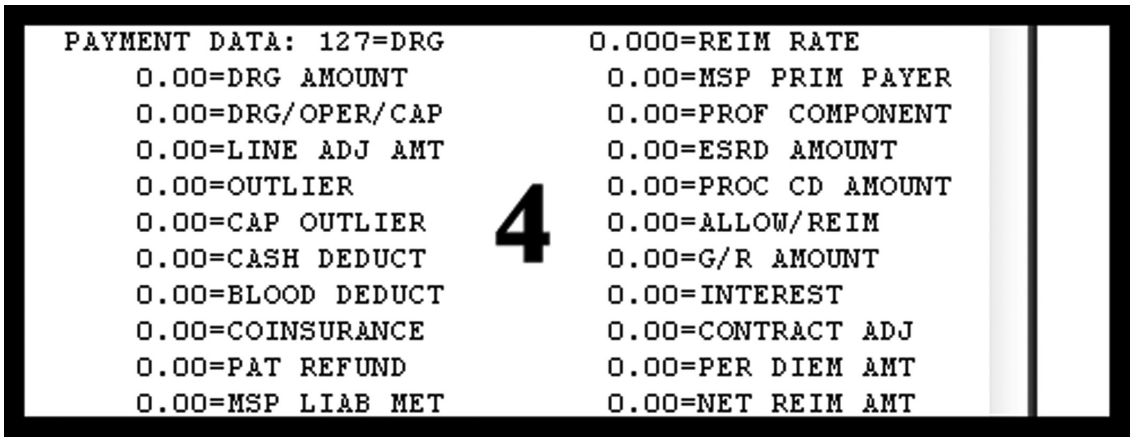


Figure 3-7. Payment Data Shown on the SC Screen

3.2.5.4 Section 4 of the SC Screen - PAYMENT DATA (Institutional ERA)

DRG - This field displays the DRG number for some Part A services. When the claim is for Part B services, this field is blank.

DRG AMOUNT - This field displays a dollar amount associated with the DRG number. This amount is calculated by the PRICER software.

- **For inpatient hospitals and SNFs**, this field displays an amount. If the claim is cancelled, this amount is negative.
- **For SNFs**, this is the dollar amount associated with the billed Medicare RUG.
- **For RHC, HHA, outpatient hospital, outpatient SNF, swing bed, CMHC, CORF, OPT, ESRD, and hospice claims**, this field shows a zero.

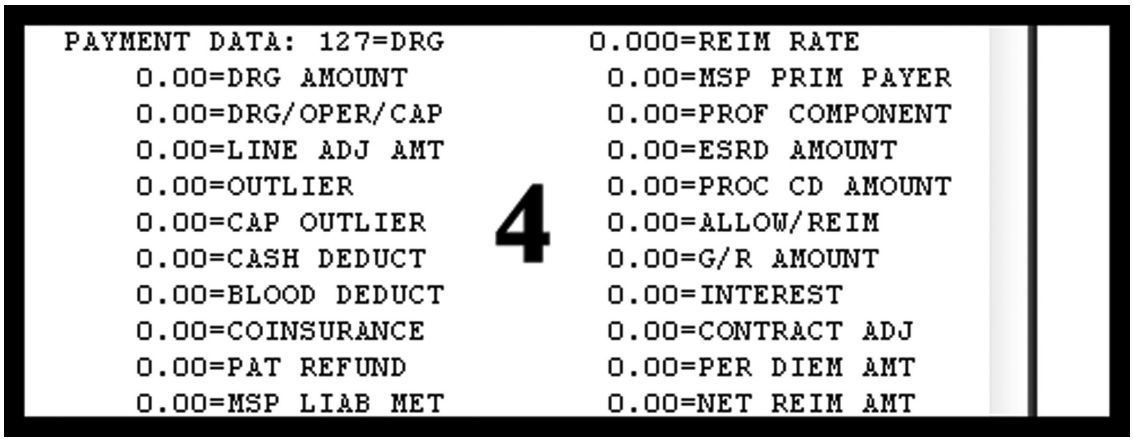
DRG/OPER/CAP - This field indicates the DRG operating capital dollar amount. This amount is factored into and is part of a hospital's PPS payment, and is based on operating costs and capital expenditures.

LINE ADJ AMT - This field indicates the total of line-item adjusted amounts. For some providers, this is the difference between the provider-billed amount (the REPORTED field in Section 2 of the SC screen) and the amount reimbursed by Medicare (NET REIM AMT field) for all revenue code lines less the coinsurance amount (COINSURANCE field) and the deductible amount (CASH DEDUCT field).

- **For RDF providers**, in addition to subtracting the coinsurance, the ESRD AMOUNT must also be subtracted.
- **For inpatient hospital and swing bed claims**, this field shows a zero.
- **For home health final claims**, the amount in this field is equal to the amount in the REPORTED field in Section 2 of the SC screen.
- **For paid RAPs and cancelled RAPs and claims**, this field shows a zero.

OUTLIER - This field reflects the dollar amount of outlier paid for a particular claim.

CAP OUTLIER - This field indicates the total outlier portions of PPS payments for capital expenditures. An amount shows in this field when an outlier was paid.



CASH DEDUCT - This field displays the dollar amount applied to the beneficiary's deductible. The beneficiary (or other insurer if applicable) is responsible for paying the provider the amount shown in this field. Deductibles vary by Medicare benefit (e.g., Part A hospital deductible, Part B deductible, blood deductible).

> **EXAMPLE:** Part A deductibles apply to hospitals. For 2010, there is a deductible of $1,100.00 for days 1-60 for each benefit period.

NOTE: Any services billed by an institutional provider, but paid from the Part B Medicare Trust Fund, may have a Part B deductible amount associated with this field. This is currently a yearly deductible amount of $155 for 2010. This has a Group Code of "PR". See Table 2-1 in Chapter 2 of this Guide for a list of Group Codes.

Deductible amounts are subject to change annually.

BLOOD DEDUCT - This field indicates the number of pints of blood that have been applied to the beneficiary's blood deductible.

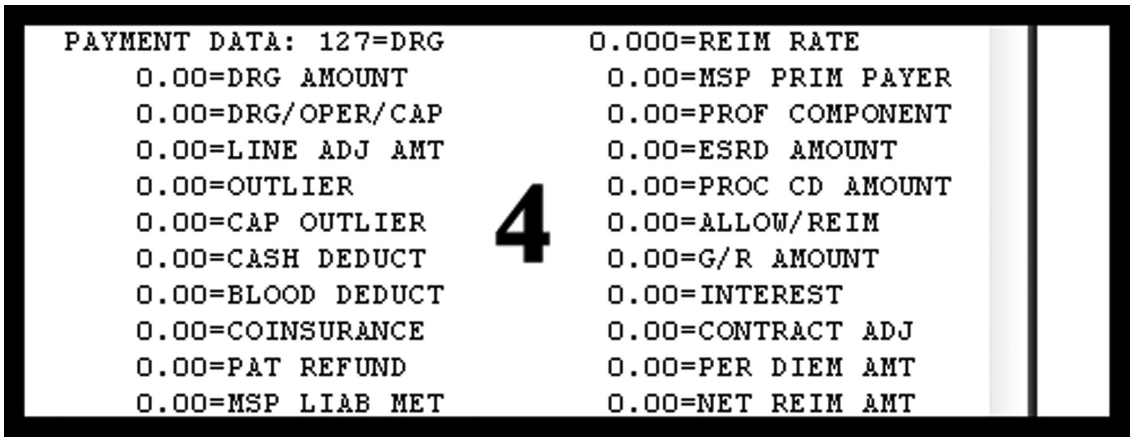
COINSURANCE - This field shows the total dollar amount of coinsurance for which the beneficiary is responsible. The beneficiary (or other insurer if applicable) is responsible for paying the provider the amount shown in this field.

- **For cancel claims**, this amount is negative.
- **For outpatient hospital, RDF, OPT, RHC or any other services in which a coinsurance would be applicable**, this field shows an amount.

> **EXAMPLE:** SNF coinsurance under Part A is $137.50 per day for 2010, which must be paid by the beneficiary for days 21-100 in the SNF. Medicare pays in full for days 1-20.

NOTE: Coinsurance amounts are subject to change annually.

PAT REFUND - This field indicates the beneficiary refund amount. This is the amount the provider owes the beneficiary for overpaid deductible and coinsurance.



MSP LIAB MET - This field indicates the amount of beneficiary and/or provider liability met by another payer for a claim if Medicare is the secondary payer. This amount includes deductible and coinsurance.

REIM RATE - This field identifies the per diem amount or percentage of reimbursement paid to a provider, depending on how the provider is reimbursed, for an individual claim. This value only applies to cost reimbursed services.

MSP PRIM PAYER - This field reflects the amount that the primary insurance paid for the services on this claim.

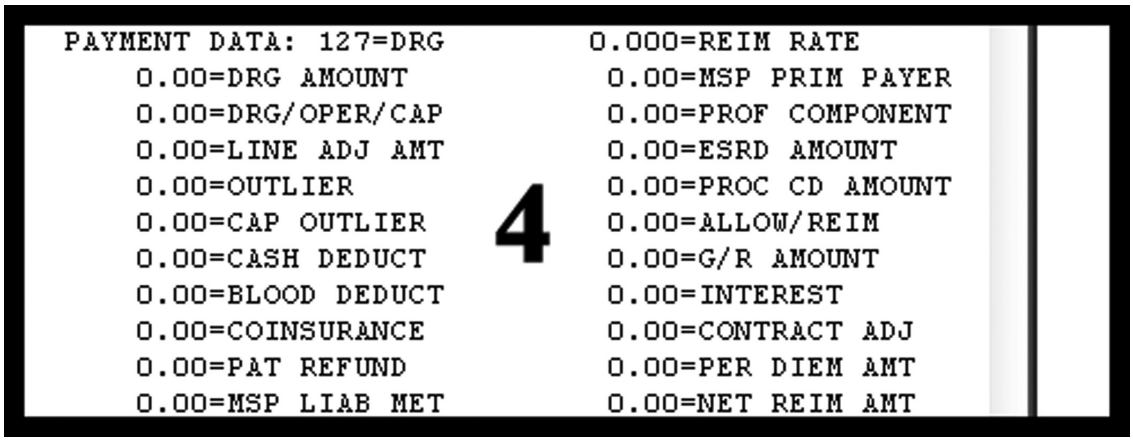
PROF COMPONENT - This field indicates whether a physician's professional component was billed on the claim as part of a technical component. This field **applies to CAHs** who have chosen the applicable payment methodology. This field shows the dollar amount of the billed professional component.

ESRD AMOUNT - This field indicates the ESRD Network Reduction amount and **only applies to RDFs**. This is the amount that Medicare's payment is reduced by to help fund the ESRD Network. The current amount is $.50 per covered session.

> **EXAMPLE:** A processed claim with six covered treatments shows an amount of $3.00 in the ESRD AMT field on the ERA.

PROC CD AMOUNT - This field indicates the procedure code amount.

- **For OPPS services**, this amount reflects the difference between the REPORTED and NCVD/DENIED fields in Section 2.
- **For outpatient services paid under the Medicare Physician Fee Schedule (MPFS)**, this is the total reimbursement amount for all of the covered services under the MPFS. For more information about the Medicare Physician Fee Schedule, go to http://www.cms.gov/PhysicianFeeSched on the CMS website.
- **For an RDF** paid under the per diem/composite rate for dates of service prior to January 1, 2011, this amount is the rate multiplied by the number of covered units.
- **For an RHC**, this amount is the covered charge.
- **For inpatient hospital, SNF, swing bed, and CAH claims**, this field shows a zero.



ALLOW/REIM - This field reflects the allowable reimbursement amount that the provider receives for the covered services, including any deductible for which the beneficiary is responsible.

G/R AMOUNT - This field previously indicated a Gramm-Rudman amount. However, Gramm-Rudman no longer applies. Therefore, this field shows a zero.

INTEREST - This field displays an amount when Medicare has paid interest on a claim. Interest is paid by Medicare when a clean claim is not paid in a timely manner.

CONTRACT ADJ - This field indicates an adjustment resulting from a contractual agreement between the payer and payee, or a regulatory requirement. Generally, these adjustments are considered a write-off for the provider and are not billed to the beneficiary. The Group Code “CO” is used for these adjustments.

PER DIEM AMT - This field identifies the per diem amount to be paid for an individual claim for providers who are reimbursed on a per diem basis. If the provider is reimbursed based on a percentage of charges, this field identifies the percentage. Few providers remain that are still reimbursed by per diem rates. Therefore, for most providers, this field shows a zero.

NET REIM AMT - This field indicates the net reimbursement amount the facility receives for the claim. This is the actual dollar amount that is paid.

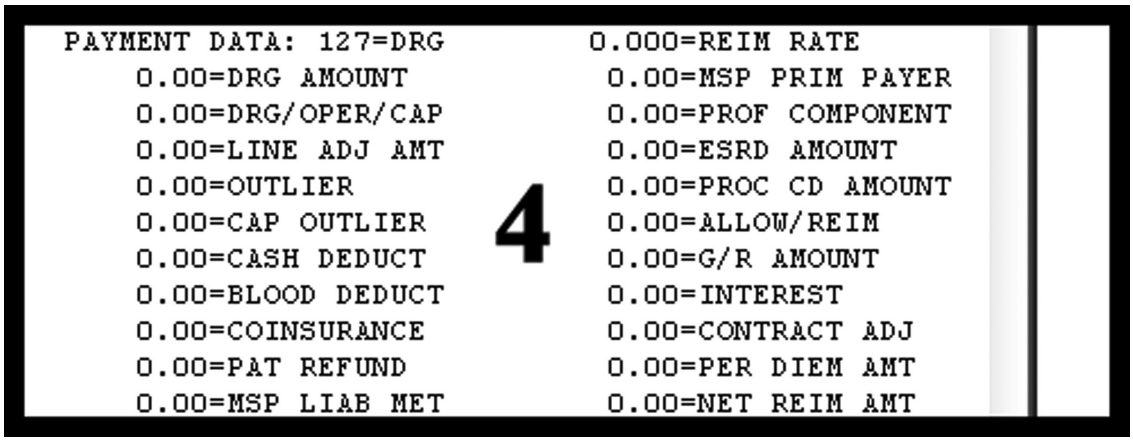
HHA and Hospice Claims Only Information

The next 12 field headers are unique to **HHAs or hospices** who have PC-Print version 2.01 or higher. These 12 fields replace the previous 9 fields seen by all other provider types and home health agencies or hospices who do not have PC-Print version 2.01 or higher: DRG, DRG AMOUNT, DRG/OPER/CAP, OUTLIER, CAP OUTLIER, BLOOD DEDUCT, PROF COMPONENT, ESRD AMOUNT, and PER DIEM AMT.

HHA SN AMT - An amount shows in this field only when a home health provider is paid on a per visit basis for SN visits (i.e., for LUPA claims). For claims paid under the Home Health Prospective Payment System (HHPPS), this field shows a zero.

HHA PT AMT - An amount shows in this field only when a home health provider is paid on a per visit basis for PT visits. For claims paid under HHPPS, this field shows a zero.

HHA ST AMT - An amount shows in this field only when a home health provider is paid on a per visit basis for ST visits. For claims paid under HHPPS, this field shows a zero.



HHA OT AMT - An amount shows in this field only when a home health provider is paid on a per visit basis for OT visits. For claims paid under HHPPS, this field shows a zero.

HHA MS AMT - An amount shows in this field only when a home health provider is paid on a per visit basis for MS worker visits. For claims paid under HHPPS, this field shows a zero.

HHA NA AMT - An amount shows in this field only when a home health provider is paid on a per visit basis for NA visits. For claims paid under HHPPS, this field shows a zero.

HSP ROUT CARE - This is not a valid field for home health providers and shows a zero.

HSP CONT CARE - This is not a valid field for home health providers and shows a zero.

HSP GENERAL - This is not a valid field for home health providers and shows a zero.

HSP RESPITE - This is not a valid field for home health providers and shows a zero.

HSP PHYS SVC - This is not a valid field for home health providers and shows a zero.

HSP OTH - This is not a valid field for home health providers and shows a zero.

Figure 3-8. Space for Claim Adjustment Reason Codes and Remittance Advice Remark Codes on the SC Screen

3.2.5.5 Section 5 of the SC Screen (Institutional ERA)

Section 5 contains space where Group Codes, Claim Adjustment Reason Codes (CARCs), and Remittance Advice Remark Codes (RARCs) for institutional providers generally appear.

For a Current List of CARCs and RARCs

Providers can review a full list of Claim Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs) to find important information regarding claims adjustments. The current codes may be found at http://www.wpc-edi.com/codes on the Internet.

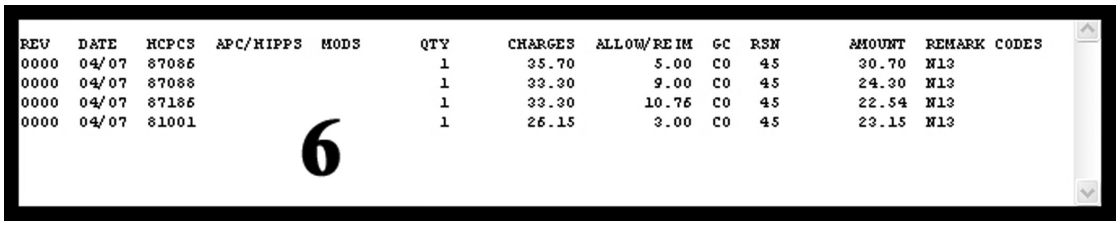


Figure 3-9. Service-Line Level Detail Portion of the SC Screen

3.2.5.6 Section 6 of the SC Screen (Institutional ERA)

Section 6 contains a breakout of charges and adjustments for a single claim on a service-line level. **Section 6 only contains data for SNF or HHA claims.** These fields only appear when an institutional provider submitted Part B charges (see Figure 3-9). The first row is column headings, and subsequent rows contain data for each service line submitted on that claim. Claim Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs) based on a service-line level may be found in this section. To access the most current code lists, visit http://www.wpc-edi.com/codes on the Internet.

REV - This field displays the specific revenue code for the individual service line. A revenue code is a 4-digit code that describes the service being provided.

DATE - This field indicates the date of service (MM/DD).

HCPCS - This field indicates the Healthcare Common Procedure Coding System (HCPCS) code, if applicable.

APC/HIPPS - This field indicates the Ambulatory Payment Classification (APC) and/or Health Insurance Prospective Payment System (HIPPS) code, if applicable.

MODS - This field displays modifiers that add specification to the HCPCS categorization.

QTY - This field displays a number indicating how many services were billed per procedure code.

CHARGES - This field indicates the billed amount per procedure.

ALLOW/REIM - This field indicates the allowed amount per procedure, or the reimbursement amount for the HCPCS code. This amount is based on different Fee Schedules, based on provider type.

GC - This field displays the Group Code, if applicable. For more information on Group Codes, see Chapter 2, Section 2.2 of this Guide.

RSN - This field displays the Claim Adjustment Reason Code (CARC) for this service line, if applicable. *CARCs supply providers with important information regarding claims adjustments. A full list of CARCs may be found at http://www.wpc-edi.com/codes on the Internet.*

AMOUNT - This field indicates the amount of any adjustment to what was billed. This amount is the difference between the amount in the CHARGES field and the amount in the ALLOW/REIM field.

REMARK CODES - This field displays any Remittance Advice Remark Codes (RARCs) associated with this service-line level item. *RARCs provide more information about adjustments made to the claim by adding specificity to the CARCs. A full list of RARCs may be found at http://www.wpc-edi.com/codes on the Internet.*

3.2.6 The Bill Type Summary (BS) Screen (Institutional ERA)

Each BS screen provides a summary of claims billed for each TOB, for each provider number, and for each FY. For example, if an HHA billed 32X and 33X claims, for FY 09 and FY 10, it would receive the following FOUR billing summaries:

- TOB 32X for FY 09
- TOB 32X for FY 10
- TOB 33X for FY 09
- TOB 33X for FY 10

The provider only receives a bill summary for those TOBs that were processed on this ERA. Therefore, if only 32X claims for FY 10 were processed on this ERA, the HHA only receives one bill summary.

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

Figure 3-10 provides an example of a BS screen. The screen has been divided into four separate sections for easy reference. The individual fields are described, by section, on the following pages.

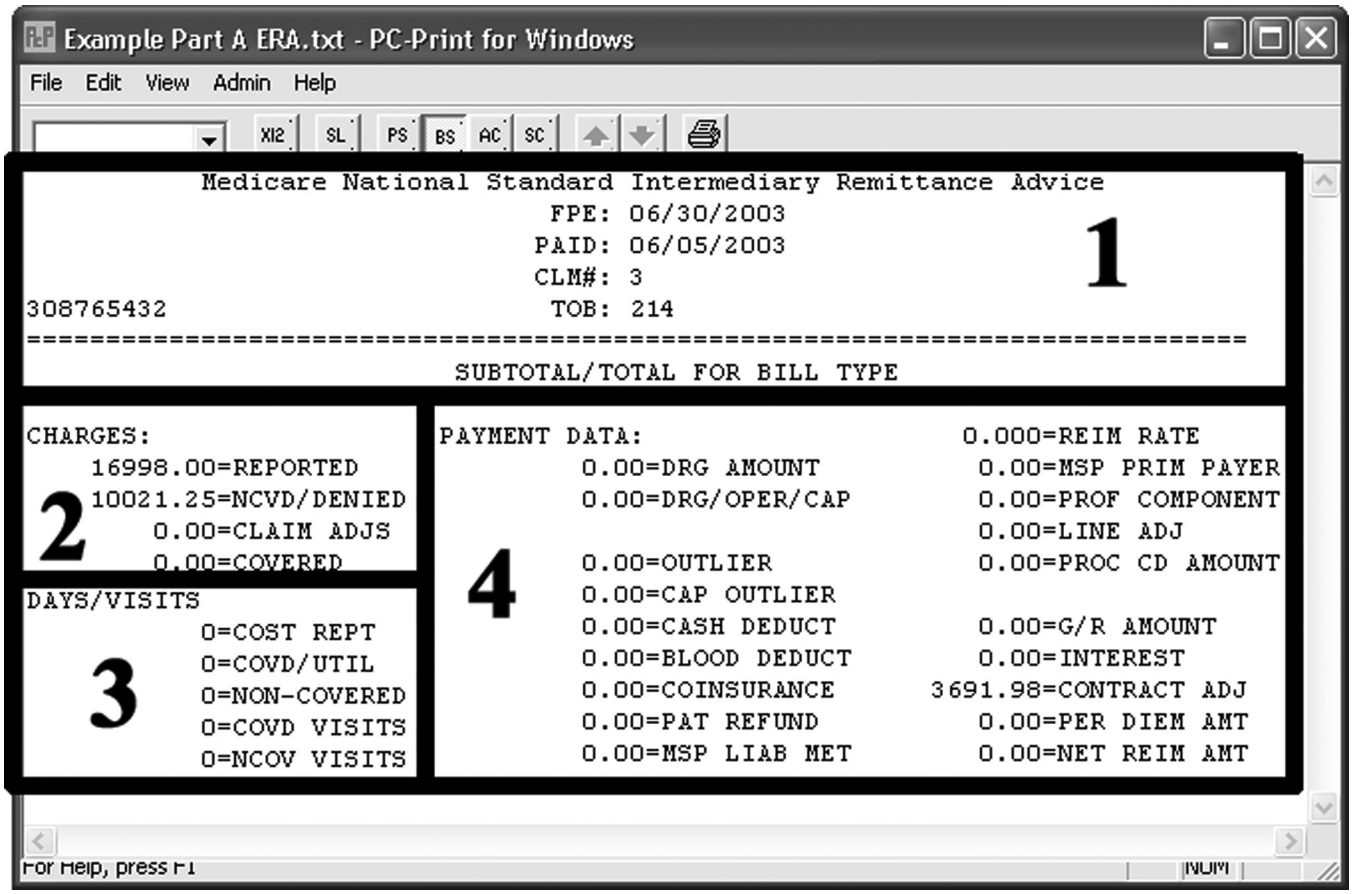


Figure 3-10. The Institutional ERA Bill Type Summary (BS) Screen

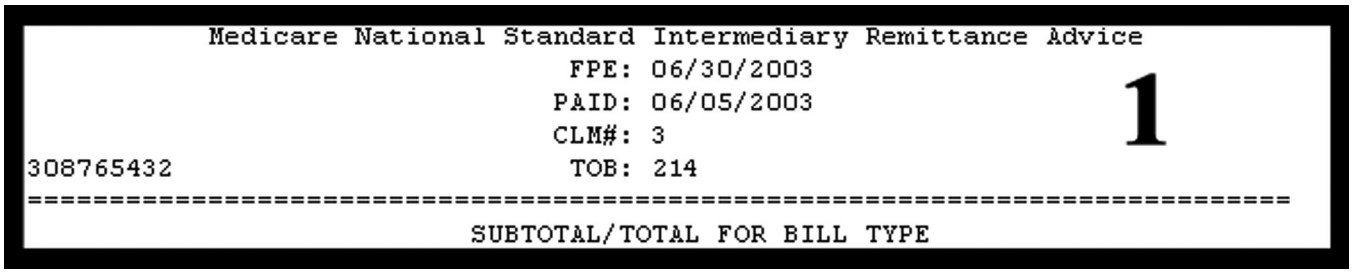


Figure 3-11. Header Information on the BS Screen

3.2.6.1 Section 1 of the BS Screen (Institutional ERA)

FPE - This field reflects the provider's Fiscal Period End (FPE).

PAID - This field indicates the date the claims were paid.

CLM# - This field reflects the total number of claims for which this BS contains data. For example, on a BS that has "32" in the TOB field, and the CLM# indicates 9, this means that the BS contains data for the 9 claims processed with TOB 32X.

Medicare Provider Number - The Medicare Provider Number is the number assigned to the provider for billing and identification purposes. This field is displayed without a field label. In Figure 3-11, the Medicare Provider Number is shown as "308765432".

> **NOTE:** The Medicare Provider Number has been replaced with the National Provider Identifier (NPI). For more information, visit http://www.cms.gov/NationalProvIdentStand on the CMS website.

TOB - This field indicates the TOB that the claim data reflects. For example, if the TOB field indicates "32", this means that the BS contains data for all claims processed with TOB 32X. The TOB is a 3-digit alphanumeric code that identifies what type of provider is billing and in what sequence. For more information on the code structure for the TOB, see Tables 3-4 through 3-8 in Section 3.2.4.2. Codes used for Medicare claims are available from Medicare Contractors. Codes are also available from the National Uniform Billing Committee (NUBC) in its official *UB-04 Data Specifications Manual* available at http://www.nubc.org on the Internet.

3.2.6.2 Section 2 of the BS Screen - CHARGES (Institutional ERA)

REPORTED - This field reflects the total dollar amount on this ERA for claims that the provider submitted with this TOB. This amount is the sum of the amounts in the REPTD CHGS field on the AC screen for claims on the ERA with this TOB.

NCVD/DENIED - This field reflects the total dollar amount of non-covered or denied charges for claims on this ERA with this TOB. This amount is the sum of the amounts in the NVCD/DENIED field on the AC screen for claims with this TOB.

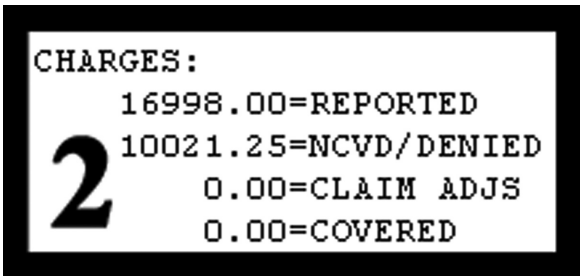


Figure 3-12. Charges Data on the BS Screen

CLAIM ADJS - This field reflects the total dollar amount of claim-level adjustments for claims on this ERA with this TOB. This amount is the sum of the amounts in the CLAIM ADJS field on the AC screen for claims with this TOB.

COVERED - This field reflects the total dollar amount of covered charges for claims on this ERA with this TOB. This amount is the sum of the amounts in the COVD CHGS field on the AC screen for claims with this TOB.

3.2.6.3 Section 3 of the BS Screen - DAYS/VISITS (Institutional ERA)

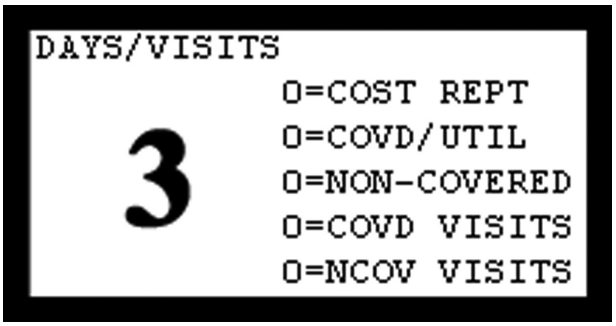


Figure 3-13. Days/Visits Data on the BS Screen

COST REPT - This field reflects the total number of days used and applied to the MCR. This amount is determined by the sum of the values in the COST field on the AC screen for claims with this TOB.

COVD/UTIL - This field indicates the total number of covered/utilized days or visits. This amount is determined by the sum of the values in the CV LN field on the AC screen for claims with this TOB.

NON-COVERED - This field identifies the total number of non-covered days/visits for this TOB. This is the total of the NCVDV fields on the AC screen for claims with this TOB.

COVD VISITS - This field indicates the number of covered visits with this TOB.

NCOV VISITS - This field indicates the total number of non-covered visits or days (for inpatient care) for this TOB. This is the total of the NCV L fields on the AC screen for claims with this TOB.

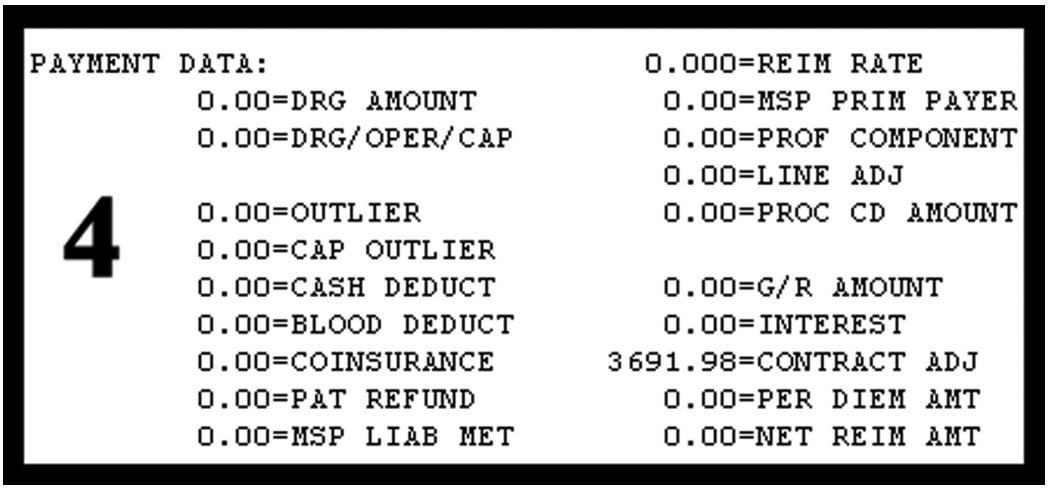


Figure 3-14. Payment Data on the BS Screen

3.2.6.4 Section 4 of the BS Screen - PAYMENT DATA (Institutional ERA)

DRG AMOUNT - This field reflects the total DRG amount for this TOB. This amount is calculated by totaling the amounts in the DRG AMOUNT field on the AC screen for claims with this TOB.

DRG/OPER/CAP - This field indicates the total operating and capital DRG amount for this TOB. This amount is calculated by totaling the amounts in the DRG O-C field on the AC screen for claims with this TOB.

OUTLIER - This field displays the total outlier amount paid for this TOB. This field is the sum of the outlier amounts shown in the CLAIM ADJS field on the AC screen for claims with this TOB.

CAP OUTLIER - This field displays the total outlier portions of PPS payments for capital. An amount shows in this field when an outlier was paid on one or more of the claims processed on this ERA.

CASH DEDUCT - This field indicates the total cash deductible for this TOB. The amount in this field is the sum of the amounts in the DEDUCTIBLES field on the AC screen for claims with this TOB.

BLOOD DEDUCT - This field indicates the total number of pints of blood that have been applied to the beneficiary's blood deductible for this TOB.

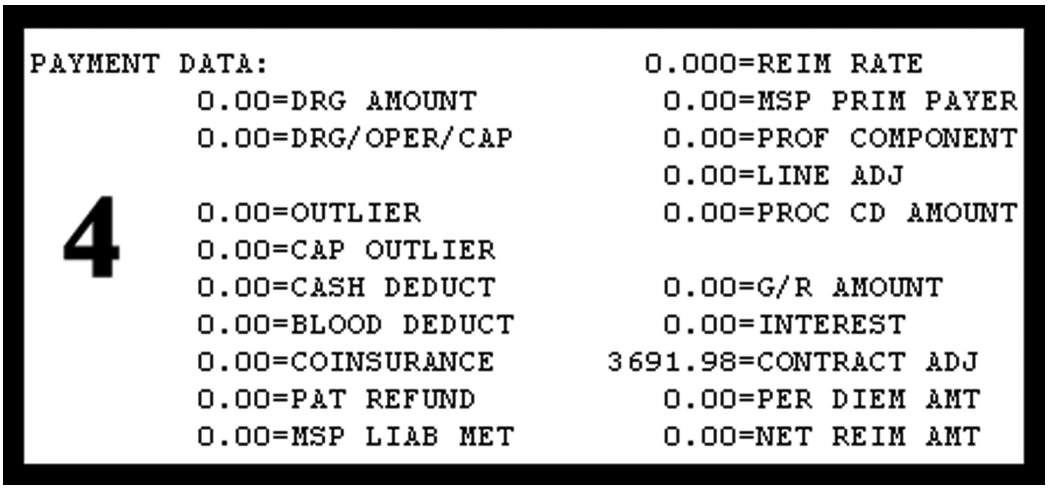
COINSURANCE - This field reflects the total coinsurance. The amount in this field is the sum of the amounts shown in the COINS AMT field on the AC screen for claims with this TOB.

PAT REFUND - This field indicates the total beneficiary refund amount for this TOB. This amount is the sum of the amounts shown in the PAT REFUND field on the AC screen for claims with this TOB.

MSP LIAB MET - This field indicates the total amount of beneficiary and/or provider liability met by another payer for this TOB. This amount is the sum of the amounts in the MSP LIAB MET field on the AC screen for claims with this TOB.

REIM RATE - This field indicates the overall percentage reimbursement rate for this TOB.

MSP PRIM PAYER - This field indicates the total MSP primary payer amount paid for claims with this TOB. This amount is the sum of the amounts shown in the MSP PRI PAY field on the AC screen for claims with this TOB.



PROF COMPONENT - This field indicates the total professional component amount for this TOB. This amount is the sum of the amounts shown in the PROF COMP field on the AC screen for claims with this TOB.

LINE ADJ - This field reflects the total line adjustment amount for this TOB. This amount is determined by totaling the amounts in the LINE ADJ AMT field on the AC screen for claims with this TOB.

PROC CD AMOUNT - This field reflects the total procedure code amount for this TOB. This amount is calculated by totaling the amounts in the PROC CD AMT fields on the AC screen for claims with this TOB.

G/R AMOUNT - This field previously indicated a Gramm-Rudman amount. However, Gramm-Rudman no longer applies. Therefore, this field shows a zero.

INTEREST - This field reflects the total amount of interest paid to the provider for this TOB. This amount is the sum of the amounts in the INTEREST field on the AC screen for claims with this TOB.

CONTRACT ADJ - This field indicates the total contractual adjustment amount. This amount is the sum of the amounts in the CONT ADJ AMT field on the AC screen for claims with this TOB.

PER DIEM AMT - This field indicates the total per diem amount for this TOB. This amount is calculated by totaling the amounts in the PERDIEM AMT field on the AC screen for claims with this TOB.

NET REIM AMT - This field indicates the total net reimbursement amount for this TOB. This amount is calculated by totaling the amounts in the NET. REIMB field on the AC screen for claims with this TOB.

3.2.7 The Provider Payment Summary (PS) Screen (Institutional ERA)

The Provider Payment Summary (PS) screen provides a summary of the provider's payments on an ERA, regardless of the TOB or FYE. Therefore, if a claim is billed using more than one provider number, a PS screen displays for each provider number.

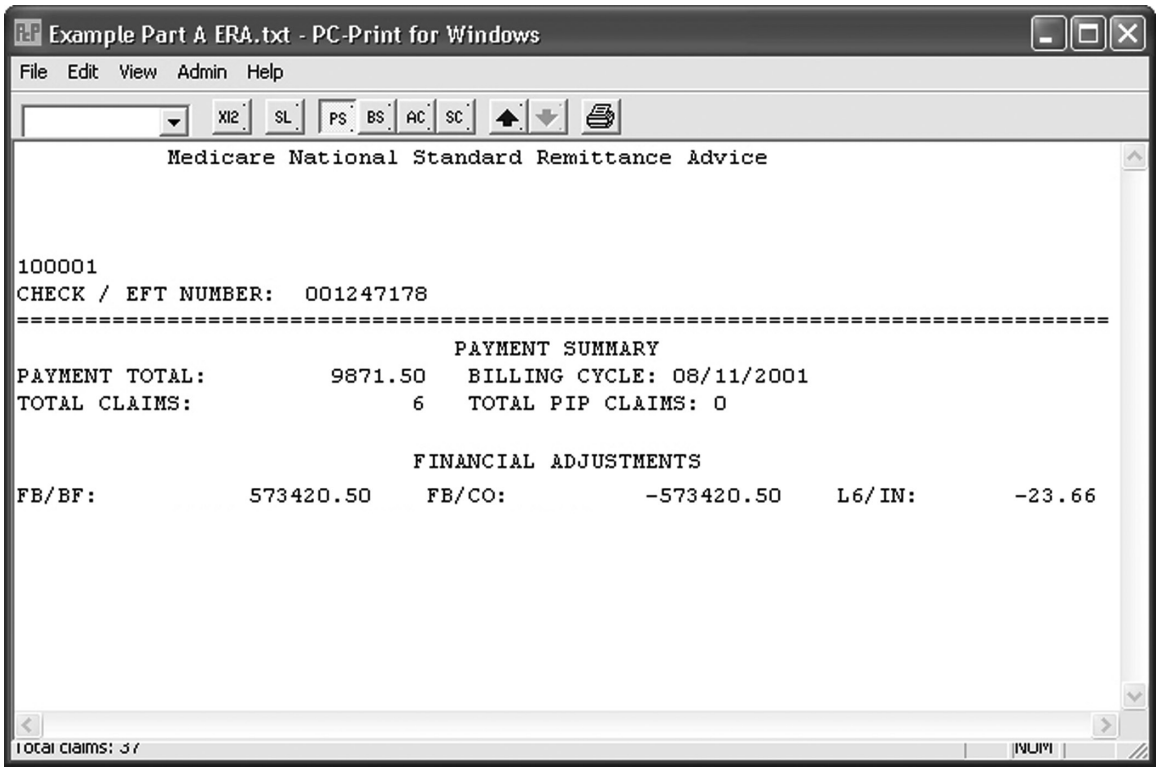


Figure 3-15. The Institutional ERA Provider Payment Summary (PS) Screen

CHECK / EFT NUMBER - This field provides the check number or Electronic Fund Transfer (EFT) number of the payment issued to the provider. If a paper check was issued, the check number begins with a zero. If the payment was issued through an EFT, the number begins with "EFT". If a provider has a no-pay remittance produced (i.e., no payment is being issued for the ERA), a sequential remittance number is displayed in this field.

PAYMENT TOTAL - This field provides the actual dollar amount that the provider receives. If a negative amount shows in this field, the amount is withheld from payment on the provider's next ERA.

TOTAL CLAIMS - This field indicates the number of claims processed and included on an ERA.

BILLING CYCLE - This field indicates the billing cycle date.

TOTAL PIP CLAIMS - This field indicates the total amount of Periodic Interim Payments (PIPs). This field only applies to providers that have elected to receive PIPs.

FINANCIAL ADJUSTMENTS - This field is used to list any provider-level adjustments that were made on the ERA. Table 3-9 lists the various Provider-Level Adjustment Reason Codes that may be used on an Institutional ERA. For a complete listing of Provider-Level Adjustment Reason Codes, refer to the *ASC X12N 835 Implementation Guide: Health Care Claim Payment/Advice*, available at http://www.wpc-edi.com/hipaa on the Internet.

NOTE: 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.

Table 3-9. Institutional ERA Provider-Level Adjustment Reason Codes

Provider-Level Adjustment Reason Code	Definition	Use
50	Late Charge	Used to identify Late Claim Filing Penalty or Medicare Late Cost Report Penalty. Code "LR" appears on an Institutional RA for a late cost report penalty (e.g., 50/LR).
51	Interest Penalty Charge	Used to identify the interest assessment for late filing. Code "IP" appears on an Institutional RA (e.g., 51/IP).
72	Authorized Return	Used to identify a refund adjustment to a provider (from a previous overpayment). Code "PR" appears on an Institutional RA (e.g., 72/PR). This adjustment should be a negative value and always be offset by some other provider-level adjustment referring to the original refund request or reason.
90	Early Payment Allowance	Used to identify an early payment allowance.
AM	Applied to Borrower's Account	Used to identify the loan repayment amount from a capitated provider for previously purchased equipment.
AP	Acceleration of Benefits	Used to reflect accelerated payment amounts or withholdings. A positive value represents a withholding. A negative value represents a payment. Code "AP" appears on an Institutional RA for "accelerated payment amounts" (e.g., AP/AP) and code "AW" for "accelerated payment withholdings" (e.g., AP/AW).
B2	Rebate	Used for the refund adjustment. Code "RF" appears on an Institutional RA (e.g., B2/RF).
B3	Recovery Allowance	Differs from Code 72. Used to represent the check received from the provider for overpayments generated by payments from other payers. Code "RA" appears on an Institutional Part A RA (e.g., B3/RA). Code "RB" appears on an Institutional Part B RA (e.g., B3/RB). This adjustment should be a negative value and always be offset by some other provider-level adjustment referring to the original refund request or reason.
BD	Bad Debt Adjustment	Used to reflect a bad debt passthrough. Code "BD" appears on an Institutional RA (e.g., BD/BD).
BN	Bonus	Used to reflect bonus payments to providers, usually to recognize performance above standards. This represents TOPS payments to institutional providers.

Provider-Level Adjustment Reason Code	Definition	Use
C5	Temporary Allowance	Used for tentative adjustments. Code “TS” appears on an Institutional RA (e.g., C5/TS).
CR	Capitation Interest	Used for interest payments to capitated providers as a result of late or previously withheld payments.
CS	Adjustment	Used to provide supporting identification. Code “CA” appears on an Institutional RA for “Manual Claim Adjustment” (e.g., CS/CA), and “AA” for “Receivable Today” (e.g., CS/AA). Code “RI” is used for Reissued Check Amount (e.g., CS/RI).
CT	Capitation Payment	Used to reflect a set dollar amount paid to a capitated provider.
CV	Capital Passthru	Used to reflect a capital passthrough. Code “CP” appears on an Institutional RA (e.g., CV/CP).
CW	Certified Registered Nurse Anesthetist Passthru	Used to reflect a certified registered nurse anesthetist passthrough. Code “CR” appears on an Institutional RA (e.g., CW/CR).
DM	Direct Medical Education Passthru	Used to reflect a direct medical education passthrough. Code “DM” appears on an Institutional RA (e.g., DM/DM).
E3	Withholding	Used to reflect a withholding of a set dollar amount or a percentage of a capitation payment, to be paid later, usually as a result of meeting performance requirements. Code “CW” appears on an Institutional RA (e.g., E3/CW).
FB	Forwarding Balance	A negative value represents a balance moving forward to a future payment advice. A positive value represents a balance being applied from a previous RA. A reference number (the original ICN and HIC) is applied for tracking purposes. Code “BF” appears on an Institutional RA for negative values (e.g., FB/BF), and code “CO” for positive values (e.g., FB/CO).
FC	Fund Allocation	Used to distribute payments to capitated providers from funds designated for allocation. The specific fund should be identified on the RA.
GO	Graduate Medical Education Passthru	Used to reflect a graduate medical education passthrough. Code “GM” appears on an Institutional RA (e.g., GO/GM).
IP	Incentive Premium Payment	Used to reflect additional payments to capitated providers. These may be used to acknowledge high quality services, permit the provider to provide additional services, or as a financial incentive for a provider to participate in the capitated plan.
IR	Internal Revenue Service Withholding	Used for Internal Revenue Service withholdings.

Provider-Level Adjustment Reason Code	Definition	Use
IS	Interim Settlement	Used for the interim rate lump sum adjustment. Code "IR" appears on an Institutional RA (e.g., IS/IR).
J1	Nonreimbursable	Used to offset claim or service level data that reflects what could be paid if not for demonstration programs or other limitation that prevents issuance of payment. For example, this is used to zero balance provider payment for Centers of Excellence and Medicare Advantage RAs.
L3	Penalty	Used for the capitation-related penalty, penalty withholding, or penalty release adjustment. Code "PW" appears on an Institutional RA for "Penalty Withhold" (e.g., L3/PW), "RS" for "Penalty Release" (e.g., L3/RS), and "SW" for "Settlement Withhold" amount (e.g., L3/SW).
L6	Interest Owed	Used for the interest paid on claims on an RA. Code "IN" appears on an Institutional RA (e.g., L6/IN).
LE	Levy	Used for IRS Levy.
LS	Lump Sum	Used for a disproportionate share adjustment, indirect medical education passthrough, non-physician passthrough, passthrough lump sum adjustment, or other passthrough amount. Code "DS" appears on an Institutional RA for "Disproportionate Share Adjustment" (e.g., LS/DS), "IM" for "Indirect Medical Education Passthrough" (e.g., LS/IM), "NP" for "Non-physician Passthrough" (e.g., LS/NP), "PS" for "Passthrough Lump Sum" (e.g., LS/PS), and "PO" for "Other Passthrough" (e.g., LS/PO).
OA	Organ Acquisition Passthru	Used to reflect an organ acquisition passthrough. Code "KA" appears on an Institutional RA (e.g., OA/KA).
OB	Offset for Affiliated Providers	Used to reflect an offset for affiliated providers. Code "OA" appears on an Institutional Part A benefit RA (e.g., OB/OA). Code "OB" appears on an Institutional Part B benefit RA (e.g., OB/OB).
PI	Periodic Interim Payment	Used for the PIP lump sum, PIP payment, or adjustment after PIP. Payments are reflected by a negative value; adjustments are reflected by a positive value. Code "PL" appears on an Institutional RA for "PIP Lump Sum" (e.g., PI/PL), "PP" for "PIP Payment" (e.g., PI/PP), and "PA" for "Adjustment After PIP" (e.g., PI/PA).
PL	Payment Final	Used for final settlement. Code "FS" appears on an Institutional RA (e.g., PL/FS).

Provider-Level Adjustment Reason Code	Definition	Use
RA	Retro-activity Adjustment	Used for capitated providers to represent adjustments due to late notification of beneficiary disenrollment from capitated plan prior to service date. Code “TR” appears on an Institutional RA (e.g., RA/TR).
RE	Return on Equity	Used to reflect a return on equity. Code “RE” appears on an Institutional RA (e.g., RE/RE).
SL	Student Loan Repayment	Used to represent a student loan repayment.
TL	Third Party Liability	Used to adjust capitation payments when another payer is responsible for payment of health care expenses.
WO	Overpayment Recovery	Used to recover previous overpayment. A reference number (the original ICN and HIC) is applied for tracking purposes. Code “OR” appears on an Institutional RA (e.g., WO/OR).
WU	Unspecified Recovery	Used for outside recovery adjustment. Code “OS” appears on an Institutional RA (e.g., WU/OS).
ZZ	Mutually Defined	Used to report hemophilia clotting factor supplement amount until data maintenance approved by ASC X12.

3.3 READING AN INSTITUTIONAL STANDARD PAPER REMITTANCE ADVICE (SPR)

3.3.1 SPR Basics

Providers who still elect to receive a paper Remittance Advice (RA) receive the Standard Paper Remittance Advice (SPR). Recipients of an SPR receive the same critical remittance information as recipients of the Electronic Remittance Advice (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 (e.g., hospitals) look different than those received by professional providers (e.g., physicians). Additionally, SPR formats may vary by the Medicare Contractor that provides the SPR. Figures (example SPRs) in this section are shown as a reference, and may vary from what providers actually see.

NOTE: In the remainder of this section, Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), and Part A Medicare Administrative Contractors (MACs) are referred to as "Medicare Contractors".

3.3.2 How Does a Provider Switch from an SPR to an ERA?

If a provider currently receives SPRs and is interested in switching to ERAs, the provider should contact the Electronic Data Interchange (EDI) department of his or her Medicare Contractor.

3.3.2.1 Electronic Funds Transfer Forms

Electronic Funds Transfer (EFT) is the preferred method of payment. Medicare Contractors must keep a signed copy of Form CMS-588, Authorization Agreement for Electronic Funds Transfer, from each provider. Providers are not allowed to pick up checks, or have them delivered through next-day, express mail, and courier services except in special cases authorized by the Centers for Medicare & Medicaid Services (CMS).

3.3.2.2 ERA and EFT Advantages

Using the ERA saves time and increases productivity by providing electronic payment adjustment information that is portable, reusable, retrievable, and storable. The ERA can be exchanged between partners with much greater ease than a paper remittance. Advantages to using the ERA and EFT include:

- Faster communication and payment notification;
- Faster account reconciliation through electronic posting;
- Less paper generated;
- Lower operating costs;
- More detailed information;
- Access to data in a variety of formats through free Medicare-supported software;
- Elimination of lost checks and SPRs; and
- Less space needed for storage.

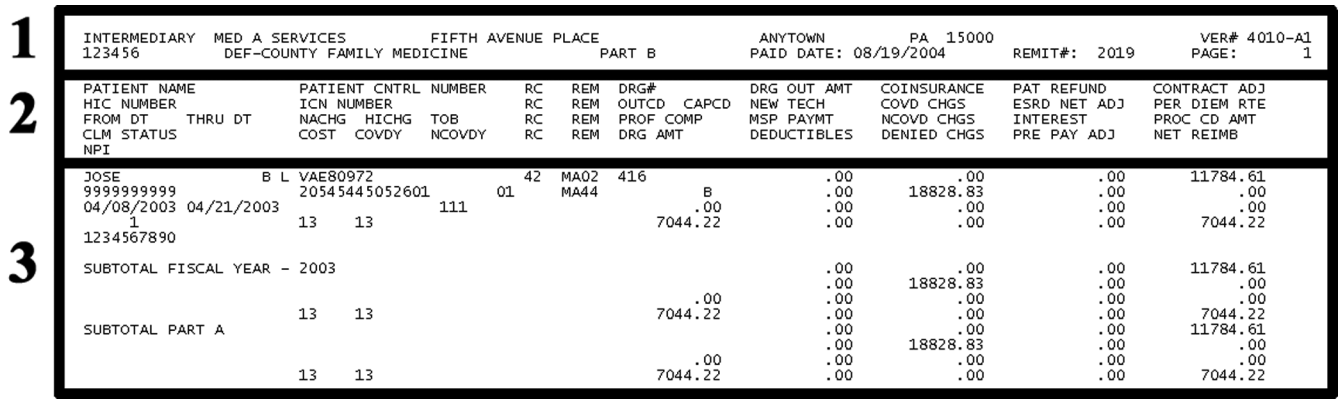
3.4 COMPONENTS OF AN INSTITUTIONAL STANDARD PAPER REMITTANCE ADVICE (SPR)

Institutional SPRs are split into two sections:

- **All Claims (AC) Page(s)** - These pages of the SPR provide detailed information for each individual claim, but not for the individual services included in a claim. Institutional providers who sometimes submit claims for Part B services (e.g., outpatient Skilled Nursing Facilities [SNFs]) may receive an RA with information regarding both Part A and Part B services. In this case, claims for Part A and Part B services are listed on separate pages of the SPR in the format described in this section.
- **Summary Page** - This page of the SPR provides information that spans all the claims included in the AC section of the SPR. For example, many of the fields in this section are totals of fields on the AC page(s).

3.4.1 The AC Page(s) (Institutional SPR)

The AC page(s) of Institutional SPRs provide a line-item account for each claim represented on the RA. Figure 3-16 is an example page from the AC section of an SPR. The lines and bold numbers on the left were added to designate particular sections of the SPR that are discussed on the following pages.



```
1
  INTERMEDIARY  MED A SERVICES          FIFTH AVENUE PLACE                ANYTOWN          PA  15000                    VER# 4010-A1
  123456          DEF-COUNTY FAMILY MEDICINE                 PART B      PAID DATE: 08/19/2004      REMIT#:  2019      PAGE:       1
2
  PATIENT NAME              PATIENT CNTRL NUMBER     RC   REM  DRG#          DRG OUT AMT    COINSURANCE     PAT REFUND      CONTRACT ADJ
  HIC NUMBER                ICN NUMBER               RC   REM  OUTCD  CAPCD  NEW TECH       COVD CHGS       ESRD NET ADJ    PER DIEM RTE
  FROM DT    THRU DT        NACHG  HICHG  TOB        RC   REM  PROF COMP     MSP PAYMT      NCOVD CHGS      INTEREST        PROC CD AMT
  CLM STATUS                COST   COVDY  NCOVDY     RC   REM  DRG AMT       DEDUCTIBLES    DENIED CHGS     PRE PAY ADJ     NET REIMB
  NPI
  JOSE                B L VAE80972                  42   MA02  416                .00            .00             .00             11784.61
  9999999999              20545445052601        01       MA44            B      .00          18828.83          .00              .00
  04/08/2003 04/21/2003                  111                      .00           .00            .00             .00              .00
      1                   13    13                          7044.22           .00            .00             .00             7044.22
  1234567890
3
  SUBTOTAL FISCAL YEAR - 2003                                                   .00            .00             .00             11784.61
                                                                                .00          18828.83          .00              .00
                                                                       .00      .00            .00             .00              .00
                          13    13                          7044.22           .00            .00             .00             7044.22
  SUBTOTAL PART A                                                               .00            .00             .00             11784.61
                                                                                .00          18828.83          .00              .00
                                                                       .00      .00            .00             .00              .00
                          13    13                          7044.22           .00            .00             .00             7044.22
```

Figure 3-16. An AC Page from an Institutional SPR

NOTE: Claims are grouped by Fiscal Year (FY). If multiple FYs are present on a single SPR, a FY subtotal appears after each group of claims. The "SUBTOTAL FISCAL YEAR - 2003" lines that appear at the bottom of Figure 3-16 are an example of this.

3.4.1.1 Section 1 of the AC Page (Institutional SPR)

Section 1 of Figure 3-16 shows the section of the SPR that contains general Medicare Contractor and provider information. The information contained in this section is header information for the SPR. This header information appears at the top of every page of the SPR. The only information that should change in this section for a given SPR is the page number.

Figure 3-17. Header Information from the AC Page of an Institutional SPR

The fields contained in this section are described in the following text. Some fields in this section do not contain labels (e.g., the paid date field is labeled "PAID DATE:" while the Medicare Contractor name is unlabeled). **These unlabeled fields are designated with an asterisk in the following field definitions.** There are two rows containing fields in this section of the Institutional SPR. The fields below are listed by line, from left to right.

NOTE: Version 004010A1 is the standard Health Insurance Portability and Accountability Act of 1996 (HIPAA) version for the ERA. The data contained in the SPR fields are designed to mirror the Version 004010A1 835.

More 835 Information

In January 2009, HHS approved the replacement of the 4010A1 versions of electronic transactions, including the 835, with the ASC X12 Version 5010. Medicare providers must be fully compliant with ASC X12 Version 5010 by January 1, 2012. Information and the latest news for the 5010 may be found at http://www.cms.gov/Versions5010andD0/01_overview.asp on the CMS website.

MEDICARE CONTRACTOR NAME* - This field lists the name of the Medicare Contractor that processed the claim(s) and produced the SPR.

STREET ADDRESS* - This field lists the street address of the Medicare Contractor.

CITY* - This field lists the city in which the Medicare Contractor is located.

STATE* - This field lists the state in which the Medicare Contractor is located.

ZIP CODE* - This field lists the Zip code of the Medicare Contractor.

PROVIDER #* - This field indicates the Medicare Provider Number of the provider receiving the SPR. The Medicare Provider Number is the number assigned to the provider for billing and identification purposes.

NOTE: The Medicare Provider Number has been replaced with the National Provider Identifier (NPI). For more information, visit http://www.cms.gov/NationalProvIdentStand on the CMS website.

PROVIDER NAME* - This field indicates the name of the provider receiving the SPR.

PART* - This field indicates the Medicare entitlement that this portion of the SPR addresses. For most inpatient services, this is "Part A". For outpatient services (and some inpatient services if the beneficiary has exhausted Part A benefits), this is "Part B".

PAID DATE - This field indicates the date that the claims represented on this SPR were paid.

REMIT # - This field is a unique number identifying this SPR.

PAGE - This field indicates the current page number of the SPR.

2

PATIENT NAME	PATIENT CNTRL NUMBER	RC	REM	DRG#	DRG OUT AMT	COINSURANCE	PAT REFUND	CONTRACT ADJ
HIC NUMBER	ICN NUMBER	RC	REM	OUTCD CAPCD	NEW TECH	COVD CHGS	ESRD NET ADJ	PER DIEM RTE
FROM DT THRU DT	NACHG HICHG TOB	RC	REM	PROF COMP	MSP PAYMT	NCOVD CHGS	INTEREST	PROC CD AMT
CLM STATUS	COST COVDY NCOVDY	RC	REM	DRG AMT	DEDUCTIBLES	DENIED CHGS	PRE PAY ADJ	NET REIMB
NPI								

3

JOSE B L	VAE80972	42	MA02	416	.00	.00	.00	11784.61
9999999999	20545445052601	01	MA44	B	.00	18828.83	.00	.00
04/08/2003 04/21/2003	111			.00	.00	.00	.00	.00
1	13 13			7044.22	.00	.00	.00	7044.22
1234567890								
SUBTOTAL FISCAL YEAR - 2003					.00	.00	.00	11784.61
					.00	18828.83	.00	.00
				.00	.00	.00	.00	.00
	13 13			7044.22	.00	.00	.00	7044.22
SUBTOTAL PART A					.00	.00	.00	11784.61
					.00	18828.83	.00	.00
				.00	.00	.00	.00	.00
	13 13			7044.22	.00	.00	.00	7044.22

Figure 3-18. Sections 2 and 3 from the AC Page of an Institutional SPR

3.4.1.2 Sections 2 and 3 of the AC Page (Institutional SPR)

The data for each claim in the AC page(s) of the SPR are contained in Section 3 of Figure 3-18. Each claim in Section 3 of Figure 3-18 consists of nine columns and four lines. Section 2 of Figure 3-18 is included on every SPR to provide a list of the fields that appears for each claim. Figure 3-19 shows this section with numbered column headers for easy reference. Claims displayed on the Institutional SPR are listed in alphabetical order by the beneficiary's last name.

Section 3 of Figure 3-18 also shows the subtotal sections on the SPR. Subtotals are provided for each FY. Sometimes institutional providers can bill Part B services. In this case, Part A and Part B (if applicable) information would be presented on separate pages of the SPR, with respective subtotals.

1	2	3	4	5	6	7	8	9
PATIENT NAME	PATIENT CNTRL NUMBER	RC	REM	DRG#	DRG OUT AMT	COINSURANCE	PAT REFUND	CONTRACT ADJ
HIC NUMBER	ICN NUMBER	RC	REM	OUTCD CAPCD	NEW TECH	COVD CHGS	ESRD NET ADJ	PER DIEM RTE
FROM DT THRU DT	NACHG HICHG TOB	RC	REM	PROF COMP	MSP PAYMT	NCOVD CHGS	INTEREST	PROC CD AMT
CLM STATUS	COST COVDY NCOVDY	RC	REM	DRG AMT	DEDUCTIBLES	DENIED CHGS	PRE PAY ADJ	NET REIMB
NPI								

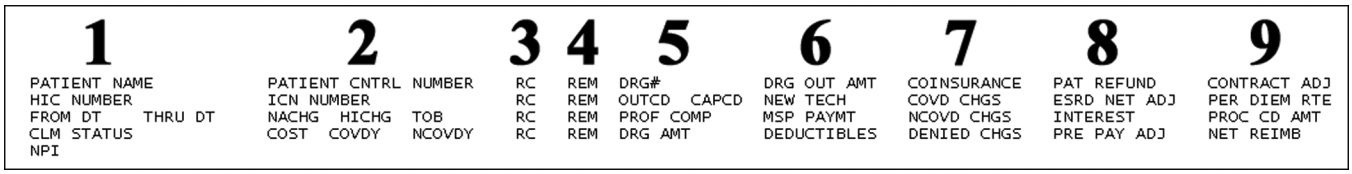
Figure 3-19. Individual Claim Fields Displayed in the AC Page

NOTE: The data contained in the SPR fields are designed to mirror the Version 004010A1 835.

3.4.1.3 Column 1 of the AC Page (Institutional SPR)

PATIENT NAME - This field contains the last name, first name (may be first initial only), and middle initial (if known/available) of the beneficiary for whom the claim was processed. If a claim was submitted by the provider using the name Jane Smith, but during processing Medicare records indicate the name of record for that beneficiary is listed as Jane Jones on the Common Working File (CWF), then the RA would show the name "Jones Jane" in this field. See the NACHG field description that follows.

HIC NUMBER - This field displays the Health Insurance Claim (HIC) number of the beneficiary for whom the claim was processed. For example, a claim was submitted by the provider using the HIC number 123456789A. If the beneficiary's HIC number was changed to 987654321B on the CWF, then the RA shows the HIC number 987654321B in this field. See the HICHG field description in Column 2.



FROM DT - This field indicates the start date of service on the processed claim.

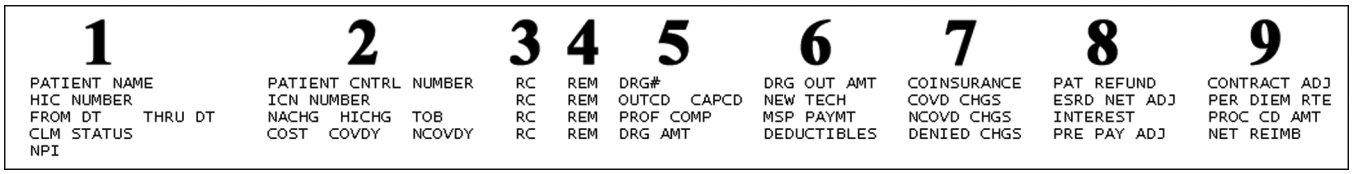
THRU DT - This field indicates the last date of service on the processed claim.

CLM STATUS - This field indicates the status of the claim (i.e., the payment result when the claim completed processing). These codes are consistent on both SPRs and ERAs. See Table 3-10 for codes used by Medicare to indicate the status of a processed claim.

Table 3-10. Claim Status Codes Used by Medicare

Code	Description
1	Paid as primary.
2	Paid as secondary.
3	Paid as tertiary.
4	Denied (this claim status shows when a claim is denied or rejected).
19	Medicare paid primary and the Intermediary sent the claim to another insurer.
20	Medicare paid secondary and the Intermediary sent the claim to another insurer.
21	Medicare paid tertiary and sent the claim to another insurer.
22	Adjustment to prior claim, reversal to previous payment [this claim status shows when a claim is cancelled (TOB XX8), including RAPs which have been autocancelled or cancelled by the provider].
23	Not a Medicare claim and the Intermediary sent claim to another insurer.

NPI - This field displays the National Provider Identifier (NPI) of the facility receiving the ERA. The NPI is the number assigned to the provider for billing and identification purposes. For more information about the NPI, visit http://www.cms.gov/NationalProvIdentStand on the CMS website.



3.4.1.4 Column 2 of the AC Page (Institutional SPR)

PATIENT CNTRL NUMBER - This field displays the Patient Control Number (PCN) that was submitted on the claim. The PCN is usually assigned by providers to each admission and provides an easy method for posting payments.

ICN NUMBER - This field displays the Internal Control Number (ICN). The 14-digit ICN is a unique number assigned to the claim at the time it is received by the Medicare Contractor. It is used to track and monitor the claim. The first six digits reflect when the claim was received. The first digit is a century code ("1" indicates 1900-1999 and "2" indicates 2000 and after). The second two digits indicate the last two digits of the year that the claim was received. The next three digits indicate the day of the year the claim was submitted, out of 365 days (366 in a leap year). The last eight digits are a unique set of numbers assigned by Medicare Contractors.

> **EXAMPLE:** A claim with ICN number 20905302000001 would have been received on February 22, 2009.

NACHG - This field indicates whether the beneficiary's name was changed during the processing of the claim. See Table 3-11 for the qualifiers associated with a beneficiary name change.

Table 3-11. Qualifiers Associated with Beneficiary Name Change

Qualifier	Description
QC	**No name change:** the name used to process the claim is the same as the name that was submitted on the claim.
74	**Name change:** the beneficiary's name was changed during the processing of the claim. The name the claim was processed with shows in the PATIENT NAME field.

HICHG - This field indicates whether the beneficiary's HIC number was changed during the processing of the claim. See Table 3-12 for the qualifiers associated with a beneficiary HIC number change.

Table 3-12. Qualifiers Associated with Beneficiary HIC Number Change

Qualifier	Description
N	**No HIC change:** the beneficiary's HIC number used to process the claim is the same as the HIC number that was submitted on the claim.
C	**HIC change:** the beneficiary's HIC number was changed during the processing of the claim. The HIC number the claim was processed with shows in the HIC NUMBER field. If the HIC number has changed, it is important to note the change for future reference.

TOB - This field indicates the Type of Bill (TOB) that the claim data reflects. The TOB is a 3-digit alphanumeric code that identifies what type of provider is billing and in what sequence. If the claim was denied or rejected, the TOB changes to XX0. See Tables 3-13 through 3-17 for details regarding the TOB code structure.[1]

[1] The Type of Bill (TOB) is technically a 4-digit code. For Medicare purposes, the leading zero is ignored, and the three pieces of information addressed by Tables 3-13 through 3-17 are used.

Codes used for Medicare claims are available from Medicare Contractors. Codes are also available from the National Uniform Billing Committee (NUBC) in its official *UB-04 Data Specifications Manual* available at http://www.nubc.org on the Internet.

Table 3-13. Type of Bill Code Structure – 1st Digit, Type of Facility[1]

Digit	Description
1	Hospital[2]
2	Skilled Nursing Facility (SNF)
3	Home Health
4	Religious Non-Medical (Hospital)
5	Reserved for National Assignment (Discontinued)
6	Intermediate Care
7	Clinic or Hospital Based Renal Dialysis Facility (Requires special information in second digit below)
8	Special Facility (Requires special information in second digit below)
9	Reserved for National Assignment

Table 3-14. Type of Bill Code Structure – 2nd Digit, Bill Classification (if first digit is 1-5)[1]

Digit	Description
1	Inpatient Part A
2	Inpatient (Part B) (Includes HHA visits under a Part B plan of treatment)
3	Outpatient or Free-Standing or Provider-based (Includes HHA visits under Part A plan of treatment and use of HHA DME under a Part A plan of treatment)
4	Other (Part B) (Includes HHA medical and other health services not under a plan of treatment, hospital and SNF for laboratory services for “non-patients”)
5	Intermediate Care - Level I
6	Intermediate Care - Level II
7	Reserved for National Assignment (Discontinued)
8	Swing bed (Used to indicate billing for SNF level of care in a hospital with an approved swing bed agreement)
9	Reserved for National Assignment

Table 3-15. Type of Bill Code Structure – 2nd Digit, Bill Classification (if first digit is 7)[1]

Digit	Description
1	Rural Health Clinic (RHC)
2	Hospital Based or Independent Renal Dialysis Facility
3	Clinic - Free-Standing (effective April 1, 2010)
4	Clinic Outpatient Physical Therapy (OPT)
5	Comprehensive Outpatient Rehabilitation Facility (CORF)
6	Community Mental Health Center (CMHC)

[1] The Type of Bill (TOB) is technically a 4-digit code. For Medicare purposes, the leading zero is ignored, and the three pieces of information addressed by Tables 3-13 through 3-17 are used.

[2] Hospital-based multi-unit complexes may also have use for the first digits 2-9 when billing non-hospital services: (e.g., hospital-based SNF).

Digit	Description
7	Federally Qualified Health Center (FQHC) (effective April 1, 2010)
8	Reserved for National Assignment
9	Other

Table 3-16. Type of Bill Code Structure – 2nd Digit, Bill Classification (if first digit is 8)[1]

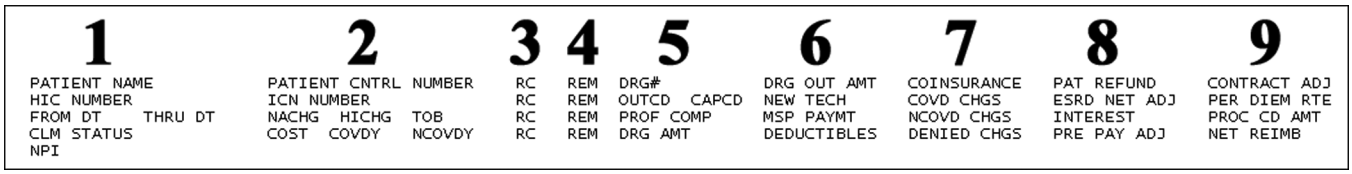
Digit	Description
1	Hospice (Non-Hospital Based)
2	Hospice (Hospital Based)
3	Ambulatory Surgical Center (ASC) Services to Hospital Outpatients
4	Free Standing Birthing Center
5	Critical Access Hospital (CAH)
6-8	Reserved for National Assignment
9	Other

Table 3-17. Type of Bill Code Structure – 3rd Digit, Frequency[1]

Digit	Description
A	Admission/Election Notice
B	Hospice/Medicare Coordinated Care Demonstration/Religious Non-Medical Health Care Institution – Termination/Revocation Notice
C	Hospice Change of Provider
D	Hospice/Medicare Coordinated Care Demonstration/Religious Non-Medical Health Care Institution – Void/Cancel
E	Hospice Change of Ownership
F-P	Adjustment Claims (Not initiated by Provider)
0	Non-Payment/Zero Claim
1	Admit Through Discharge Claim
2	Interim - First Claim [Also used for Home Health Prospective Payment System (HHPPS) Request for Anticipated Payment (RAP)]
3	Interim - Second and Continuing Claim(s) (Not valid for PPS bills. Exception: SNF PPS bills)
4	Interim - Last Claim (Not valid for PPS bills. Exception: SNF PPS bills)
5	Late Charge(s) Only
7	Replacement of Prior Claim (Initiated by Provider)
8	Void/Cancel of Prior Claim
9	Home Health Prospective Payment System (HHPPS) Episode Final Claim

EXAMPLE: In a 214 TOB, the "2" indicates a Skilled Nursing Facility (SNF); the "1" indicates an inpatient stay; and the "4" indicates that the beneficiary was discharged.

[1] The Type of Bill (TOB) is technically a 4-digit code. For Medicare purposes, the leading zero is ignored, and the three pieces of information addressed by Tables 3-13 through 3-17 are used.



COST - This field indicates the number of days used and applied to the Medicare Cost Report (MCR).

- A value displays in this field for **inpatient hospital, SNF, swing bed, and home health final claims**.
- This field does not apply to and shows a zero for **Rural Health Clinic (RHC), home health Request for Anticipated Payment (RAP), hospice, outpatient hospital, outpatient SNF, Community Mental Health Center (CMHC), Comprehensive Outpatient Rehabilitation Facility (CORF), Outpatient Physical Therapy (OPT), and Renal Dialysis Facility (RDF) claims**.
- **For cancel claims**, this field is negative.
- **For claims that are denied or rejected**, this field shows a zero.

COVDY - This field indicates the number of covered days or visits.

- A value shows in this field for **inpatient hospital, SNF, hospice, swing bed, and home health final claims**.
- This field does not apply to and shows a zero for **RHC, hospice, outpatient hospital, outpatient SNF, CMHC, CORF, OPT, RDF, and home health RAP claims**.
- **For cancel claims**, this field is negative.
- **For claims that are denied or rejected**, this field shows a zero.

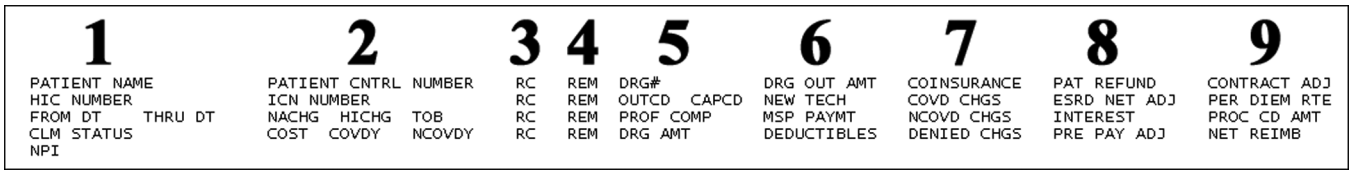
NCOVDY - This field shows the number of non-covered days or visits. Non-covered days or visits are submitted by the provider when it is known that days or visits are not covered by Medicare. Providers do not anticipate payment on non-covered days or visits they submit. A value appears in this field when the provider has submitted non-covered days or visits, or the day(s) or visit(s) was/were partially denied. A value appears in this field **for an inpatient hospital and a SNF**. A value also appears in this field **for home health final claims** in cases where partially denied services result in a Low Utilization Payment Adjustment (LUPA).

3.4.1.5 Column 3 of the AC Page (Institutional SPR)

RC - This column header field displays the Claim Adjustment Reason Codes (CARCs) associated with this claim. *CARCs supply providers with important information regarding claims adjustments. A full list of CARCs may be found at http://www.wpc-edi.com/codes on the Internet.*

3.4.1.6 Column 4 of the AC Page (Institutional SPR)

REM - This field displays Remittance Advice Remark Codes (RARCs). *RARCs provide more information about adjustments made to the claim by adding specificity to the CARCs. A full list of RARCs may be found at http://www.wpc-edi.com/codes on the Internet.*



3.4.1.7 Column 5 of the AC Page (Institutional SPR)

DRG # - This field provides the Diagnosis Related Group (DRG) number assigned to the claims. The DRG number is determined based on the age, sex, discharge status, principal diagnosis, secondary diagnosis, and procedures performed on the beneficiary.

- A value only appears in this field **for some inpatient hospitals**.

OUTCD - This field shows an outlier code of 70 to indicate when an operating Prospective Payment System (PPS) cost outlier was paid to a hospital provider. **This field does not apply to home health providers.**

CAPCD - This field indicates the capital pay code, specifying the provider's PPS capital payment code. **A value only appears in this field for hospital providers.** There are only three valid values for this field:

A - hold harmless - cost payment for old capital;

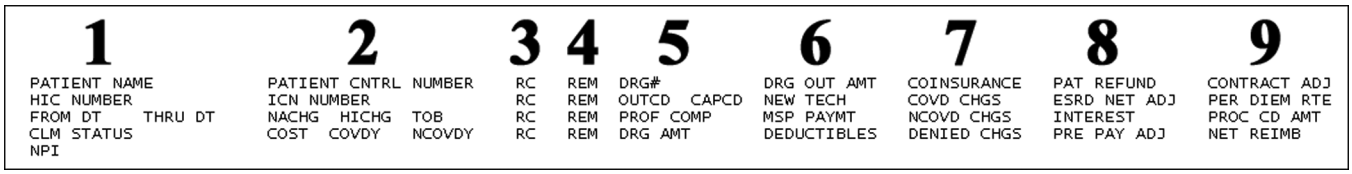
B - hold harmless - 100 percent federal rate; and

C - fully prospective blended rates.

PROF COMP - This field indicates whether a physician's professional component was billed on the claim. **This field only applies to Critical Access Hospitals (CAHs)** that have chosen the applicable payment methodology. This field shows the dollar amount of the billed professional component.

DRG AMT - This field indicates the dollar amount associated with the DRG code that has been adjusted based on the wage index. This field applies **only to some inpatient hospital providers**.

- An amount appears in this field only **for inpatient hospitals and SNFs**. If the claim is cancelled, this amount is negative.
- **For SNFs**, this is the dollar amount associated with the billed Medicare Resource Utilization Group (RUG).
- **For RHC, Home Health Agency (HHA), outpatient hospital, outpatient SNF, swing bed, CMHC, CORF, OPT, and hospice claims**, this field shows a zero.



3.4.1.8 Column 6 of the AC Page (Institutional SPR)

DRG OUT AMT - This field indicates whether an outlier payment was made in addition to the DRG payment. This field applies only **to inpatient hospital providers**. A value only appears in this field when a hospital provider is paid an outlier in addition to the DRG amount.

NEW TECH - This field reflects the dollar amount of the funds Medicare pays for "new technology" drugs and devices. This is in addition to the regular payment.

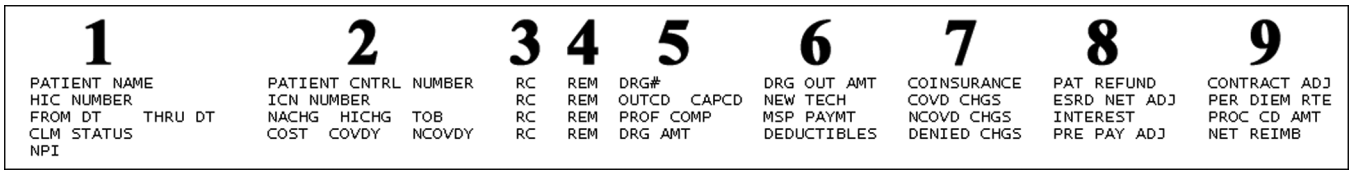
MSP PAYMT - This field indicates the Medicare Secondary Payer (MSP) Primary Payer amount. An amount appears in this field when the primary insurance has made payment toward the services on this claim. The amount is consistent with the amount reported by the provider on the claim.

DEDUCTIBLES - This field displays the dollar amount applied to the beneficiary's deductible. The beneficiary (or other insurer, if applicable) is responsible for paying the provider the amount shown in this field. Deductibles vary by Medicare benefit (e.g., Part A hospital deductible, Part B deductible, blood deductible).

> **EXAMPLE:** Part A deductibles apply to hospitals. For 2010, there is a deductible of $1,100.00 for days 1-60 for each benefit period.

NOTE: Any services billed by an institutional provider, but paid from the Part B Medicare Trust Fund, may have a Part B deductible amount associated with this field. This is currently a yearly deductible amount of $155 for 2010. This has a Group Code of "PR". See Table 2-1 in Chapter 2 of this Guide for a complete list of Group Codes.

Deductible amounts are subject to change annually.



3.4.1.9 Column 7 of the AC Page (Institutional SPR)

COINSURANCE - This field shows the total dollar amount of coinsurance for which the beneficiary is responsible. The beneficiary (or other insurer, if applicable) is responsible for paying the provider the amount shown in this field.

- **For cancel claims**, this amount is negative.
- An amount appears in this field **for outpatient hospital, RDF, OPT, RHC or any other services in which coinsurance applies**.

> **EXAMPLE:** SNF coinsurance under Part A is $137.50 per day for 2010, which must be paid by the beneficiary for days 21-100 in the SNF. Medicare pays in full for days 1-20.

NOTE: Coinsurance amounts are subject to change annually.

COVD CHGS - This field indicates the dollar amount of charges covered by Medicare. The combination of covered and non-covered charges is the total dollar amount of charges submitted by the provider. This amount does not necessarily match the net reimbursement amount.

- **For cancel claims and RAPs**, this amount is negative.
- If a **claim was billed as non-covered or fully denied,** a zero amount appears in this field.

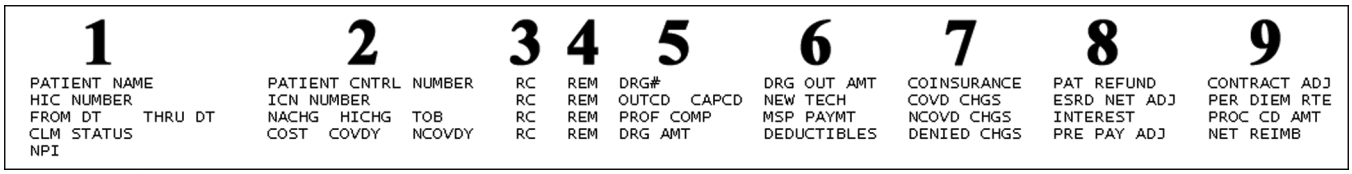
NCOVD CHGS - This field shows the dollar amount of the charges that are not covered by Medicare. This amount may reflect provider submitted non-covered charges, or partially denied charges. An amount also appears in this field when an **HHA** submits a RAP when the beneficiary has an open MSP record on Health Insurance Query A (HIQA)/Health Insurance Query for Home Health Agencies (HIQH).

An amount is **not** displayed in this field if:

- The charges were fully denied by MR (this amount shows in the DENIED CHGS field); or
- The claim was a cancel (this shows in the COVD CHGS field as a negative amount).

If an adjustment claim was submitted, the original claim appears on the RA as a cancel claim (TOB XX8). The amount in the NCOVD CHGS field appears as a negative amount.

DENIED CHGS - This field indicates the dollar amount of charges that were denied. *It is important to note that an amount in this field does not necessarily indicate MR denied the charges.* Charges appear in this field when the claim was denied for MR or any other reason. To clearly identify the reason for the charges showing in the DENIED CHGS column, reference the Claim Adjustment Reason Codes (CARCs) provided in the RC field and/or the Remittance Advice Remark Codes (RARCs) in the REM field.



3.4.1.10 Column 8 of the AC Page (Institutional SPR)

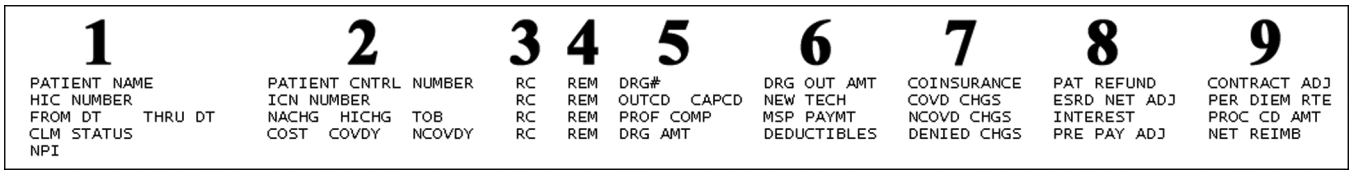
PAT REFUND - This field indicates the beneficiary refund amount. This is the amount the provider owes the beneficiary for overpaid deductible and coinsurance.

ESRD NET ADJ - This field indicates the ESRD Network Reduction amount and **only applies to RDFs**. This is the amount that Medicare's payment is reduced by to help fund the ESRD Network. The current amount is $.50 per covered session.

> **EXAMPLE:** A processed claim with six covered treatments shows an amount of $3.00 in the ESRD NET ADJ field on the SPR.

INTEREST - This field shows an amount when Medicare has paid interest on a claim. Medicare pays interest when a clean claim is not paid in a timely manner.

PRE PAY ADJ - This field indicates any presumptive payment adjustment on a claim. This field shows an amount when forced balancing of the SPR is required.



3.4.1.11 Column 9 of the AC Page (Institutional SPR)

CONTRACT ADJ - This field indicates an adjustment resulting from a contractual agreement between the payer and payee, or a regulatory requirement. Generally, these adjustments are considered a write-off for the provider and are not billed to the beneficiary. The Group Code “CO” is used for these adjustments.

PER DIEM RTE - This field identifies the per diem amount to be paid for an individual claim from providers who are reimbursed on a per diem basis. If the provider is reimbursed on a percentage of charges, this field identifies the percentage. Few providers remain that are still reimbursed by per diem rates. Therefore, for most providers, this field shows a zero amount.

PROC CD AMT - This field indicates the procedure code amount.

- **For Outpatient Prospective Payment System (OPPS) services**, this amount reflects the difference between the COVD CHGS and the NCVD CHGS fields.
- **For outpatient services paid under the Medicare Physician Fee Schedule (MPFS)**, this is the total reimbursement amount for all of the covered services under the MFS. For more information about the Medicare Physician Fee Schedule, go to http://www.cms.gov/PhysicianFeeSched on the CMS website.
- **For an RDF** paid under the per diem/composite rate for dates of service prior to January 1, 2011, this amount is the rate multiplied by the number of covered units.
- **For an RHC**, this amount is the covered charge.
- **For inpatient hospital, SNF, swing bed, and CAH claims**, this field shows a zero.

NET REIMB - This field displays the net reimbursement for each claim.

3.4.2 The Summary Page (Institutional SPR)

The summary page of an Institutional SPR provides a summary of all the claims present on the SPR. Figure 3-20 is an example of a summary page from an Institutional SPR. This page has been divided into six separate sections for easy viewing. The lines and large bold numbers were added to designate particular sections of the summary page that are discussed on the following pages.

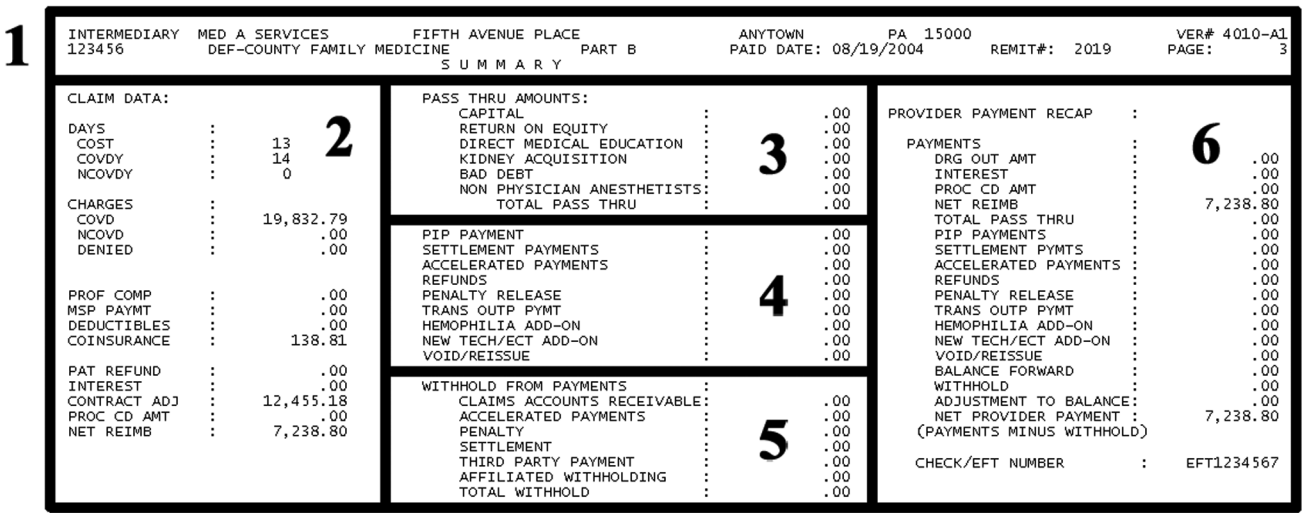


Figure 3-20. Summary Page from an Institutional SPR

3.4.2.1 Section 1 of the Summary Page (Institutional SPR)

The information in Section 1 of the summary page is identical to the header information described in the AC section (Section 3.4.1.1). The only information that differs in this section is the page number.

3.4.2.2 Section 2 of the Summary Page - Claim Data (Institutional SPR)

Section 2 of the summary page of the SPR (depicted in Figure 3-21) displays totals for all the claims referenced on this SPR. The fields displayed in this section are listed below.

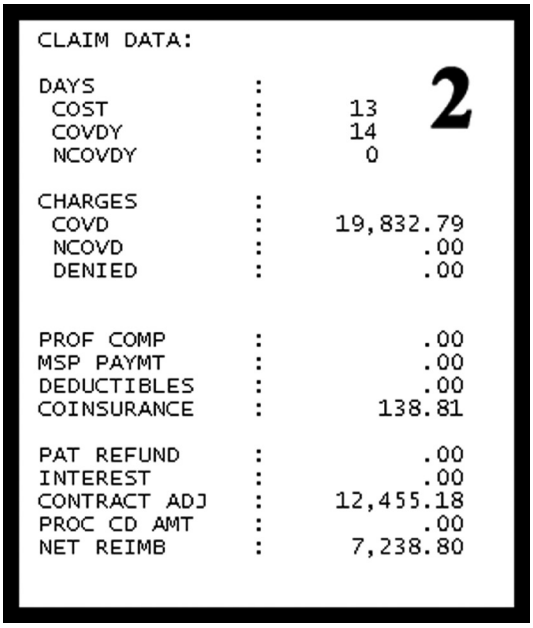


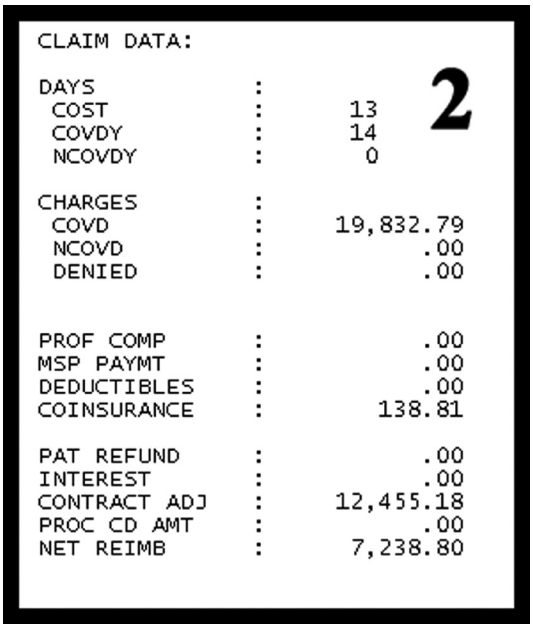
Figure 3-21. Claim Data on the SPR Summary Page

DAYS - This is a header for the following three fields. No data is displayed for this field.

COST - This field summarizes the total number of days applied to the MCR for claims processed on this SPR. The value in this field is a total of all values in the COST field on the AC page(s).

COVDY - This field summarizes the covered days or visits for claims processed on this SPR. The value in this field is a total of all values in the COVDY field on the AC page(s).

NCOVDY - This field summarizes the non-covered days for claims processed on this SPR. The value in this field is a total of all values in the NCOVDY field on the AC page(s).



CHARGES - This is a header for the following three fields. No data is displayed for this field.

COVD - This field summarizes the covered charges for claims processed on this SPR. The value in this field is a total of all values in the COVD CHGS field on the AC page(s).

NCOVD - This field summarizes the non-covered charges for claims processed on this SPR. The value in this field is a total of all values in the NCOVD CHGS field on the AC page(s).

DENIED - This field summarizes the denied charges for claims processed on this SPR. The value in this field is a total of all values in the DENIED CHGS field on the AC page(s).

PROF COMP - This field summarizes the professional component amount for claims processed on this SPR. The value in this field is a total of all values in the PROF COMP field on the AC page(s).

MSP PAYMT - This field summarizes the MSP payments made for claims processed on this SPR. The value in this field is a total of all values in the MSP PAYMT field on the AC page(s).

DEDUCTIBLES - This field summarizes the deductible payments owed to the provider by beneficiaries for claims processed on this SPR. The value in this field is a total of all values in the DEDUCTIBLES field on the AC page(s).

COINSURANCE - This field summarizes the coinsurance amount owed to the provider by beneficiaries for claims processed on this SPR. The value in this field is a total of all values in the COINSURANCE field on the AC page(s).

PAT REFUND - This field summarizes the beneficiary refund amount. The value in this field is a total of all values in the PAT REFUND field on the AC page(s).

INTEREST - This field summarizes the interest paid to the provider for clean claims that were not processed in a timely manner. The value in this field is a total of all values in the INTEREST field on the AC page(s).

CONTRACT ADJ - This field summarizes the contractual adjustment amount for claims processed on this SPR. This field is a total of all values in the CONTRACT ADJ field on the AC page(s).

PROC CD AMT - This field summarizes the procedure code payable amount for claims processed on this SPR. This amount is a total of all amounts in the PROC CD AMT field on the AC page(s).

NET REIMB - This amount indicates the total dollar amount that a provider receives for claims. This amount is a total of all amounts in the NET REIMB field on the AC page(s).

3.4.2.3 Section 3 of the Summary Page - Pass Thru Amounts (Institutional SPR)

This field (see Figure 3-22) is a header for the following seven fields. These fields apply **to hospitals paid under a PPS**. Pass through amounts are cost reimbursed services paid on a biweekly basis in addition to the Claim Payment Amount for claims processed on this RA. Therefore, any amounts shown in the following fields are paid in addition to any claims processed on this RA.

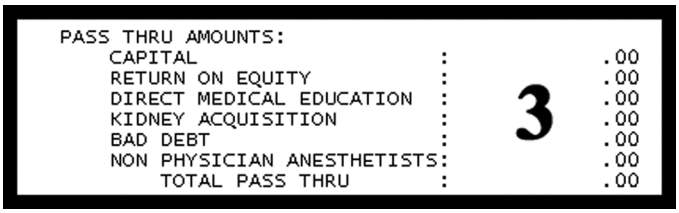


Figure 3-22. Pass Through Amounts Data on the SPR Summary Page

CAPITAL - This field is not applicable at this time. Therefore, this field shows a zero.

RETURN ON EQUITY - This field is not applicable at this time. Therefore, this field shows a zero.

DIRECT MEDICAL EDUCATION - This field reflects an additional payment made to a hospital for services provided by an intern and/or resident physician. This field only applies to a limited number of hospitals that have received approval for medical education.

KIDNEY ACQUISITION - This field indicates the additional payment amount that a certified hospital receives for kidney acquisition. This field only applies to a limited number of hospitals that have been approved for kidney acquisition.

BAD DEBT - This field indicates the dollar amount of reimbursable bad debts. Bad debts are coinsurance and deductibles that a hospital is unable to collect from a beneficiary.

NON PHYSICIAN ANESTHETISTS - This field indicates the reimbursement amount that a hospital receives for Certified Registered Nurse Anesthetist (CRNA) services.

TOTAL PASS THRU - This field shows a total of the amounts shown in the previous six fields.

3.4.2.4 Section 4 of the Summary Page (Institutional SPR)

PIP PAYMENT - This field (see Figure 3-23) indicates the dollar amount of the Periodic Interim Payment (PIP) that the provider received. PIP providers receive these payments bi-weekly as their reimbursement amount, regardless of the claims processed on the RA. Therefore, PIP providers do not receive additional reimbursement for claims. **Only inpatient hospital, inpatient rehabilitation, and SNF providers** are eligible for PIP payments.

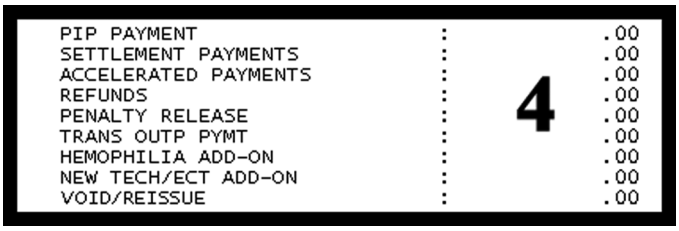


Figure 3-23. Additional Fields on the SPR Summary Page

SETTLEMENT PAYMENTS - This field reflects refund amounts issued for settlement payments. A settlement payment can be issued for the following three reasons:

- Cost Report Settlements (tentative and final);
- Lump Sum Adjustments calculated during Interim Rate Reviews; and
- Any refunds issued due to excessive funds being withheld on overpayment withholdings.

A refund for the third reason occurs if an amount was withheld from the provider's claims payments and a check is received from the provider a few days later. The amount is refunded to the provider since it was collected twice.

ACCELERATED PAYMENTS - This field indicates the dollar amount of an accelerated payment that a provider received. Accelerated payments are authorized by the Centers for Medicare & Medicaid Services (CMS).

REFUNDS - This field shows refunds unrelated to settlement payments. Examples include reissuing a check that was voided, or refunding a claim payment made to Medicare in error.

PENALTY RELEASE - This field reflects a release of money previously withheld from a provider on penalty withhold. Penalty withholds may occur due to non-receipt of a credit balance report, payment suspension, or an unfiled MCR.

TRANS OUTP PYMT - This field indicates the amount of a Transitional Outpatient Payment (TOP). TOPs were developed to prevent losses due to payments under the OPPS. Therefore, this field applies only to providers who are reimbursed under OPPS. TOPs are paid on a monthly basis.

HEMOPHILIA ADD-ON - This field reflects the additional payment amount an inpatient hospital provider receives for hemophilia blood clotting factor. An add-on payment is generated when a claim is billed with a Healthcare Common Procedure Coding System (HCPCS) code for hemophilia blood clotting factor and the beneficiary has a diagnosis of hemophilia. This payment is in addition to the DRG payment that a hospital receives, and is based on the number of units billed.

NEW TECH/ECT ADD-ON - This field reflects the dollar amount of the funds Medicare pays for "new technology" drugs and devices. This is in addition to the regular payment.

VOID/REISSUE - This field contains the amount of a check/payment that has been voided and reissued.

3.4.2.5 Section 5 of the Summary Page - Withhold From Payments (Institutional SPR)

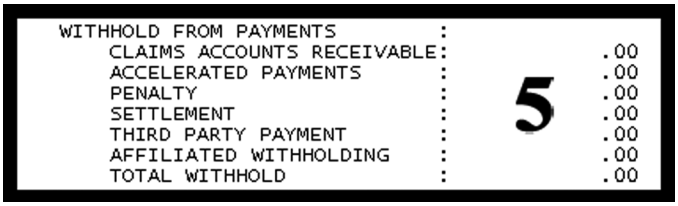


Figure 3-24. Withhold from Payments Data on the SPR Summary Page

CLAIMS ACCOUNTS RECEIVABLE - This field (see Figure 3-24) identifies the amount withheld from the current SPR's net reimbursement and applied to an existing claim receivable balance. The claim receivable balance would have been created and carried forward from net negative reimbursement on a previous SPR. Common causes of net negative reimbursement on an SPR include cancellation or adjustment to a previous paid claim. When the net negative reimbursement exceeds total payments, a claim receivable balance carries forward and offsets future payments. Providers need to monitor negative net reimbursement totals on SPRs in order to identify the claim receivable withholdings that are recouped on future SPRs.

ACCELERATED PAYMENTS - This field indicates the dollar amount being withheld to recover an accelerated payment previously paid to the provider.

PENALTY - This field indicates the amount of payment withheld from a provider due to an unfiled MCR, a payment suspension, or a credit balance report not being submitted in a timely manner.

SETTLEMENT - This field indicates the dollar amount withheld from a provider due to an unpaid settlement owed to Medicare.

THIRD PARTY PAYMENT - This field indicates the dollar amount withheld from the provider due to a third party payment. A third party payment means that payment was made to a third party for services that are also covered under Medicare.

AFFILIATED WITHHOLDING - This field contains the payment amount withheld from an affiliated provider.

TOTAL WITHHOLD - This field indicates the total amount withheld on this RA. That is, the total of the previous six fields (CLAIMS ACCOUNT RECEIVABLE, ACCELERATED PAYMENTS, PENALTY, SETTLEMENT, THIRD PARTY PAYMENT, and AFFILIATED WITHHOLDING).

3.4.2.6 Section 6 - Provider Payment Recap (Institutional SPR)

Section 6 of the summary page of the SPR (depicted in Figure 3-25) displays all provider payment on this SPR. The fields referenced in this section are displayed as follows.

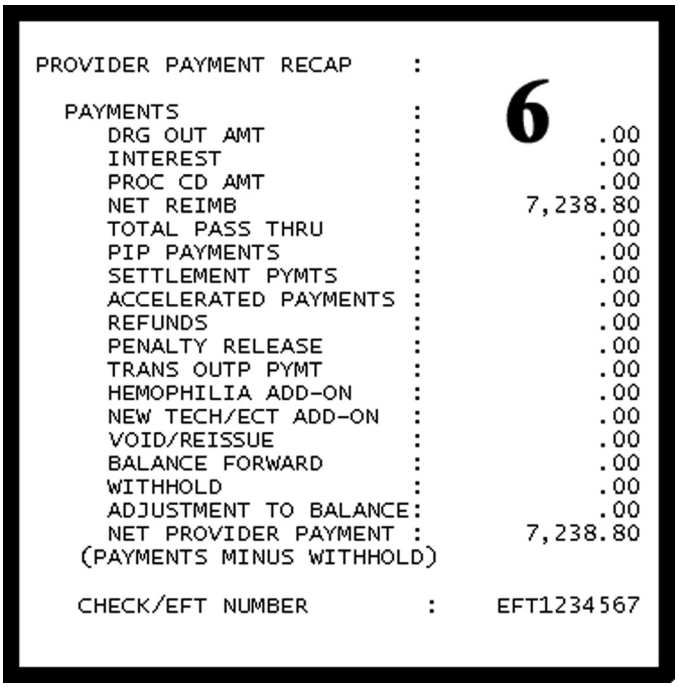


Figure 3-25. Provider Payment Recap Data on the SPR Summary Page

PAYMENTS - This is a header for the following 17 fields. No data is displayed for this field.

DRG OUT AMT - This field reflects the total DRG Outlier Amount for claims processed on this SPR.

INTEREST - This field displays the total amount when Medicare has paid interest on any claim. Interest is paid by Medicare when a clean claim is not paid in a timely manner.

PROC CD AMT - This field indicates the total of the amounts shown in the PROC CD AMT field of the AC page(s). That is, the total procedure code payable amount.

NET REIMB - This field indicates the total of the amounts shown in the NET REIMB field of the AC page(s). That is, the total net reimbursement that the provider receives for claims processed on this SPR.

TOTAL PASS THRU - The amount in this field reflects the total pass thru amounts processed on this SPR.

PIP PAYMENTS - The amount in this field reflects the total PIP payment amount paid on this SPR. A provider cannot receive both claims payments and PIP; only one or the other.

SETTLEMENT PYMTS - The amount in this field reflects the total settlement payments paid on this SPR.

ACCELERATED PAYMENTS - The amount in this field indicates the total accelerated payments paid on this SPR.

REFUNDS - The amount in this field indicates the total refund amount paid on this SPR.

PENALTY RELEASE - The amount in this field indicates the total penalty release amount paid on this SPR.

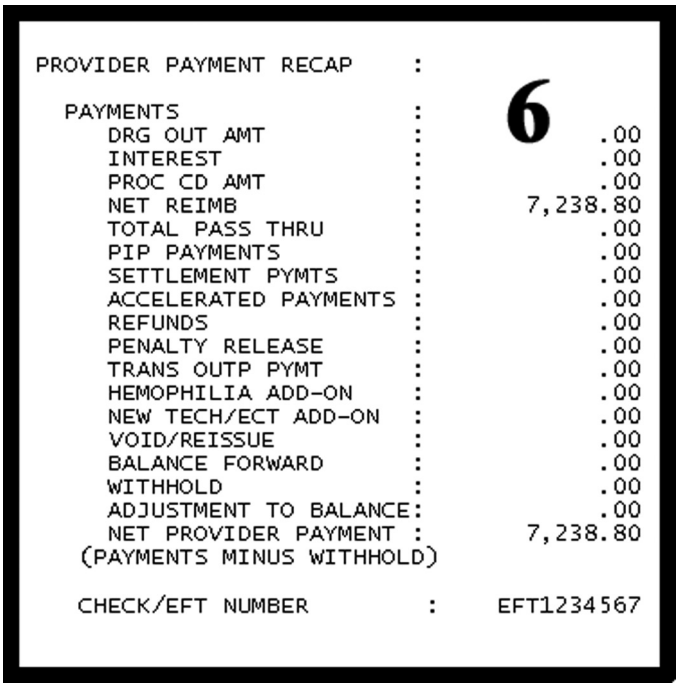
TRANS OUTP PYMT - The amount in this field indicates the total TOP amount paid on this SPR.

HEMOPHILIA ADD-ON - This field indicates the total amount of the hemophilia add-on amount paid on this SPR.

NEW TECH/ECT ADD-ON - This field reflects the total dollar amount of the funds Medicare pays for "new technology" drugs and devices. This is in addition to the regular payment.

VOID/REISSUE - This field contains the amount of a check/payment that has been voided and reissued.

BALANCE FORWARD - This field reflects whether an outstanding balance owed to the Medicare Program is carried forward to the next SPR. An outstanding balance is carried forward to the next SPR when the provider has insufficient funds to satisfy the claim receivable created on this SPR. A claim receivable results whenever the net reimbursement total on an SPR is negative.



WITHHOLD - This field indicates the total amount withheld (claims account receivables, accelerated payments, penalties, or settlements) for claims processed on this SPR.

ADJUSTMENT TO BALANCE - This field indicates the total of presumptive payment adjustments claims. This field shows an amount when forced balancing of the SPR is required.

NET PROVIDER PAYMENT - The amount in this field indicates the net amount being paid to the provider. This amount should match the amount of the check or Electronic Funds Transfer (EFT) issued to the provider.

CHECK/EFT NUMBER - This field indicates the check or EFT transaction number through which payment was issued. If a paper check is issued, this field begins with a zero. If payment was made through an EFT transaction, this field begins with "EFT". If no payment is issued, the RA number is inserted.

3.5 BALANCING AN INSTITUTIONAL REMITTANCE ADVICE (RA)

Remittance balancing reconciles differences between payment amounts shown on the Remittance Advice (RA) with the amounts actually billed by the provider. Balancing requires that the total paid is equal to the total billed, plus or minus any payment adjustments. According to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), every electronic transaction issued by a Medicare Contractor must balance at the service-line, claim, and transaction levels.

DISCLAIMER

The examples included in this section are for demonstration purposes only. The field names may vary depending on the software the provider/receiver uses to view the RA. Service-line balancing may not apply to some institutional providers.

3.5.1 What Are the General Rules for Remittance Balancing?

The following Electronic Remittance Advice (ERA) field completion and calculation rules apply to the corresponding fields in the Standard Paper Remittance Advice (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 is reported in the claim or service adjustment segments with the appropriate Group Codes, Claim Adjustment Reason Codes (CARCs), and Remittance Advice Remark Codes (RARCs) explaining the adjustments. The same adjustment may not be reported at both the claim and the service-line level of an RA. Every provider-level adjustment is likewise reported in the provider-level adjustment section of the SPR (PLB segment in the 835);
- Any positive adjustments (e.g., deductible paid by the beneficiary) reduce the provider's amount of payment from Medicare; and
- Any negative adjustments (e.g., interest on a clean claim that is paid after the 30th day from receipt) increase the amount of the payment from Medicare. Any adjustment reported with a negative sign reflects an increase in Medicare payment.

3.5.2 Transaction-Level Balancing an Institutional RA

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

The transaction-level balancing formula is:

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

3.5.2.1 On an Institutional ERA

The Provider Payment Summary (PS) screen is used to perform transaction-level balancing. This screen provides a summary of the provider's payments (shown in the PAYMENT TOTAL field), regardless of the Type of Bill (TOB) or Fiscal Year End (FYE) (see Figure 3-26). This screen may also include a FINANCIAL ADJUSTMENTS field that appears only if financial adjustments have been made. The amount in the FINANCIAL ADJUSTMENTS field should be used to determine total provider adjustments. If claims are billed using more than one provider number, there is a separate PS screen for each provider number.

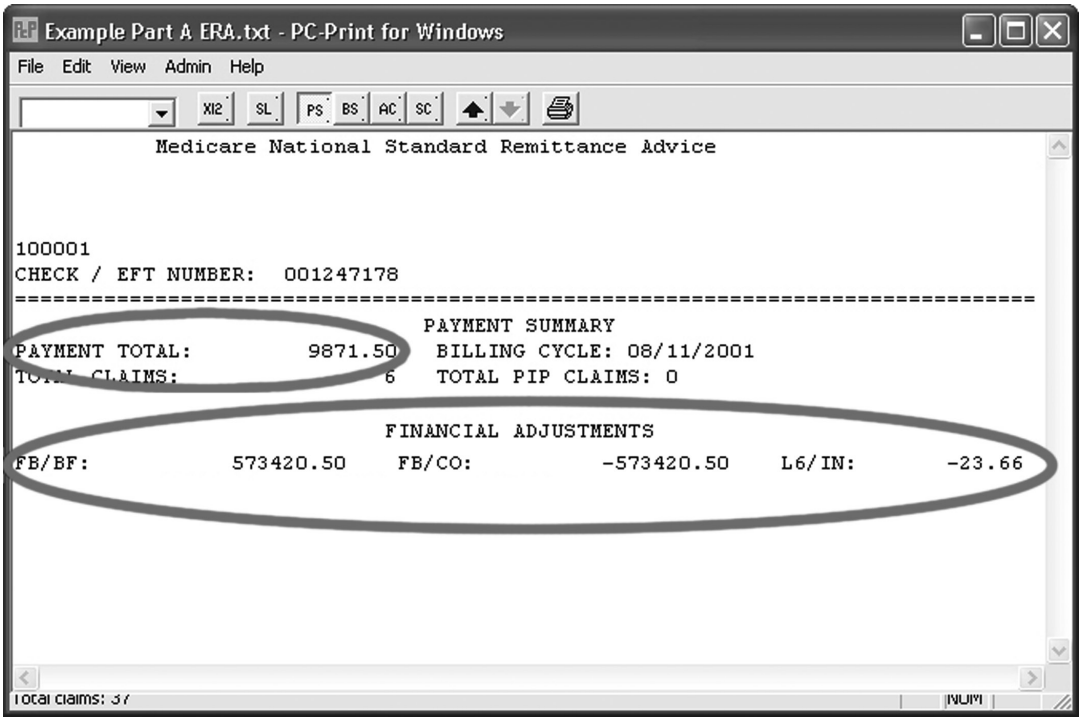


Figure 3-26. The PS Screen of an Institutional ERA Used for Transaction-Level Balancing

3.5.2.2 On an Institutional SPR

The PROVIDER PAYMENT RECAP section located on the Summary Page is used to locate fields involved in transaction-level balancing (see Figure 3-27). To obtain the total payment amount, add all the amounts in the PAYMENTS section (including DRG OUT AMT, INTEREST, PROC CD AMT, NET REIMB, TOTAL PASS THRU, PIP PAYMENTS, SETTLEMENT PYMTS, ACCELERATED PAYMENTS, REFUNDS, PENALTY RELEASE, TRANS OUTP PYMT, HEMOPHILIA ADD-ON, NEW TECH/ECT ADD-ON, VOID/REISSUE, BALANCE FORWARD, WITHHOLD, and ADJUSTMENT TO BALANCE). The WITHHOLD field is a negative amount which represents the total provider adjustments (found in Section 5 of Figure 3-27). This should result in the amount of the provider's reimbursement check (NET PROVIDER PAYMENT in Section 6 of Figure 3-27).

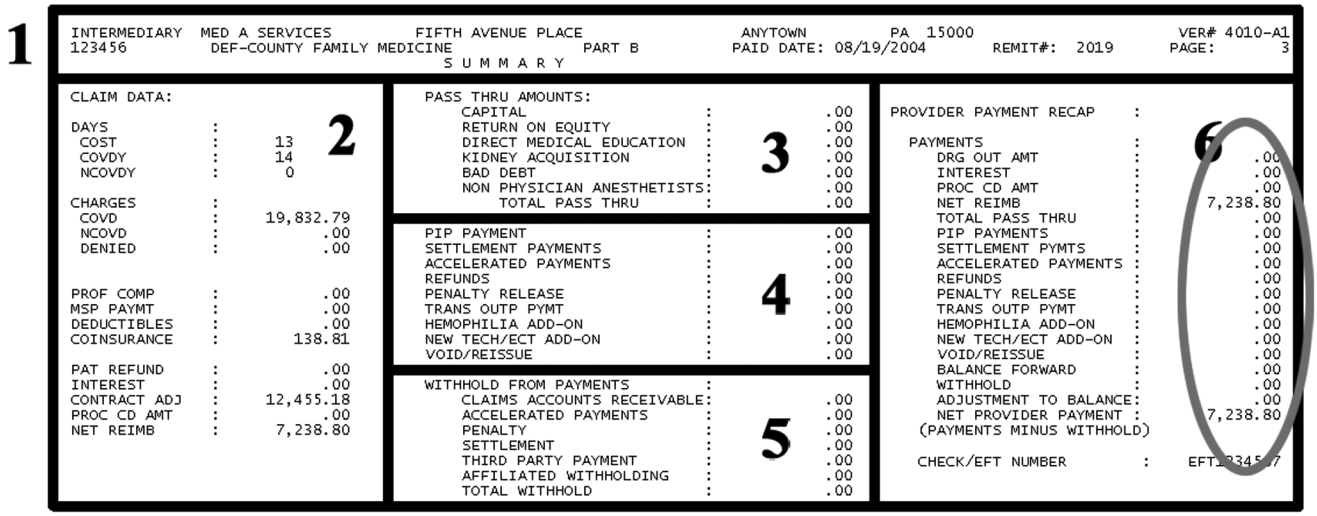


Figure 3-27. The Summary Page of an Institutional SPR Used for Transaction-Level Balancing

Table 3-18 shows the figures and fields that are used to balance the SPR shown in Figure 3-27 at the transaction level.

Table 3-18. Example Transaction-Level Balancing Fields

Dollar Amount	Field used for balancing this SPR	Description
7,238.80	NET REIMB	Total of claim payment amounts.
-0.00	None	Total Provider-Level Adjustments[1]
7,238.80	NET PROVIDER PAYMENT	The Check/EFT Amount. This amount equals the total of claim payment amounts minus the total provider-level adjustments. Therefore, this SPR balances at the transaction level.

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

3.5.3 Claim-Level Balancing an Institutional RA

Claim-level balancing encompasses the entire claim for one beneficiary. Providers use claim-level balancing to settle an individual claim. Claim-level balancing subtracts the sum of all adjustments applied to a claim from the submitted charges for a claim. The same adjustment cannot be taken at both the service-line and the claim levels.

The claim-level balancing formula is:

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

3.5.3.1 On an Institutional ERA

On an Institutional ERA, all the fields required for claim-level balancing may be found in the Payment Data Section of the Single Claim (SC) screen (see Section 4 of Figure 3-28). The DRG AMOUNT field is the total submitted charge for the claim, and the paid amount for the claim may be found in the NET REIM AMT field. All the other fields in this section of the SC screen constitute the "Monetary adjustment amounts applied to this claim" portion of the equation. These fields include DRG/OPER/CAP, LINE ADJ AMT, OUTLIER, CAP OUTLIER, CASH DEDUCT, BLOOD DEDUCT, COINSURANCE, PAT REFUND, MSP LIAB MET, REIM RATE, MSP PRIM PAYER, PROF COMPONENT, ESRD AMOUNT, PROC CD AMOUNT, ALLOW/REIM, G/R AMOUNT, INTEREST, CONTRACT ADJ, and PER DIEM AMT.

When service-line payment information is present, adjustments are reported either at the claim level or the service-line level, but not in both. When specific service-line details are present (these appear in Section 6 of Figure 3-28), the claim-level balancing includes balancing the total claim charge to the sum of the related service charges.

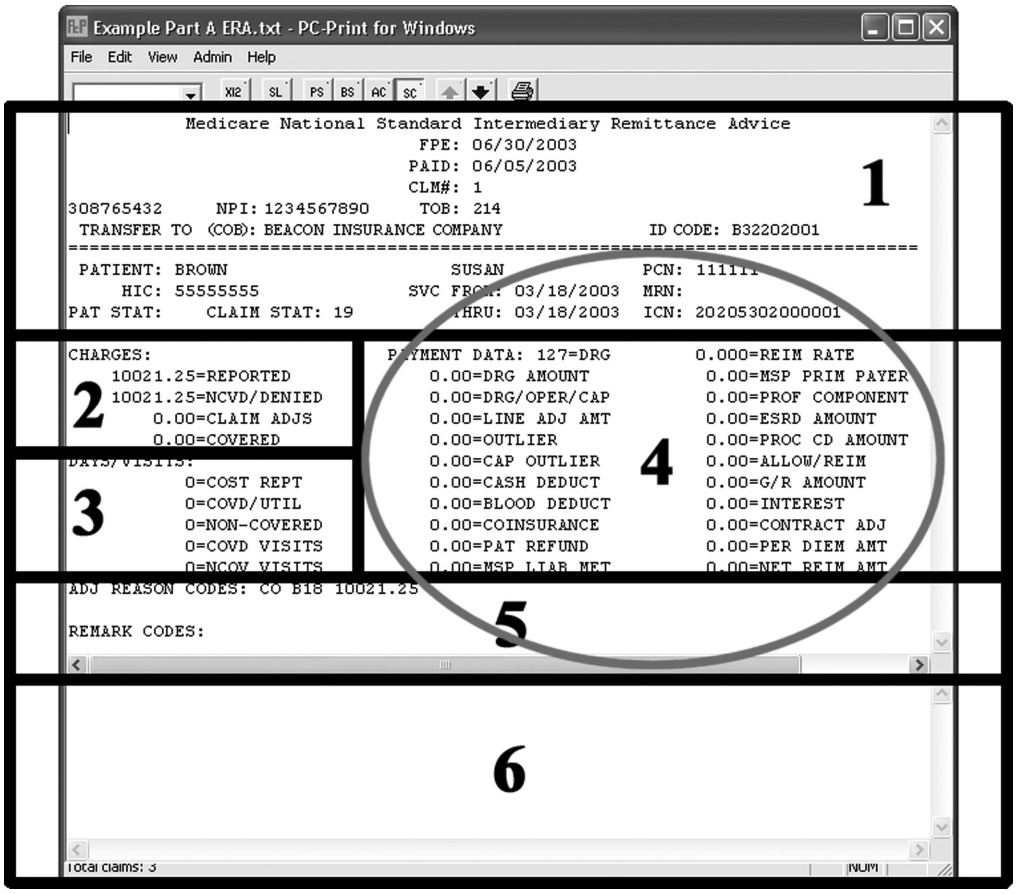


Figure 3-28. The SC Screen of an Institutional ERA Used for Claim-Level Balancing

3.5.3.2 On an Institutional SPR

To perform claim-level balancing on an Institutional SPR, subtract all adjustments (found in DRG OUT AMT, NEW TECH, MSP PAYMT, DEDUCTIBLES, COINSURANCE, DENIED CHGS, PAT REFUND, ESRD NET ADJ, INTEREST, PRE PAY ADJ, CONTRACT ADJ, PER DIEM RTE, and PROC CD AMT) from the COVD CHGS field. The resulting amount should equal the NET REIMB (see Figure 3-29). These amounts are found on the All Claims (AC) Page of an SPR (in Section 3 of Figure 3-29).

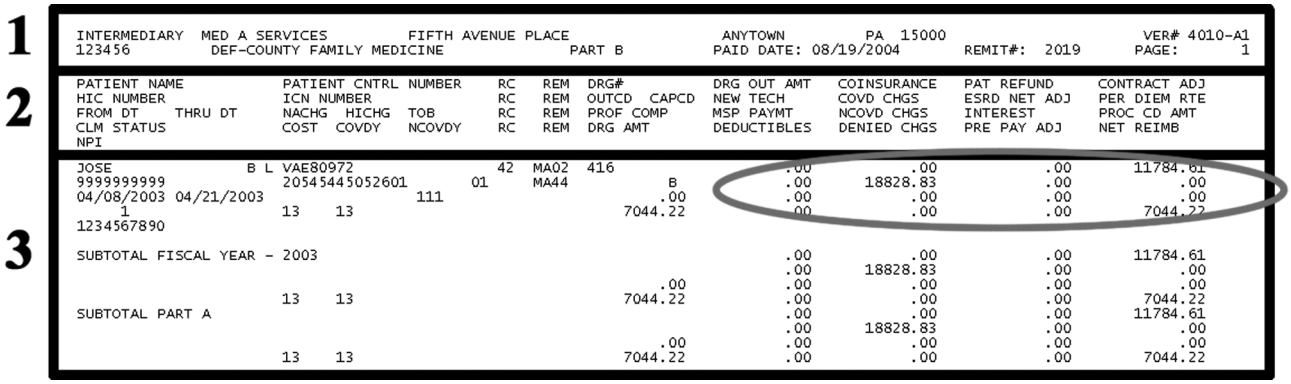


Figure 3-29. The AC Page of an Institutional SPR Used for Claim-Level Balancing

Table 3-19 shows the figures that are used to balance a claim from SPR shown in Figure 3-29.

Table 3-19. Example Claim-Level Balancing Fields

Dollar Amount	Field used for balancing this claim	Description
18,828.83	COVD CHGS	Total submitted charge for this claim.
-11,784.00	CONTRACT ADJ	A claim-level adjustment due to a contractual agreement between the payer and the payee.
7,044.22	NET REIMB	The paid amount for this claim. This amount equals the total claim payment amount minus the total claim-level adjustments. Therefore, this claim balances.

3.5.4 Service-Line-Level Balancing an Institutional RA

Service-line-level balancing allows the provider to reconcile totals for service-line entries on individual claims. Most institutional providers do not perform service-line-level balancing.

The service-line-level balancing formula is:

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

3.5.4.1 On an Institutional ERA

To complete service-line-level balancing, providers should use the SC screen. The service-line fields are located in Section 6 of the SC screen (see Figure 3-30). Submitted service-line charges are found under the CHARGES field header, adjustments are found under the ALLOW/REIM field header, and the paid amount for the service is found under the AMOUNT header. Service-line-level balancing is only required when institutional providers bill Part B services. Field definitions for all the fields in Section 6 are provided in the SC screen section (Section 3.2.5.6) of this chapter.

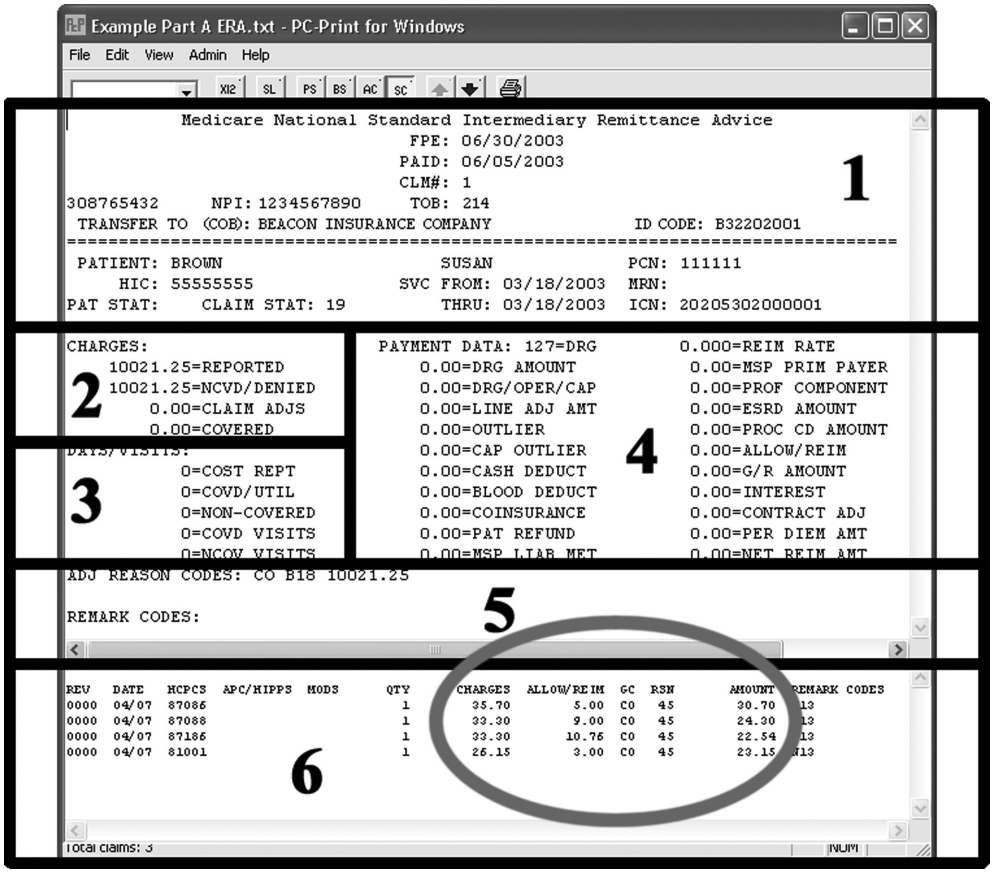


Figure 3-30. The SC Screen of an Institutional ERA Used for Service-Line-Level Balancing

3.5.4.2 On an Institutional SPR

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

Notes

Notes

Chapter 4: Reading a Professional Remittance Advice (RA)

4.1 INTRODUCTION

Chapter 1 of this Guide introduced the uses for the Remittance Advice (RA) and the advantages of the Electronic Remittance Advice (ERA) format for providers and their billers. Chapter 2 introduced the purpose and basic components of both the electronic and paper versions of the RA.

This chapter specifically targets providers that submit claims to Carriers, Durable Medical Equipment Medicare Administrative Contractors (DME MACs), or Part B MACs, and is organized in three major sections. The sections provide more detailed information on how to read the Professional RA (institutional providers that submit claims to Fiscal Intermediaries [FIs], Regional Home Health Intermediaries [RHHIs], or Part A MACs should refer to Chapter 3 of this Guide). The first section provides guidance for reading a Professional ERA. For providers that elect to receive this information on paper, the next section provides similar guidance for reading a Professional Standard Paper Remittance Advice (SPR). 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.

After claims are processed by Medicare Contractors, an RA is generated as a companion to the payment or as an explanation of no payment. Providers that submit claims to Carriers, DME MACs, or Part B MACs receive a Professional RA.

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

The required fields are mandatory for Medicare Contractors to include in the RA. The use of situational fields depends on data content and business context (Medicare requirements), and is used if the situation applies. For example, if the payment is based on a procedure code (Healthcare Common Procedure Coding System/Current Procedural Terminology [HCPCS/CPT-4]) that is different than the procedure code submitted on the claim (e.g., the Medicare Contractor revised the HCPCS/CPT-4 code during processing), both procedure code fields appear in the 835. If there is no difference between the adjudicated procedure code (required field) and the submitted procedure code (situational field), only the adjudicated procedure code field appears in the 835. The submitted code field does not appear because the situation does not apply.

The Professional SPR is standardized to assure that the provider receives the necessary information. The SPR mirrors the information provided in an ERA.

4.2 READING A PROFESSIONAL ELECTRONIC REMITTANCE ADVICE (ERA)

4.2.1 ERA Basics

Electronic Remittance Advices (ERAs) are available electronically to providers for a specified period of time defined by the Medicare Contractor. ERAs offer professional providers additional flexibility when viewing their 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.

NOTE: In the remainder of this section, Carriers, Durable Medical Equipment Medicare Administrative Contractors (DME MACs), and Part B MACs are referred to as "Medicare Contractors".

4.2.2 How Is an ERA Generated?

The ERA is produced in the Health Insurance Portability and Accountability Act of 1996 (HIPAA)-compliant Accredited Standards Committee (ASC) X12N 835 format. In this Guide, this is referred to as Transaction 835 ("the 835").

The 835 sent to providers by Medicare Contractors is a variable-length record designed for wire (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 Guide refers to the 004010A1 version of the ASC X12N 835, which has been adopted under HIPAA as the standard.

More 835 Information

In January 2009, HHS approved the replacement of the 4010A1 versions of electronic transactions, including the 835, with the ASC X12 Version 5010. Medicare providers must be fully compliant with ASC X12 Version 5010 by January 1, 2012. Information and the latest news for the 5010 may be found at http://www.cms.gov/Versions5010andD0/01_overview.asp on the Centers for Medicare & Medicaid Services (CMS) website.

NOTE: 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 (i.e., financial institution). For example, Remittance Advice Remark Codes (RARCs) explaining any adjustment in reimbursement may not be sent regularly by the entity receiving the 835.

4.2.3 How Can the Information in an ERA Be Viewed?

Since the ASC X12N 835 format is meant for electronic transfers only, the data are not easily readable. Provider personnel can view and print the information provided in an ERA using special translator software.

Free translator software for viewing HIPAA 835 files is now available for professional providers through their Medicare Contractor. This software is called Medicare Remit Easy Print (MREP). Professional providers can use either the free MREP software or purchase other proprietary translator software. Providers using other proprietary software to view and print ERAs 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 is designed to allow providers to view and print the ERA, to run special reports, and to search the ERA to find information easily. Providers use the MREP software by importing 835s received from their Medicare Contractor. Once imported, these files may be printed in a format similar to a Standard Paper Remittance Advice (SPR), or viewed directly in the MREP software. MREP software is available for download at http://www.cms.gov/AccesstoDataApplication/02_MedicareRemitEasyPrint.asp on the CMS website.

4.2.3.1 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 providers to view or print their remittance information quickly in a format similar to an SPR.
- A Tabbed Information View - This tabbed view allows providers to view *only the information they select* from a particular ERA. Six tabs give providers 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 Remittance Advice Remark Codes (RARCs) that appear on the ERA.
- Special Reports - Special reports give providers 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.

Additional MREP Information

To learn more about the MREP software and how to receive the 835, providers should contact their Medicare Contractor.

Full details regarding importing, archiving, and deleting files from the MREP software, as well as complete MREP operating instructions may be found in the *MREP User Guide*.

Medicare Part B Electronic Data Interchange (EDI) Helpline phone numbers are available at http://www.cms.gov/ElectronicBillingEDITrans on the CMS website.

4.2.3.2 Why Should Providers Use the MREP Software?

The MREP software offers many benefits to providers. The MREP software:

- Saves time and money;
- Generates special reports and provides detailed information in case of corrections and adjustments;
- Prints specific claim information to be sent to other payers;
- Provides an easy way to navigate and view information;
- Allows quick and easy access to claim information through the search function and other features; and
- Eliminates physical filing and storage space needs by archiving, restoring, and deleting files.

The software allows providers to print remittance information directly from their computer the same day the 835 is received. In addition, the software can produce several helpful reports and allows providers to find a specific claim (or multiple claims) based on customized search criteria. Providers may also print as many or as few claims as needed in a format similar to an SPR to be forwarded to other payers for secondary or tertiary payment.

DISCLAIMER

In this portion of the Guide, ERA examples are shown as they would be displayed using the MREP software. The format may appear differently depending on the type of software used to view the ERA.

The MREP software and HIPAA code sets (medical and non-medical) are subject to periodic revision. Therefore, providers should update their software and reliance on this Guide when required.

4.2.4 Using the MREP Software

To print quickly from an 835, providers can use the "Report" function, as shown in Figure 4-1. When the provider selects 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.

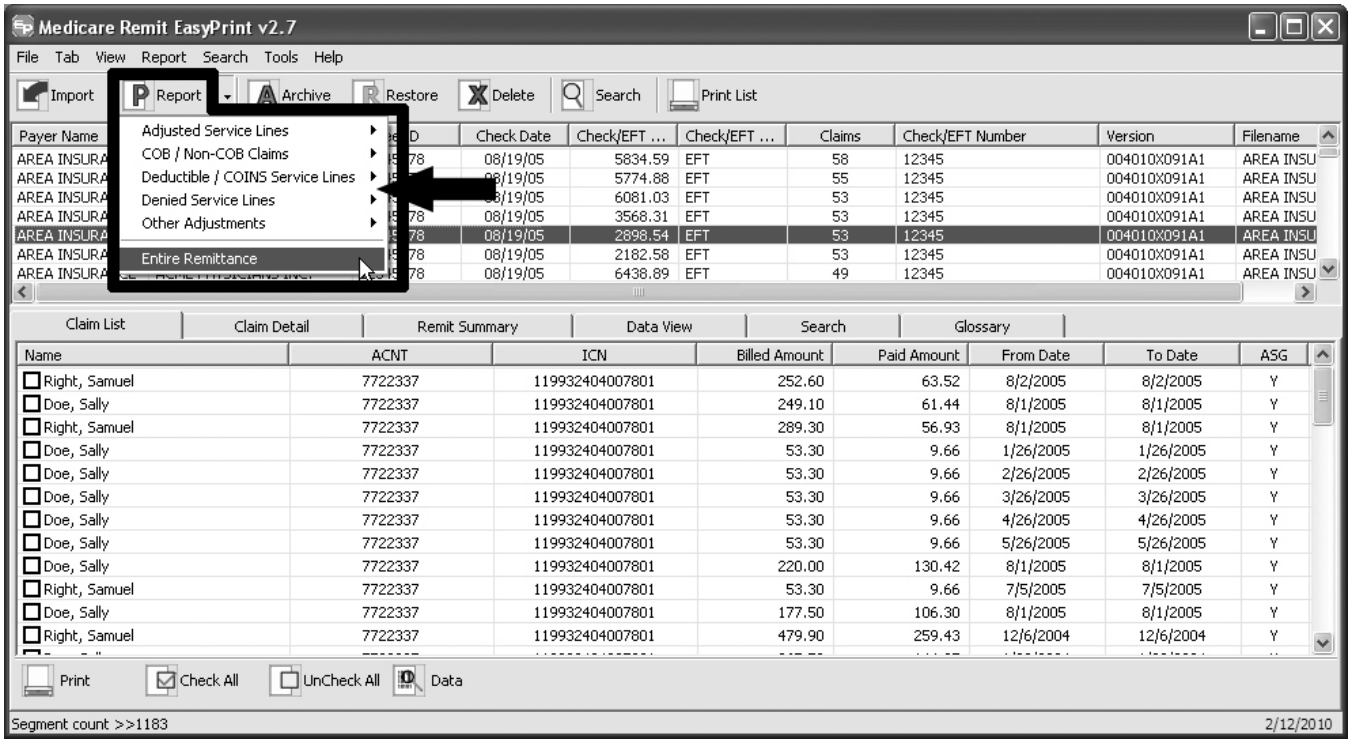


Figure 4-1. Using the Entire Remittance Report in the MREP Software to Print an SPR

For a detailed look at the paper remittance that is produced using the Entire Remittance report, refer to Section 4.4, Components of the Professional SPR. This section provides a full list of fields and their definitions, and highlights the few differences that exist between SPRs received from Medicare Contractors and paper remittances generated from the MREP software.

The differences that currently exist between SPRs received from Medicare Contractors and paper remittances generated from the MREP software are:

- The totals section - The paper remittance generated from the MREP software includes totals for all claims, assigned and unassigned (see Section 4.4.2.5).
- The handling of adjusted claims - The paper remittance generated from the MREP software mirrors the 835 by showing the adjusted and the replacement claim (see Section 4.4.2.4).
- The bulletin board section - The MREP software omits this section because it is not included in the HIPAA-compliant 835 format (see Section 4.4.1).

NOTE: Future revisions to the 835 may result in additional differences, as not all 835 revisions may be implemented in exactly the same manner in the SPR as they are in the paper remittances generated from the MREP software.

4.2.5 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. Figure 4-2 shows the MREP software after several 835s have been imported. Section 1 of Figure 4-2 provides a list of imported 835s. When the provider selects an 835 from this list, information about that 835 is displayed in Section 2. The six tabs that are used to view remittance information are discussed on the following pages.

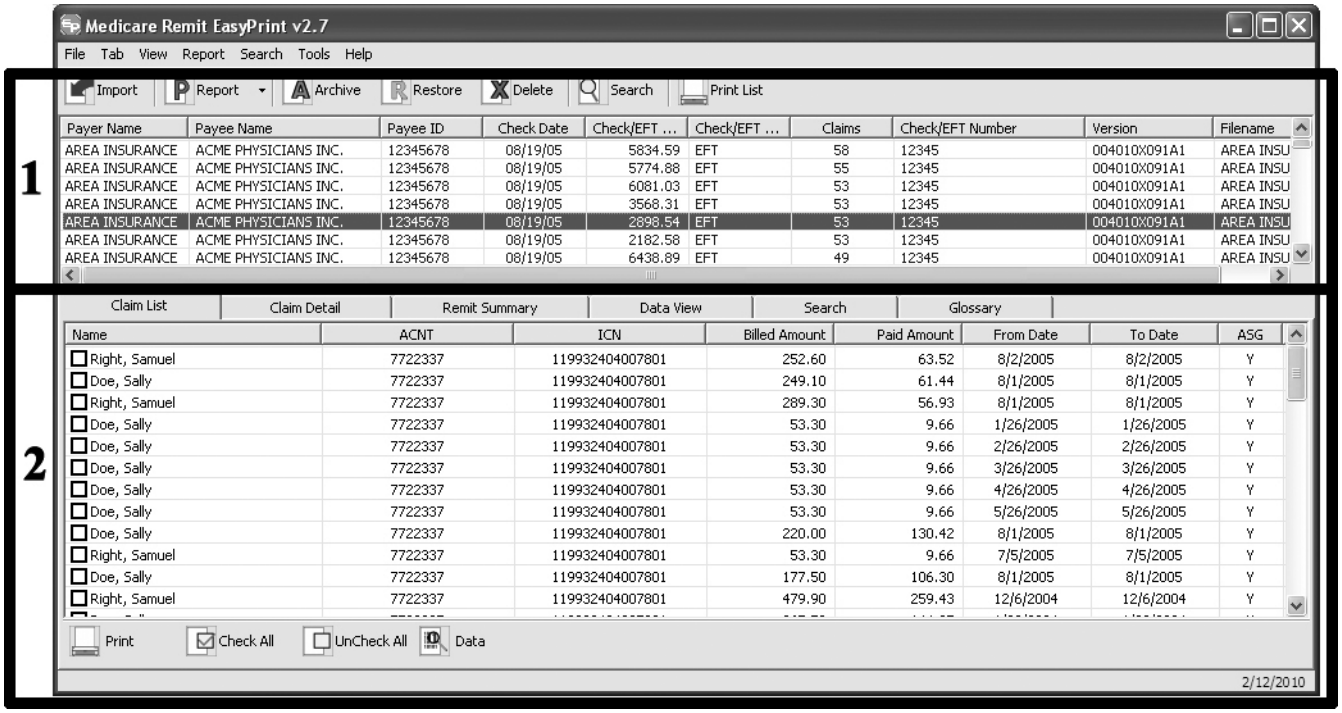


Figure 4-2. The MREP Software with Multiple 835s Ready for Viewing

4.2.5.1 The Claim List Tab (Professional ERA)

The Claim List tab (see Figure 4-3) gives providers the ability to view information for any number of claims within an 835. After selecting an 835 from the top window, providers then select individual claims from this tab. Providers select claims by clicking on the check box to the left of each claim. Providers may then use the Claim Detail tab to display information only for the selected claims.

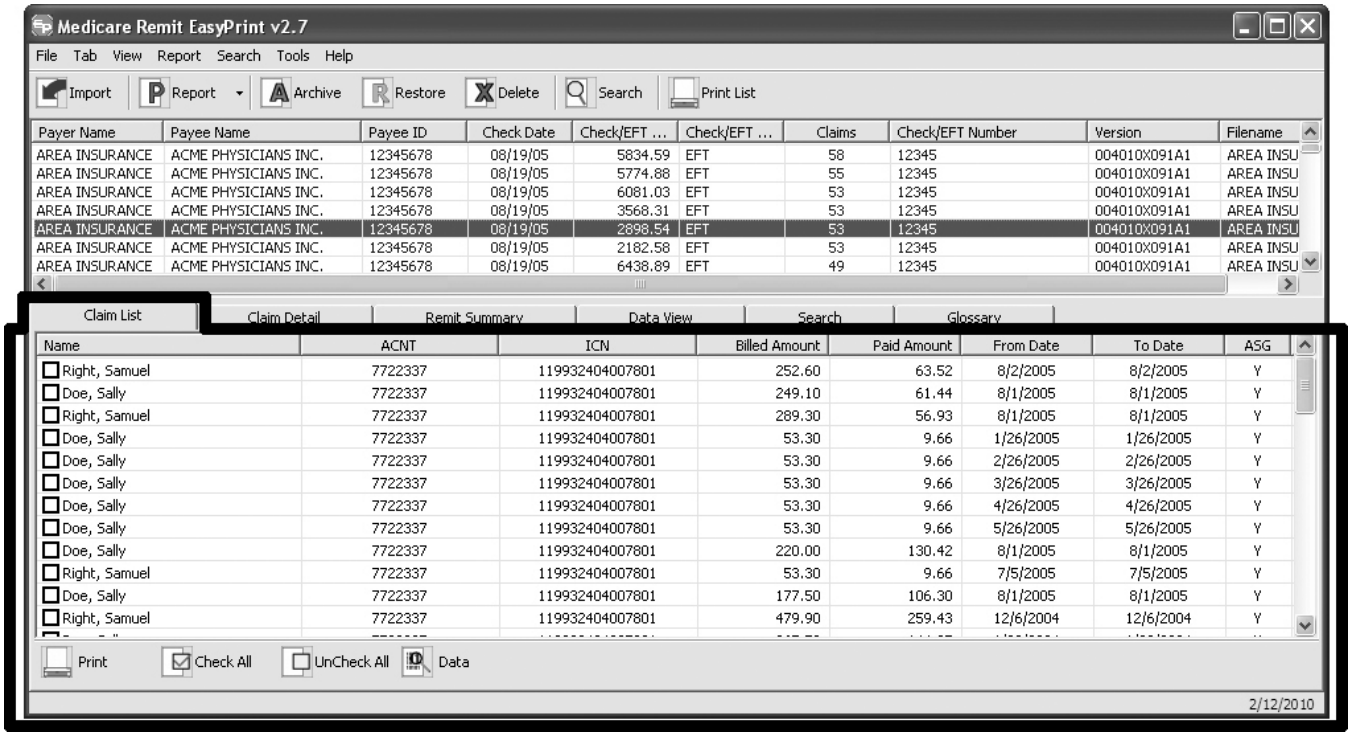


Figure 4-3. The Claim List Tab

4.2.5.2 The Claim Detail Tab (Professional ERA)

The Claim Detail tab (see Figure 4-4) shows providers detailed information for the claims selected in the Claim List tab. Providers may use this tab to view or print information for specific claims to be forwarded to other payers for secondary/tertiary payment. Glossary information, including Group Codes, Claim Adjustment Reason Codes (CARCs), and Remittance Advice Remark Codes (RARCs) are displayed for only those claims selected in the Claim List tab. See Table 2-1 in Chapter 2 of this Guide for a list of Group Codes. For more information on CARCs and RARCs, refer to Section 4.2.5.6.

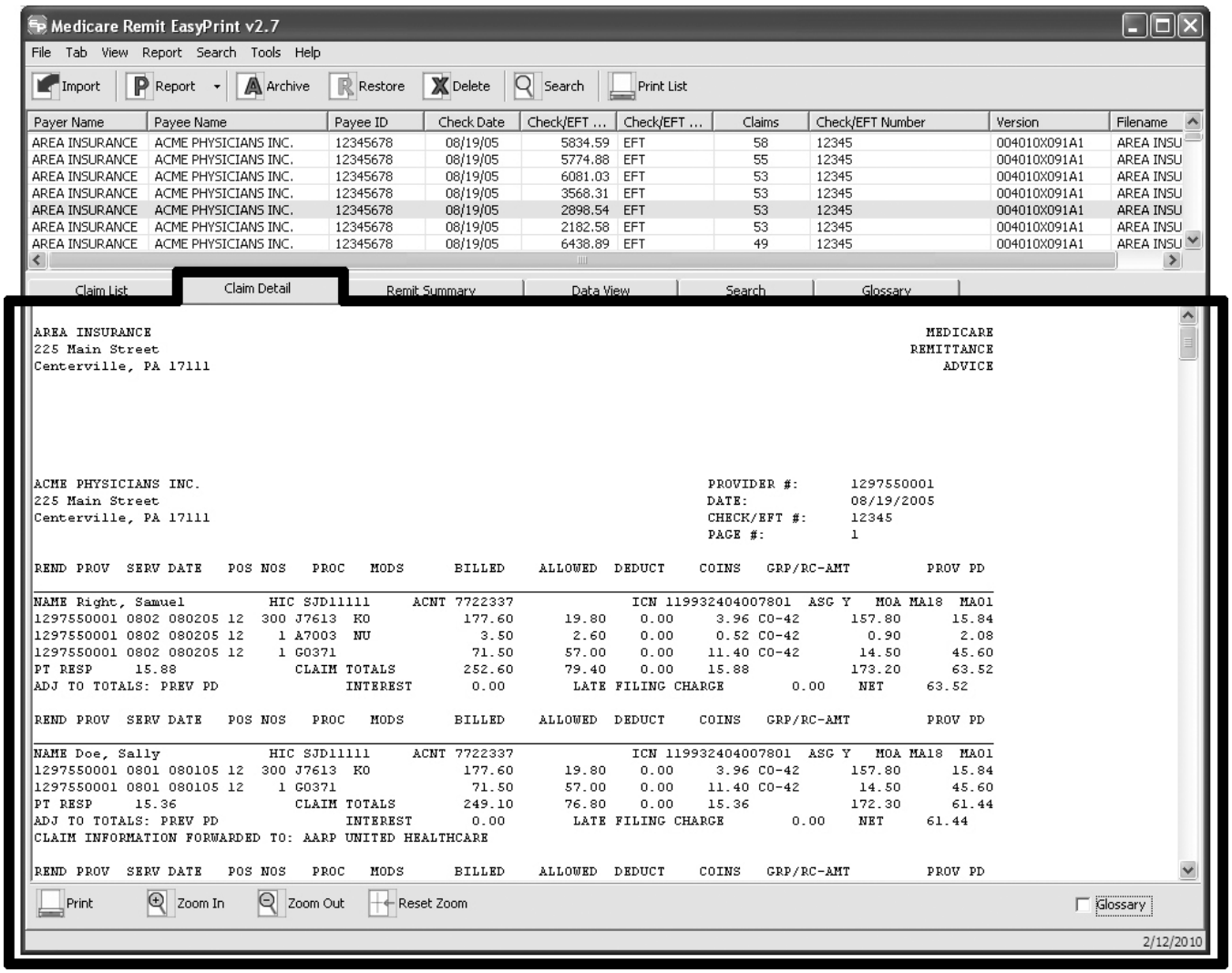


Figure 4-4. The Claim Detail Tab

The information shown in the Claim Detail tab is presented in a format similar to an SPR. However, total information across all selected claims is not presented as shown at the end of an SPR. For a description of how to read the detailed claim information presented in this tab, refer to Sections 4.4.1 and 4.4.2.1 through 4.4.2.4 of this Guide.

4.2.5.3 The Remit Summary Tab (Professional ERA)

The Remit Summary tab is used to display totals for all claims in this RA. These are the totals that appear in the totals section at the end of a paper remittance generated from the MREP software. Providers may notice a difference in the way totals for the entire RA are presented on an SPR (see Figure 4-5) and on the Remit Summary tab (see Figure 4-6) in the MREP software. Although most of the information presented in this tab is the same as the information presented in the TOTALS section of the SPR, the formatting differs.

3

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 4-5. Totals as Shown on an SPR

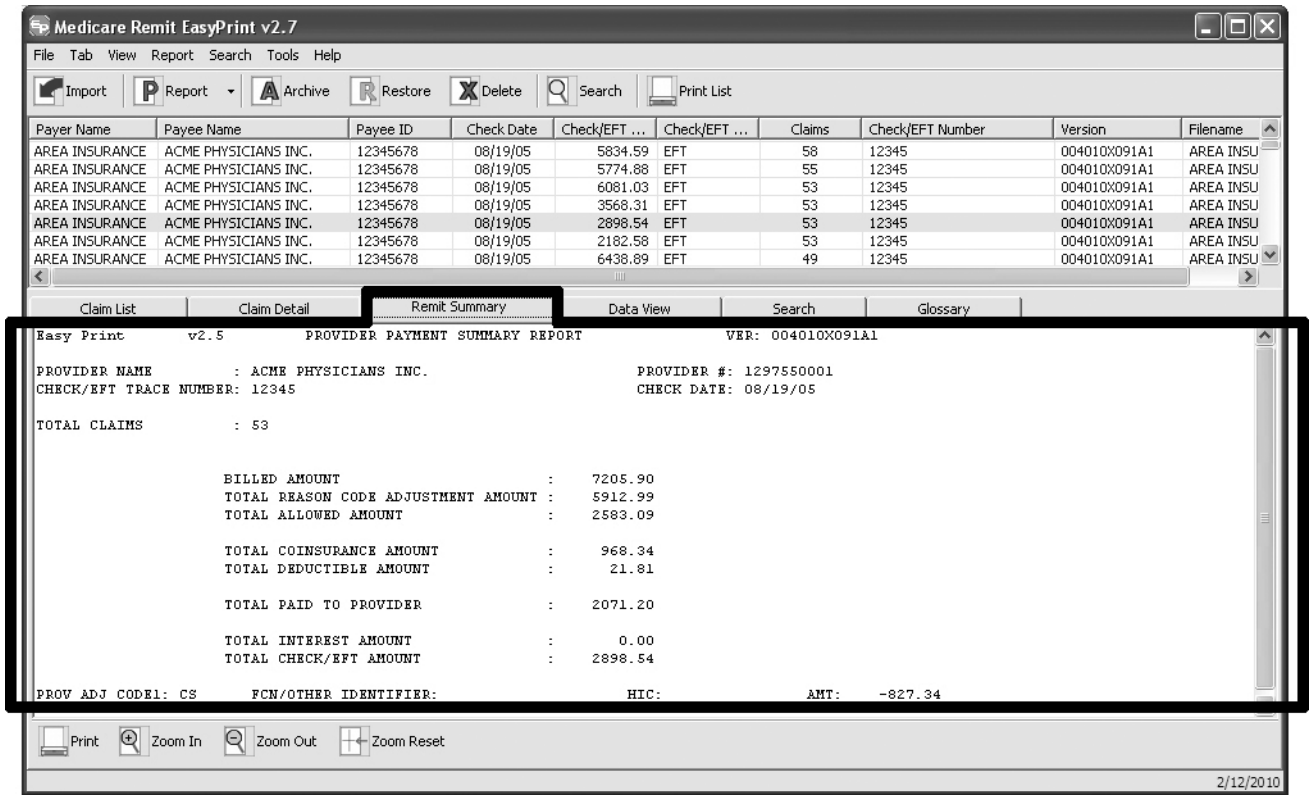


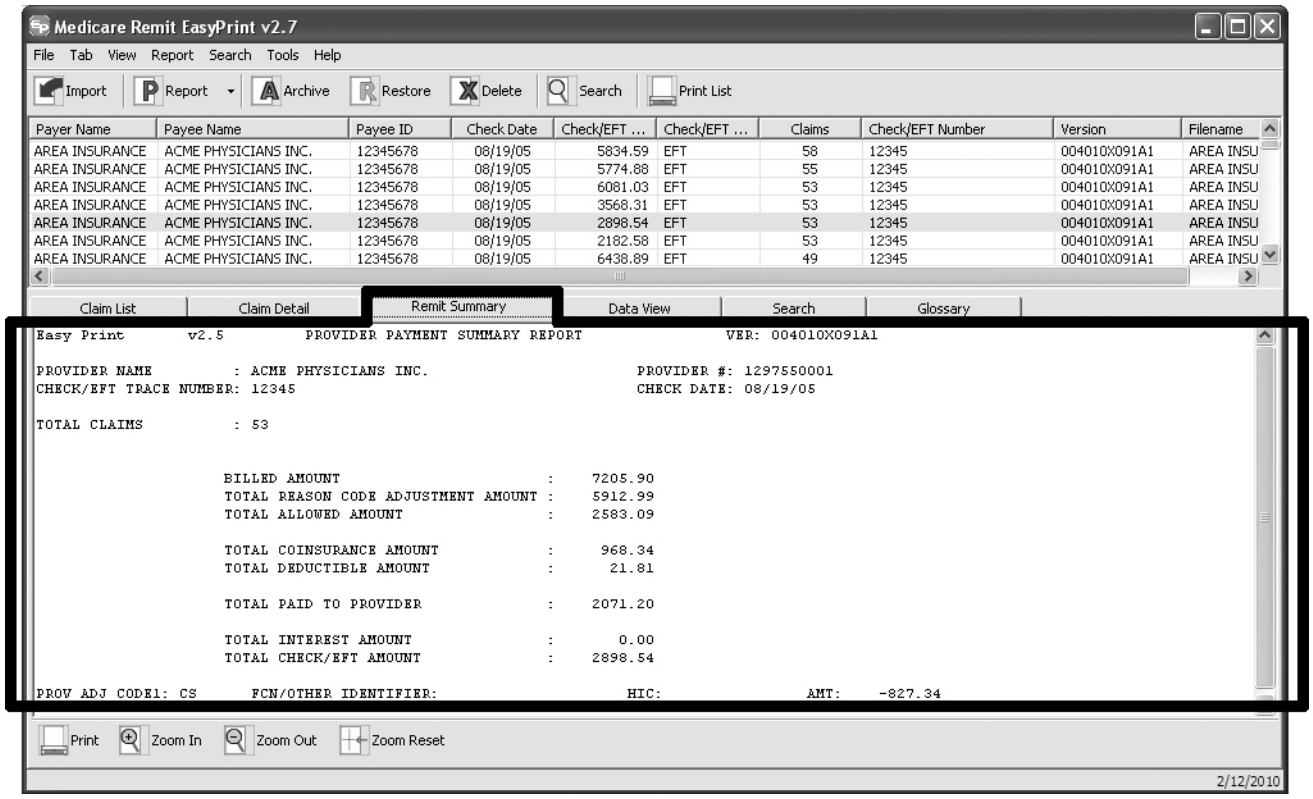
Figure 4-6. The Remit Summary Tab

Field definitions for non-header information (from TOTAL CLAIMS and below) in this section have been listed below.

TOTAL CLAIMS - This field displays the total number of claims in this 835.

BILLED AMOUNT - This field displays the total amount billed for all claims in this 835.

TOTAL REASON CODE ADJUSTMENT AMOUNT - This field indicates the total amount of adjustments made to claims due to Claim Adjustment Reason Codes (CARCs) listed on each service line. This excludes interest, late filing charges, deductibles, and amounts previously paid for rendered services.



TOTAL ALLOWED AMOUNT - This field displays the total amount allowed for all claims in this 835.

TOTAL COINSURANCE AMOUNT - This field indicates the total coinsurance amount for all claims that are the beneficiaries' responsibility.

TOTAL DEDUCTIBLE AMOUNT - This field displays the total amount applied to the beneficiaries' deductibles for all claims in this 835.

TOTAL PAID TO PROVIDER - This field displays the total payment amount for claims before any provider adjustments are applied.

TOTAL INTEREST AMOUNT - This field indicates the total interest for all claims in this 835.

TOTAL CHECK/EFT AMOUNT - This field contains the amount of the check or EFT that the provider receives.

PROV ADJ CODE - This field indicates the provider-level adjustment reason code. Table 4-1 lists the various Provider-Level Adjustment Reason Codes that may be used on a Professional ERA. For a complete listing of Provider-Level Adjustment Codes, see Chapter 3, Table 3-9 of this Guide or refer to the *ASC X12N 835 Implementation Guide: Health Care Claim Payment/Advice*, available at http://www.wpc-edi.com/hipaa on the Internet.

NOTE: 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.

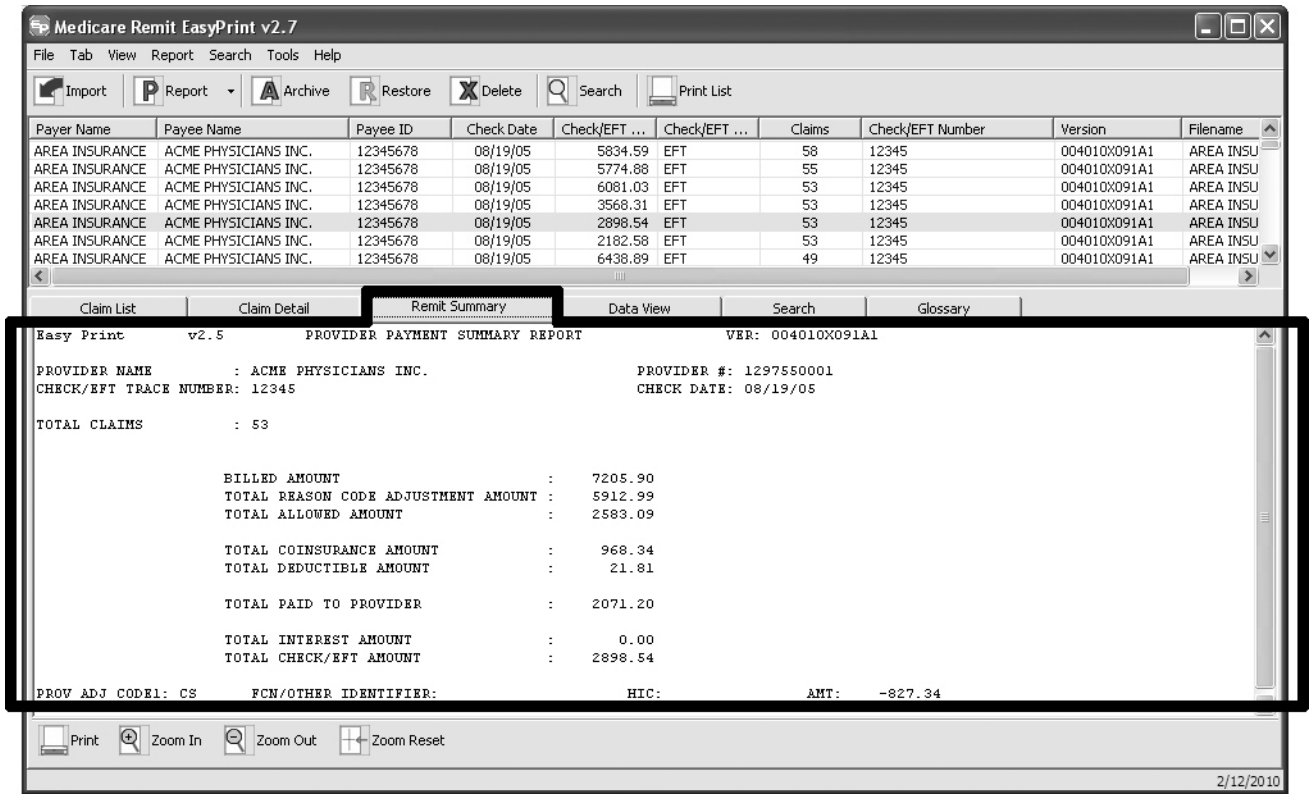
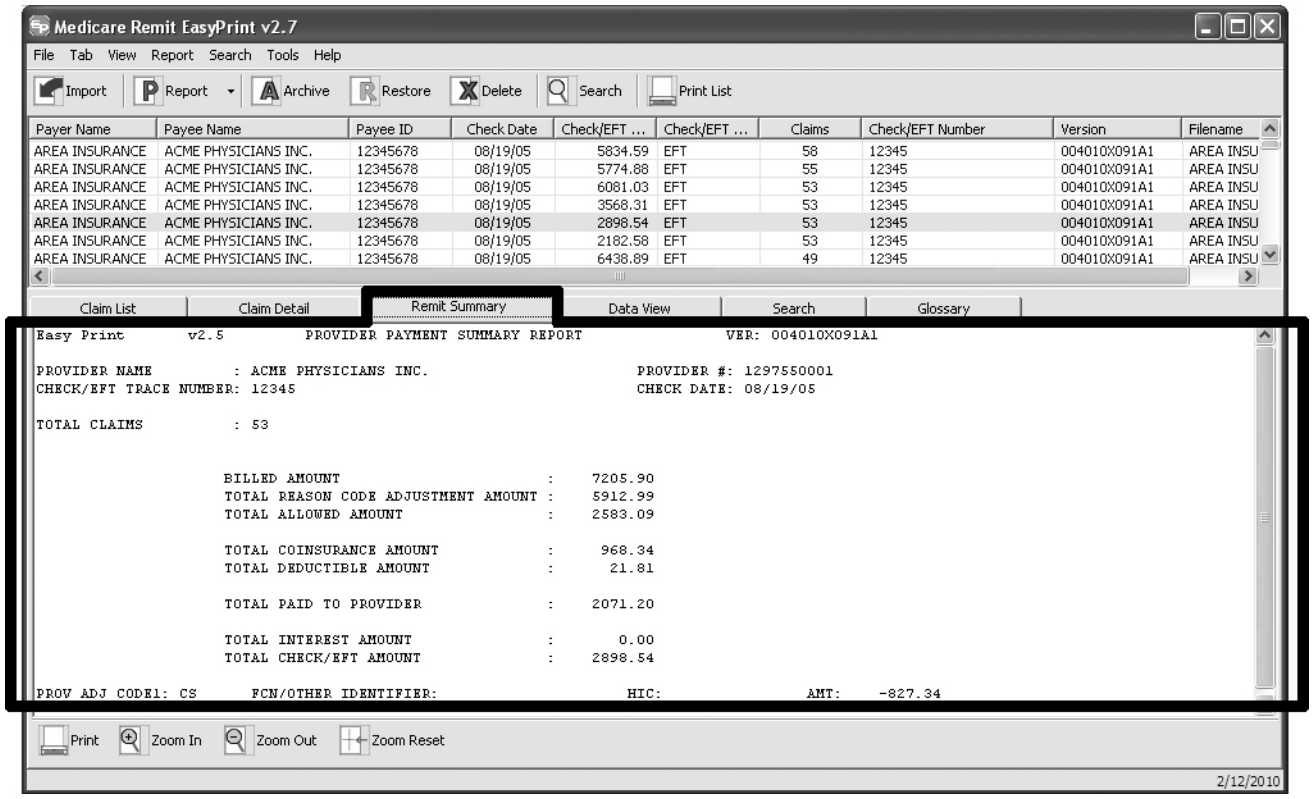


Table 4-1. Professional ERA Provider-Level Adjustment Reason Code Definitions

Provider-Level Adjustment Reason Code	Definition	Use
50	Late Charge	Used to identify Late Claim Filing Penalty.
72	Authorized Return	Used to identify a refund adjustment to a provider (from a previous overpayment). This adjustment should be a negative value and always be offset by some other provider-level adjustment referring to the original refund request or reason.
AP	Acceleration of Benefits	Used to reflect accelerated payment amounts or withholdings. A positive value represents a withholding. A negative value represents a payment.
B2	Rebate	Used for the refund adjustment.
CS	Adjustment	Used to provide supporting identification. Code “RI” is used on a Professional RA for a Reissued Check Amount (e.g., CS/RI).
FB	Forwarding Balance	A negative value represents a balance moving forward to a future payment advice. A positive value represents a balance being applied from a previous payment advice. A reference number (the original ICN and HIC) is applied for tracking purposes.
IR	Internal Revenue Service Withholding	Used for Internal Revenue Service withholdings.



Provider-Level Adjustment Reason Code	Definition	Use
J1	Nonreimbursable	Used to offset claim or service level data that reflects what could be paid if not for demonstration programs or other limitation that prevents issuance of payment. For example, this is used to zero balance provider payment for Centers of Excellence and Medicare Advantage RAs.
L6	Interest Owed	Used for the interest paid on claims on an RA.
LE	Levy	Used for IRS Levy.
SL	Student Loan Repayment	Used to represent a student loan repayment.
WO	Overpayment Recovery	Used to recover previous overpayment. A reference number (the original ICN and HIC) is applied for tracking purposes.

FCN/OTHER IDENTIFIER - This field indicates the Financial Control Number (FCN) that this adjustment relates to when the adjustment refers to a claim that appeared on a previous RA. This usually matches the Internal Control Number (ICN) field of the previous claim. If the adjustment in question does not relate to a specific claim, this field is blank.

HIC - This field indicates the Health Insurance Claim (HIC) number of the beneficiary when the adjustment refers to a claim that appeared on a previous RA. If the adjustment in question does not relate to a specific claim, this field is blank.

AMT - This field indicates the amount of the provider-level adjustment. These adjustments can either decrease the payment (a positive number) or increase the payment (a negative number).

4.2.5.4 The Data View Tab (Professional ERA)

The Data View tab allows providers to view the loops and segments of the ASC X12N 835 004010A1 format. For more information on 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/hipaa on the Internet.

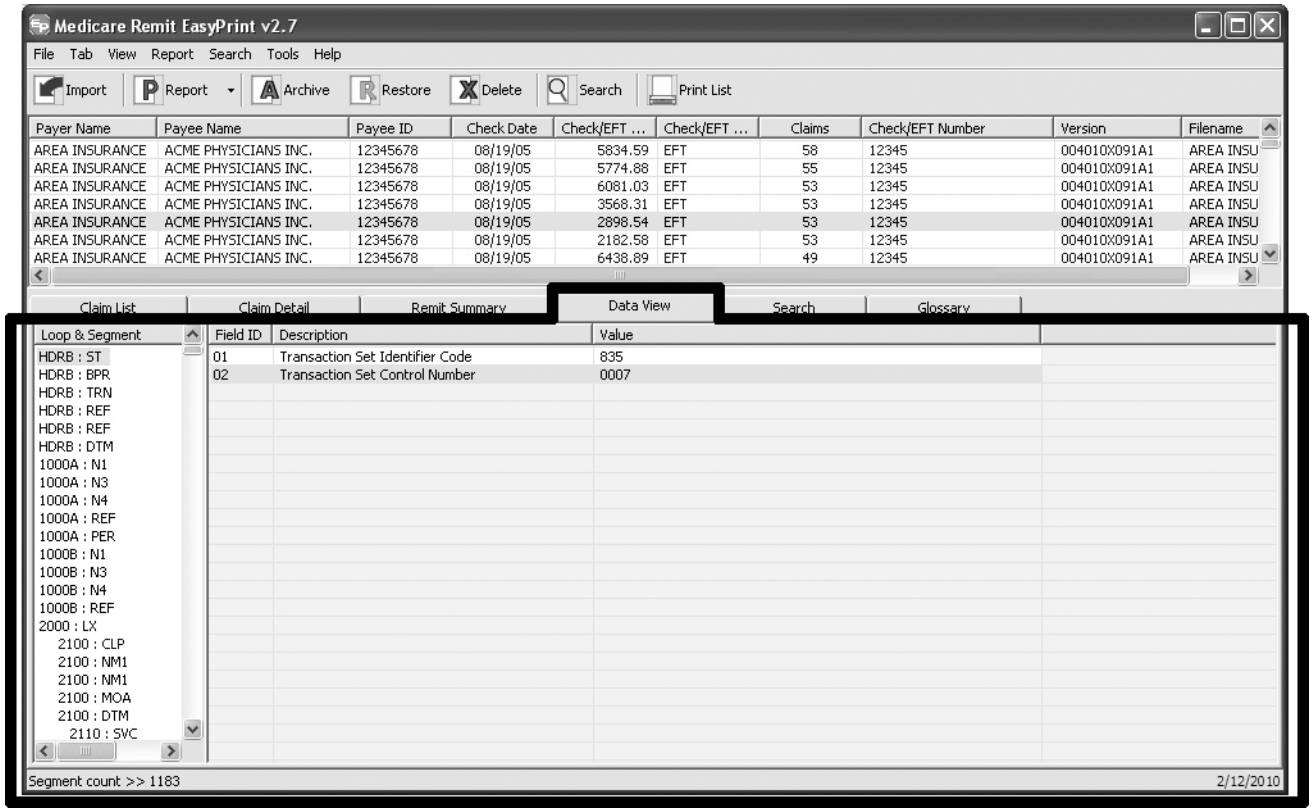


Figure 4-7. The Data View Tab

4.2.5.5 The Search Tab (Professional ERA)

The Search tab gives providers the ability to search for specific information within claims on an RA. Providers 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), and
- Service Date.

Once the search is complete, the software provides a list of claims that matched the requested search criteria. The provider 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.

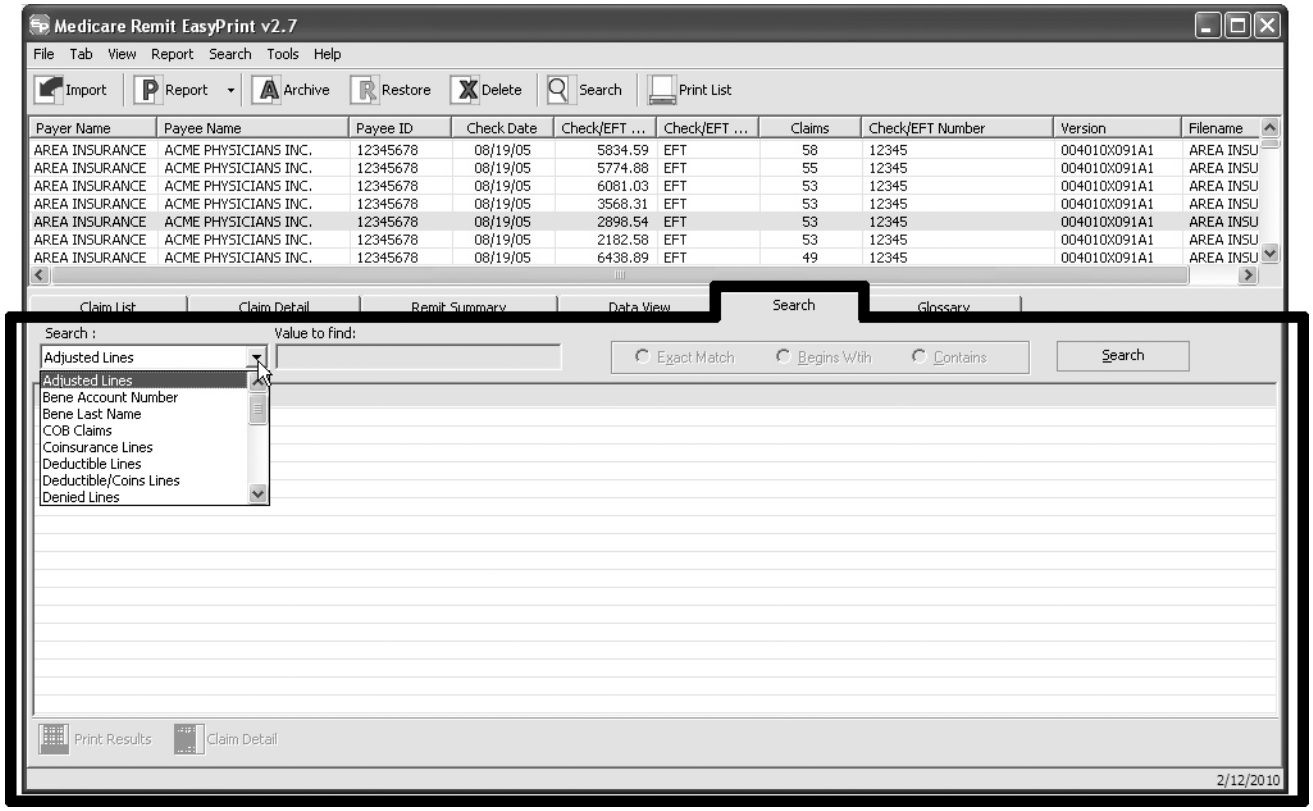


Figure 4-8. The Search Tab

4.2.5.6 The Glossary Tab (Professional ERA)

The Glossary tab provides a list of all Group Codes, Remittance Advice Remark Codes (RARCs), Claim Adjustment Reason Codes (CARCs), and Provider-Level Adjustment Reason Codes that appear on any claim in the ERA. Medicare Contractors will notify providers of necessary updates for the MREP software to accommodate code set changes. File updates will be available three times a year. Providers can sign up with their Medicare Contractor to be notified automatically when updates are available.

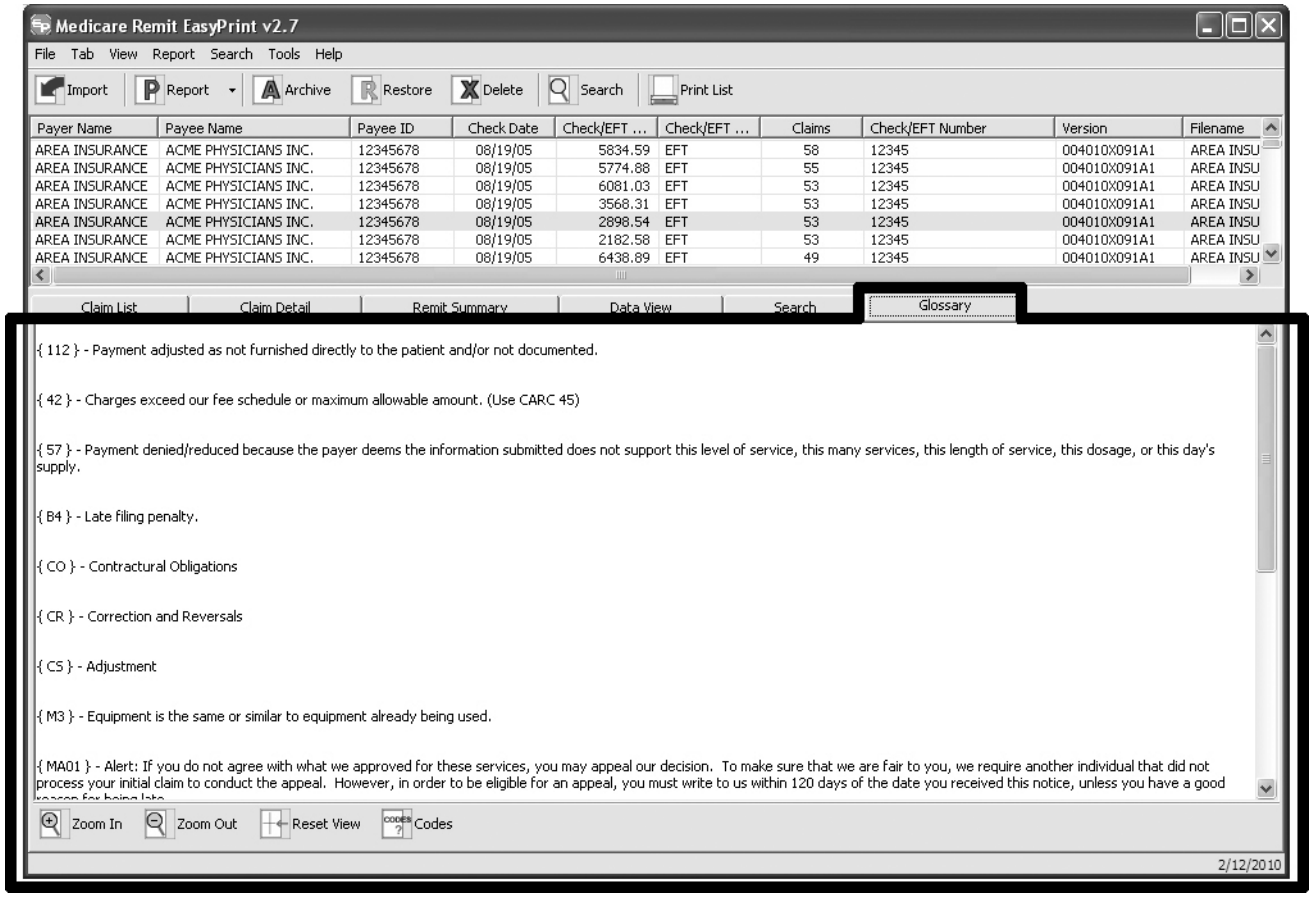


Figure 4-9. The Glossary Tab

4.2.6 Generating Special Reports Using the MREP Software

In addition to the tabbed view that gives providers multiple ways in which to view remittance information, the MREP software provides the following automated special reports. The Entire Remittance Report is discussed in Section 4.2.4.

4.2.6.1 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.

4.2.6.2 COB Claims and Non-COB Claims Reports

The **Coordination of Benefits (COB) Claims report** shows all claims that have been forwarded to an additional payer(s) by the Medicare Contractor. Alternatively, the **Non-COB Claims report** shows all claims that were **not** forwarded to an additional payer. These reports allow providers to quickly view claims by their COB status. These two reports may be accessed from the "COB / Non-COB Claims" option under the "Report" menu in the MREP software.

4.2.6.3 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 providers to view quickly those claims for which beneficiaries (or other insurer, if applicable) must pay coinsurance or some portion of the deductible. These three reports may be accessed from the "Deductible / COINS Service Lines" option under the "Report" menu in the MREP software.

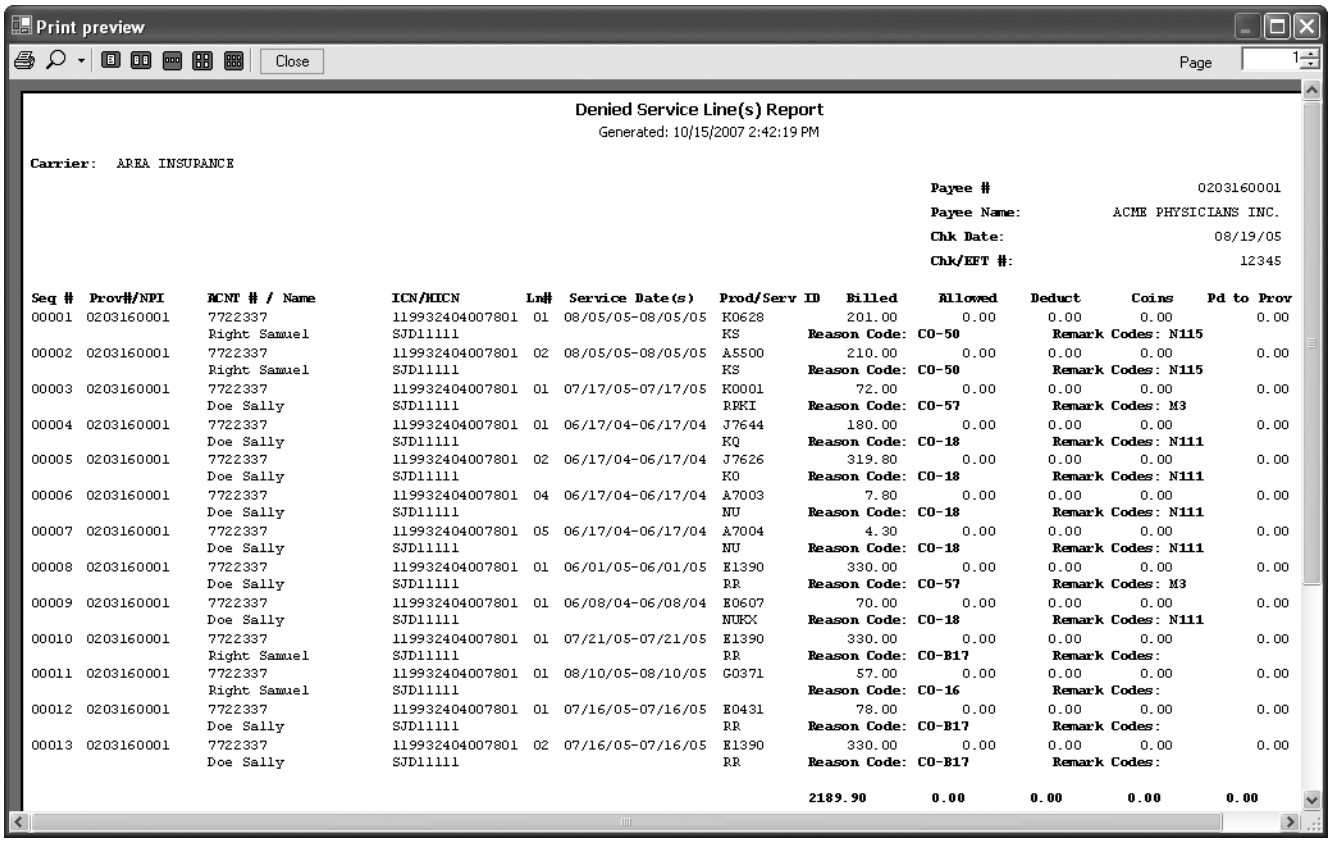
4.2.6.4 The Denied Service Lines Report

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).

4.2.6.5 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.

4.2.6.6 Fields Appearing on MREP Special Reports



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Page 1

Denied Service Line(s) Report

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Carrier: AREA INSURANCE

Payee # 0203160001
Payee Name: ACME PHYSICIANS INC.
Chk Date: 08/19/05
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	0203160001	7722337	119932404007801	01	08/05/05-08/05/05	K0628	201.00	0.00	0.00	0.00	0.00
		Right Samuel	SJD11111			KS	Reason Code: CO-50		Remark Codes: N115		
00002	0203160001	7722337	119932404007801	02	08/05/05-08/05/05	A5500	210.00	0.00	0.00	0.00	0.00
		Right Samuel	SJD11111			KS	Reason Code: CO-50		Remark Codes: N115		
00003	0203160001	7722337	119932404007801	01	07/17/05-07/17/05	K0001	72.00	0.00	0.00	0.00	0.00
		Doe Sally	SJD11111			RPKI	Reason Code: CO-57		Remark Codes: M3		
00004	0203160001	7722337	119932404007801	01	06/17/04-06/17/04	J7644	180.00	0.00	0.00	0.00	0.00
		Doe Sally	SJD11111			KQ	Reason Code: CO-18		Remark Codes: N111		
00005	0203160001	7722337	119932404007801	02	06/17/04-06/17/04	J7626	319.80	0.00	0.00	0.00	0.00
		Doe Sally	SJD11111			K0	Reason Code: CO-18		Remark Codes: N111		
00006	0203160001	7722337	119932404007801	04	06/17/04-06/17/04	A7003	7.80	0.00	0.00	0.00	0.00
		Doe Sally	SJD11111			NU	Reason Code: CO-18		Remark Codes: N111		
00007	0203160001	7722337	119932404007801	05	06/17/04-06/17/04	A7004	4.30	0.00	0.00	0.00	0.00
		Doe Sally	SJD11111			NU	Reason Code: CO-18		Remark Codes: N111		
00008	0203160001	7722337	119932404007801	01	06/01/05-06/01/05	E1390	330.00	0.00	0.00	0.00	0.00
		Doe Sally	SJD11111			RR	Reason Code: CO-57		Remark Codes: M3		
00009	0203160001	7722337	119932404007801	01	06/08/04-06/08/04	E0607	70.00	0.00	0.00	0.00	0.00
		Doe Sally	SJD11111			NUKX	Reason Code: CO-18		Remark Codes: N111		
00010	0203160001	7722337	119932404007801	01	07/21/05-07/21/05	E1390	330.00	0.00	0.00	0.00	0.00
		Right Samuel	SJD11111			RR	Reason Code: CO-B17		Remark Codes:		
00011	0203160001	7722337	119932404007801	01	08/10/05-08/10/05	G0371	57.00	0.00	0.00	0.00	0.00
		Right Samuel	SJD11111				Reason Code: CO-16		Remark Codes:		
00012	0203160001	7722337	119932404007801	01	07/16/05-07/16/05	E0431	78.00	0.00	0.00	0.00	0.00
		Doe Sally	SJD11111			RR	Reason Code: CO-B17		Remark Codes:		
00013	0203160001	7722337	119932404007801	02	07/16/05-07/16/05	E1390	330.00	0.00	0.00	0.00	0.00
		Doe Sally	SJD11111			RR	Reason Code: CO-B17		Remark Codes:		
							2189.90	0.00	0.00	0.00	0.00

Figure 4-10. The Denied Service Lines Report

Figure 4-10 contains an example of one of the special reports that can be generated from the MREP software. The special reports generated by the MREP software share the same general formatting, and have many of the same fields. This section contains an alphabetical list of all the possible fields displayed on MREP special reports.

> **NOTE:** All the fields on the Entire Remittance report are not included in this list. For a detailed look at the paper remittance that is produced using the Entire Remittance report, refer to Section 4.4, Components of the Professional SPR.

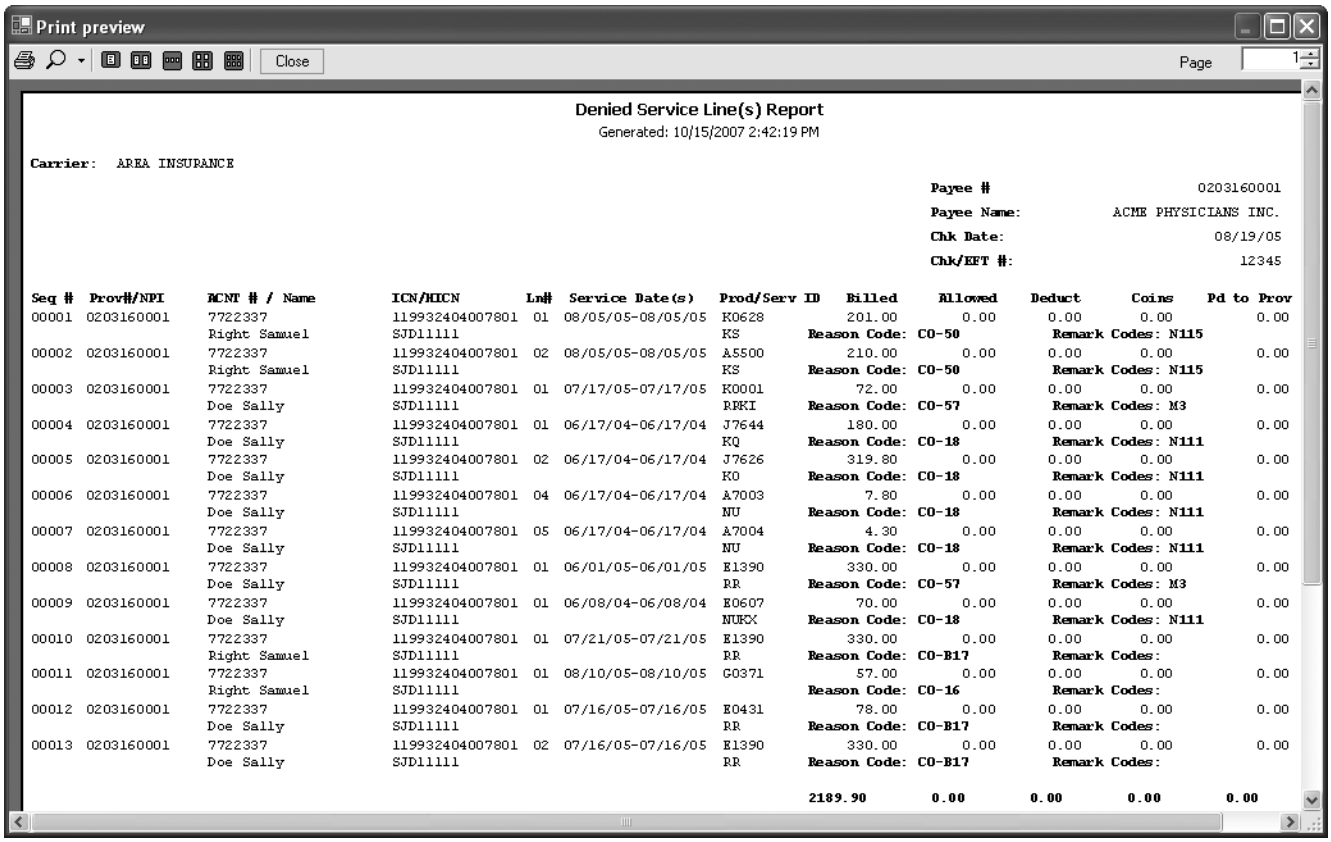
ACNT # / NAME - This field displays the account number (any internal number assigned to the individual electronic claim by the provider; a zero appears if no internal number is submitted with the claim) and the last name and first name of the beneficiary for whom the claim was processed.

ALLOWED - This field displays the Medicare-allowed amount for the service.

BILLED - This field displays the amount that the provider billed for the service.

CARRIER - This field displays the name of the Medicare Contractor that processed the claim(s) and produced the 835.

CHK DATE - This field displays the date on which payment was issued for the claims processed in this 835.



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Page 1

Denied Service Line(s) Report

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Carrier: AREA INSURANCE

Payee # 0203160001
Payee Name: ACME PHYSICIANS INC.
Chk Date: 08/19/05
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	0203160001	7722337	119932404007801	01	08/05/05-08/05/05	K0628	201.00	0.00	0.00	0.00	0.00
		Right Samuel	SJD11111			KS	Reason Code: CO-50		Remark Codes: N115		
00002	0203160001	7722337	119932404007801	02	08/05/05-08/05/05	A5500	210.00	0.00	0.00	0.00	0.00
		Right Samuel	SJD11111			KS	Reason Code: CO-50		Remark Codes: N115		
00003	0203160001	7722337	119932404007801	01	07/17/05-07/17/05	K0001	72.00	0.00	0.00	0.00	0.00
		Doe Sally	SJD11111			RPKI	Reason Code: CO-57		Remark Codes: M3		
00004	0203160001	7722337	119932404007801	01	06/17/04-06/17/04	J7644	180.00	0.00	0.00	0.00	0.00
		Doe Sally	SJD11111			KQ	Reason Code: CO-18		Remark Codes: N111		
00005	0203160001	7722337	119932404007801	02	06/17/04-06/17/04	J7626	319.80	0.00	0.00	0.00	0.00
		Doe Sally	SJD11111			K0	Reason Code: CO-18		Remark Codes: N111		
00006	0203160001	7722337	119932404007801	04	06/17/04-06/17/04	A7003	7.80	0.00	0.00	0.00	0.00
		Doe Sally	SJD11111			NU	Reason Code: CO-18		Remark Codes: N111		
00007	0203160001	7722337	119932404007801	05	06/17/04-06/17/04	A7004	4.30	0.00	0.00	0.00	0.00
		Doe Sally	SJD11111			NU	Reason Code: CO-18		Remark Codes: N111		
00008	0203160001	7722337	119932404007801	01	06/01/05-06/01/05	E1390	330.00	0.00	0.00	0.00	0.00
		Doe Sally	SJD11111			RR	Reason Code: CO-57		Remark Codes: M3		
00009	0203160001	7722337	119932404007801	01	06/08/04-06/08/04	E0607	70.00	0.00	0.00	0.00	0.00
		Doe Sally	SJD11111			NUKX	Reason Code: CO-18		Remark Codes: N111		
00010	0203160001	7722337	119932404007801	01	07/21/05-07/21/05	E1390	330.00	0.00	0.00	0.00	0.00
		Right Samuel	SJD11111			RR	Reason Code: CO-B17		Remark Codes:		
00011	0203160001	7722337	119932404007801	01	08/10/05-08/10/05	G0371	57.00	0.00	0.00	0.00	0.00
		Right Samuel	SJD11111				Reason Code: CO-16		Remark Codes:		
00012	0203160001	7722337	119932404007801	01	07/16/05-07/16/05	E0431	78.00	0.00	0.00	0.00	0.00
		Doe Sally	SJD11111			RR	Reason Code: CO-B17		Remark Codes:		
00013	0203160001	7722337	119932404007801	02	07/16/05-07/16/05	E1390	330.00	0.00	0.00	0.00	0.00
		Doe Sally	SJD11111			RR	Reason Code: CO-B17		Remark Codes:		
							2189.90	0.00	0.00	0.00	0.00

CHK/EFT # - This field indicates the check or EFT transaction number through which payment was issued. If a paper check is issued, this field contains the check number. The RA number is inserted if no payment is issued.

COINS - This field displays the coinsurance amount. If an amount is displayed in this field, this is the amount that the beneficiary (or other insurer, if applicable) is responsible for paying the provider.

- For Part B coinsurance, the beneficiary is responsible for 20 percent of the allowed charges. Some beneficiaries have insurance that pays this 20 percent.

  NOTE: Coinsurance amounts are subject to change annually.

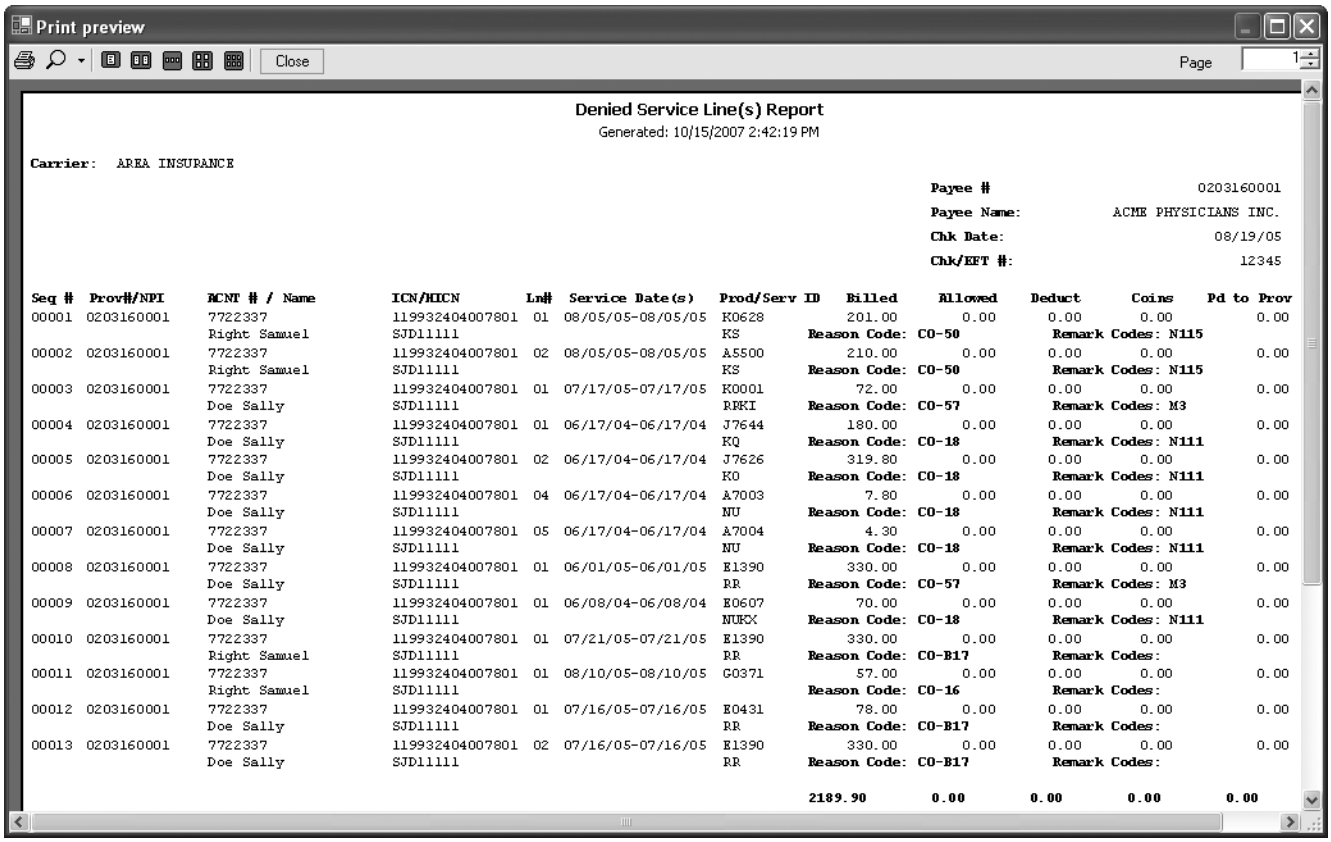
DEDUCT - This field displays the amount of any deductible applied to the service line. If an amount is displayed in this field, this is the amount that the beneficiary (or other insurer, if applicable) is responsible for paying the provider.

- For 2010, there is a yearly deductible of $155.00 for professional services. Some supplemental insurance plans may cover the deductible amount.

  NOTE: Deductible amounts are subject to change annually.

ICN/HICN - This field contains the Internal Control Number (ICN) and the Health Insurance Claim Number (HICN). The ICN is a unique 13-digit number assigned to the claim at the time it is received by the Medicare Contractor. It is used to track and monitor the claim. The HICN is the number of the beneficiary for whom the claim was processed.

LN # - This field indicates which service line within a particular claim is being referenced on this report.



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Page 1

Denied Service Line(s) Report

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Carrier: AREA INSURANCE

Payee # 0203160001
Payee Name: ACME PHYSICIANS INC.
Chk Date: 08/19/05
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	0203160001	7722337	119932404007801	01	08/05/05-08/05/05	K0628	201.00	0.00	0.00	0.00	0.00
		Right Samuel	SJD11111			KS	Reason Code: CO-50		Remark Codes: N115		
00002	0203160001	7722337	119932404007801	02	08/05/05-08/05/05	A5500	210.00	0.00	0.00	0.00	0.00
		Right Samuel	SJD11111			KS	Reason Code: CO-50		Remark Codes: N115		
00003	0203160001	7722337	119932404007801	01	07/17/05-07/17/05	K0001	72.00	0.00	0.00	0.00	0.00
		Doe Sally	SJD11111			RPKI	Reason Code: CO-57		Remark Codes: M3		
00004	0203160001	7722337	119932404007801	01	06/17/04-06/17/04	J7644	180.00	0.00	0.00	0.00	0.00
		Doe Sally	SJD11111			KQ	Reason Code: CO-18		Remark Codes: N111		
00005	0203160001	7722337	119932404007801	02	06/17/04-06/17/04	J7626	319.80	0.00	0.00	0.00	0.00
		Doe Sally	SJD11111			K0	Reason Code: CO-18		Remark Codes: N111		
00006	0203160001	7722337	119932404007801	04	06/17/04-06/17/04	A7003	7.80	0.00	0.00	0.00	0.00
		Doe Sally	SJD11111			NU	Reason Code: CO-18		Remark Codes: N111		
00007	0203160001	7722337	119932404007801	05	06/17/04-06/17/04	A7004	4.30	0.00	0.00	0.00	0.00
		Doe Sally	SJD11111			NU	Reason Code: CO-18		Remark Codes: N111		
00008	0203160001	7722337	119932404007801	01	06/01/05-06/01/05	E1390	330.00	0.00	0.00	0.00	0.00
		Doe Sally	SJD11111			RR	Reason Code: CO-57		Remark Codes: M3		
00009	0203160001	7722337	119932404007801	01	06/08/04-06/08/04	E0607	70.00	0.00	0.00	0.00	0.00
		Doe Sally	SJD11111			NUKX	Reason Code: CO-18		Remark Codes: N111		
00010	0203160001	7722337	119932404007801	01	07/21/05-07/21/05	E1390	330.00	0.00	0.00	0.00	0.00
		Right Samuel	SJD11111			RR	Reason Code: CO-B17		Remark Codes:		
00011	0203160001	7722337	119932404007801	01	08/10/05-08/10/05	G0371	57.00	0.00	0.00	0.00	0.00
		Right Samuel	SJD11111				Reason Code: CO-16		Remark Codes:		
00012	0203160001	7722337	119932404007801	01	07/16/05-07/16/05	E0431	78.00	0.00	0.00	0.00	0.00
		Doe Sally	SJD11111			RR	Reason Code: CO-B17		Remark Codes:		
00013	0203160001	7722337	119932404007801	02	07/16/05-07/16/05	E1390	330.00	0.00	0.00	0.00	0.00
		Doe Sally	SJD11111			RR	Reason Code: CO-B17		Remark Codes:		
							2189.90	0.00	0.00	0.00	0.00

PAYEE # - This field indicates the National Provider Identifier (NPI) of the facility receiving the ERA. The NPI is the number assigned to the provider for billing and identification purposes. For more information about the NPI, visit http://www.cms.gov/NationalProvIdentStand on the CMS website.

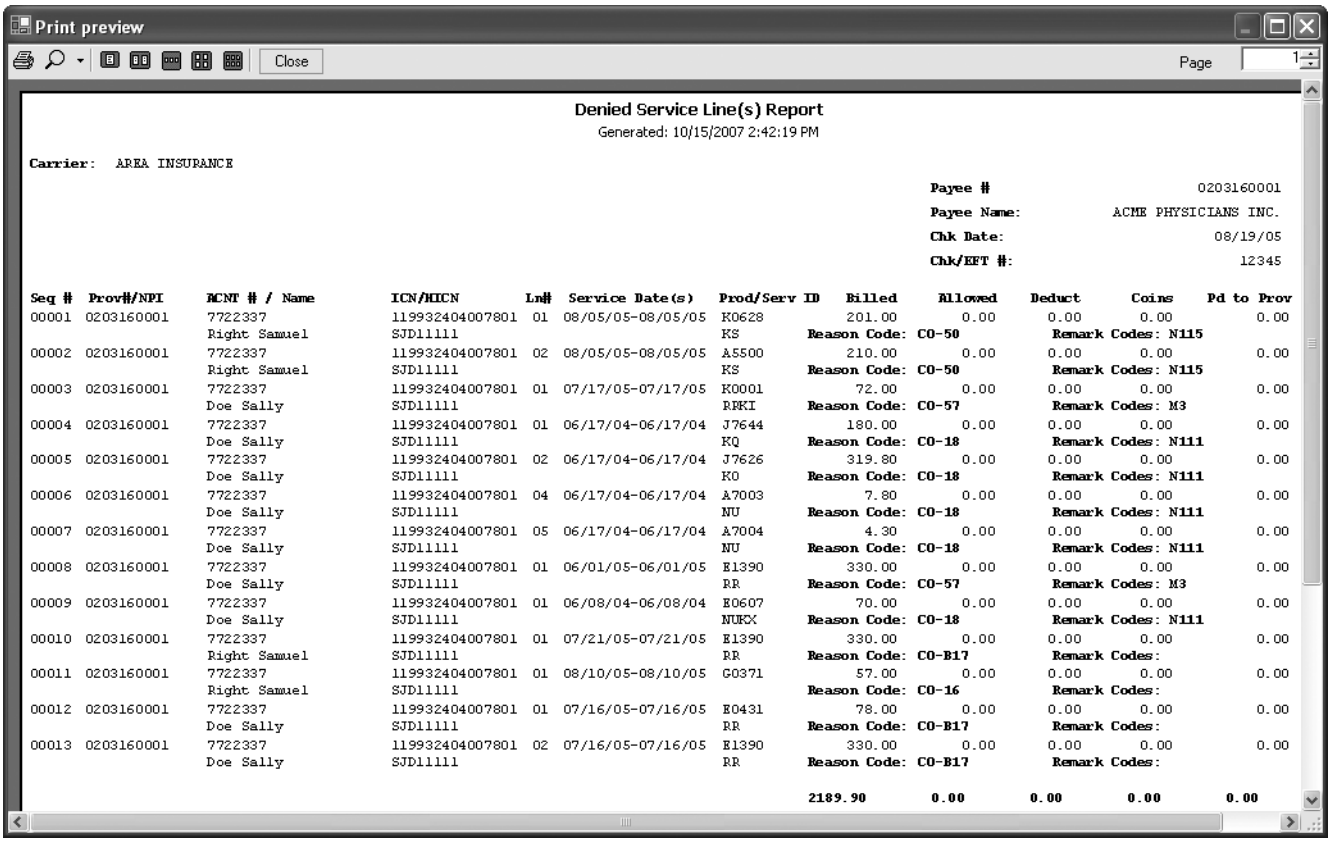
PAYEE NAME - This field displays the name of the provider that submitted the claims addressed in this 835.

PD TO PROV - This field contains the total amount that the provider was paid for the service.

PROD/SERV ID - This field provides a code that identifies the procedure or service performed for the indicated service line. This field may contain one of two items:

- Specific procedures (and all modifiers billed to that procedure) are identified with a Healthcare Common Procedure Coding System (HCPCS) code. Information on HCPCS codes (including a list of Level II HCPCS codes) may be found at http://www.cms.gov/HCPCSReleaseCodeSets on the CMS website.
- Drug products are identified with a unique, three-segment number called the National Drug Code (NDC). A directory of NDCs is available at http://www.fda.gov/Drugs/InformationOnDrugs/ucm142438.htm on the Internet.

PROV#/NPI - This field displays the NPI of the rendering provider for this service line, if the NPI is available. The NPI is the number assigned to the rendering provider for billing and identification purposes. For more information about the NPI, visit http://www.cms.gov/NationalProvIdentStand on the CMS website.



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Denied Service Line(s) Report

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Carrier: AREA INSURANCE

Payee # 0203160001
Payee Name: ACME PHYSICIANS INC.
Chk Date: 08/19/05
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		Right Samuel	SJD11111			KS	Reason Code: CO-50		Remark Codes: N115		
00002	0203160001	7722337	119932404007801	02	08/05/05-08/05/05	A5500	210.00	0.00	0.00	0.00	0.00
		Right Samuel	SJD11111			KS	Reason Code: CO-50		Remark Codes: N115		
00003	0203160001	7722337	119932404007801	01	07/17/05-07/17/05	K0001	72.00	0.00	0.00	0.00	0.00
		Doe Sally	SJD11111			RRKI	Reason Code: CO-57		Remark Codes: M3		
00004	0203160001	7722337	119932404007801	01	06/17/04-06/17/04	J7644	180.00	0.00	0.00	0.00	0.00
		Doe Sally	SJD11111			KQ	Reason Code: CO-18		Remark Codes: N111		
00005	0203160001	7722337	119932404007801	02	06/17/04-06/17/04	J7626	319.80	0.00	0.00	0.00	0.00
		Doe Sally	SJD11111			KO	Reason Code: CO-18		Remark Codes: N111		
00006	0203160001	7722337	119932404007801	04	06/17/04-06/17/04	A7003	7.80	0.00	0.00	0.00	0.00
		Doe Sally	SJD11111			NU	Reason Code: CO-18		Remark Codes: N111		
00007	0203160001	7722337	119932404007801	05	06/17/04-06/17/04	A7004	4.30	0.00	0.00	0.00	0.00
		Doe Sally	SJD11111			NU	Reason Code: CO-18		Remark Codes: N111		
00008	0203160001	7722337	119932404007801	01	06/01/05-06/01/05	E1390	330.00	0.00	0.00	0.00	0.00
		Doe Sally	SJD11111			RR	Reason Code: CO-57		Remark Codes: M3		
00009	0203160001	7722337	119932404007801	01	06/08/04-06/08/04	E0607	70.00	0.00	0.00	0.00	0.00
		Doe Sally	SJD11111			NUKX	Reason Code: CO-18		Remark Codes: N111		
00010	0203160001	7722337	119932404007801	01	07/21/05-07/21/05	E1390	330.00	0.00	0.00	0.00	0.00
		Right Samuel	SJD11111			RR	Reason Code: CO-B17		Remark Codes:		
00011	0203160001	7722337	119932404007801	01	08/10/05-08/10/05	G0371	57.00	0.00	0.00	0.00	0.00
		Right Samuel	SJD11111				Reason Code: CO-16		Remark Codes:		
00012	0203160001	7722337	119932404007801	01	07/16/05-07/16/05	E0431	78.00	0.00	0.00	0.00	0.00
		Doe Sally	SJD11111			RR	Reason Code: CO-B17		Remark Codes:		
00013	0203160001	7722337	119932404007801	02	07/16/05-07/16/05	E1390	330.00	0.00	0.00	0.00	0.00
		Doe Sally	SJD11111			RR	Reason Code: CO-B17		Remark Codes:		
							2189.90	0.00	0.00	0.00	0.00

REASON CODE - This field contains any Group Codes and Claim Adjustment Reason Codes (CARCs) associated with this service line. There are four possible Group Codes for Medicare. See Table 2-1 in Chapter 2 of this Guide for a list of Group Codes.

REMARK CODES - This field indicates any Remittance Advice Remark Codes (RARCs) associated with the claim.

> **NOTE:** CARCs and RARCs are listed along with their definitions in the glossary section of the SPR. *A complete listing of CARCs and RARCs can be found at http://www.wpc-edi.com/codes on the Internet.*

SEQ # - This field indicates the sequence number assigned by the MREP software and is not a field from the 835.

SERVICE DATE(S) - This field displays the date(s) of service.

4.3 READING A PROFESSIONAL STANDARD PAPER REMITTANCE ADVICE (SPR)

4.3.1 SPR Basics

Providers who still elect to receive a paper Remittance Advice (RA) receive the Standard Paper Remittance Advice (SPR). Recipients of an SPR receive the same critical remittance information as recipients of the Electronic Remittance Advice (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 (e.g., hospitals) look different than those received by professional providers (e.g., physicians). Additionally, SPR formats may vary by the Medicare Contractor that provides the SPR. Figures (example SPRs) in this section are shown as a reference, and may vary from what providers actually see.

NOTE: In the remainder of this section, Carriers, Durable Medical Equipment Medicare Administrative Contractors (DME MACs), and Part B MACs are referred to as "Medicare Contractors".

4.3.1.1 Types of SPRs

Providers may also generate their own SPR by choosing to receive an electronic 835 file and using the Medicare Remit Easy Print (MREP) software to view and print the 835 in SPR format. There are slight differences between SPRs received from a Medicare Contractor and SPRs generated from the MREP software (referred to as the MREP SPR).

The remainder of this chapter addresses how to read SPRs received from a Medicare Contractor, and uses text boxes to highlight the differences that appear in MREP SPRs.

More 835 Information

In January 2009, HHS approved the replacement of the 4010A1 versions of electronic transactions, including the 835, with the ASC X12 Version 5010. Medicare providers must be fully compliant with ASC X12 Version 5010 by January 1, 2012. Information and the latest news for the 5010 may be found at http://www.cms.gov/Versions5010andD0/01_overview.asp on the Centers for Medicare & Medicaid Services (CMS) website.

4.3.2 How Does a Provider Switch from an SPR to an ERA?

If a provider currently receives SPRs and is interested in switching to ERAs, the provider should contact the Electronic Data Interchange (EDI) department of his or her Medicare Contractor.

NOTE: **Effective June 1, 2006:** Carriers and DME MACs stopped sending the SPR to providers who also received an ERA for 45 days or more.

4.3.2.1 Electronic Funds Transfer (EFT) Forms

All providers entering the Medicare Program for the first time must use EFT in order to receive payments. Any provider not currently on EFT that submits any change to its existing enrollment data must also submit a Form CMS-588, Authorization Agreement for Electronic Funds Transfer, to convert to EFT. Eventually, all existing providers/entities will be required to make the transition to EFT.

4.3.2.2 ERA and EFT Advantages

Using the ERA saves time and increases productivity by providing electronic payment adjustment information that is portable, reusable, retrievable, and storable. The ERA can be exchanged between partners with much greater ease than a paper remittance. Advantages to using the ERA and EFT include:

- Faster communication and payment notification;
- Faster account reconciliation through electronic posting;
- Less paper generated;
- Lower operating costs;
- More detailed information;
- Access to data in a variety of formats through free Medicare-supported software;
- Elimination of lost checks and SPRs; and
- Less space needed for storage.

4.4 COMPONENTS OF THE PROFESSIONAL STANDARD PAPER REMITTANCE ADVICE (SPR)

Professional SPRs are split into four basic sections:

- **Header Information (Section 1 of Figures 4-11 and 4-12)** - This section contains header information and a bulletin board section.
- **Assigned Claims (Sections 2 and 3 of Figure 4-11)** - This section provides detailed information for each individual assigned claim.
- **Unassigned Claims (Section 2 of Figure 4-12)** - This section provides detailed information for each individual unassigned claim.
- **Glossary (Section 3 of Figure 4-12)** - This section lists all Claim Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs) and their appropriate text that appear on the SPR.

The example SPR shown in Figure 4-11 and 4-12 consists of two pages. Header information and the assigned claims are contained on the first page (Figure 4-11), while unassigned claim information and the glossary are contained on the second page (Figure 4-12).

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:  01/28/03
SOMEWHERE, NJ   16666-0200                                      CHECK/EFT #:  000234569
*****************************************************************************************************************
*                                                                                                               *
*                      WELCOME TO THE MEDICARE PART B STANDARD PAPER REMITTANCE                                 *
*                                                                                                               *
*                                                                                                               *
*                                                                                                               *
*                                                                                                               *
```

2

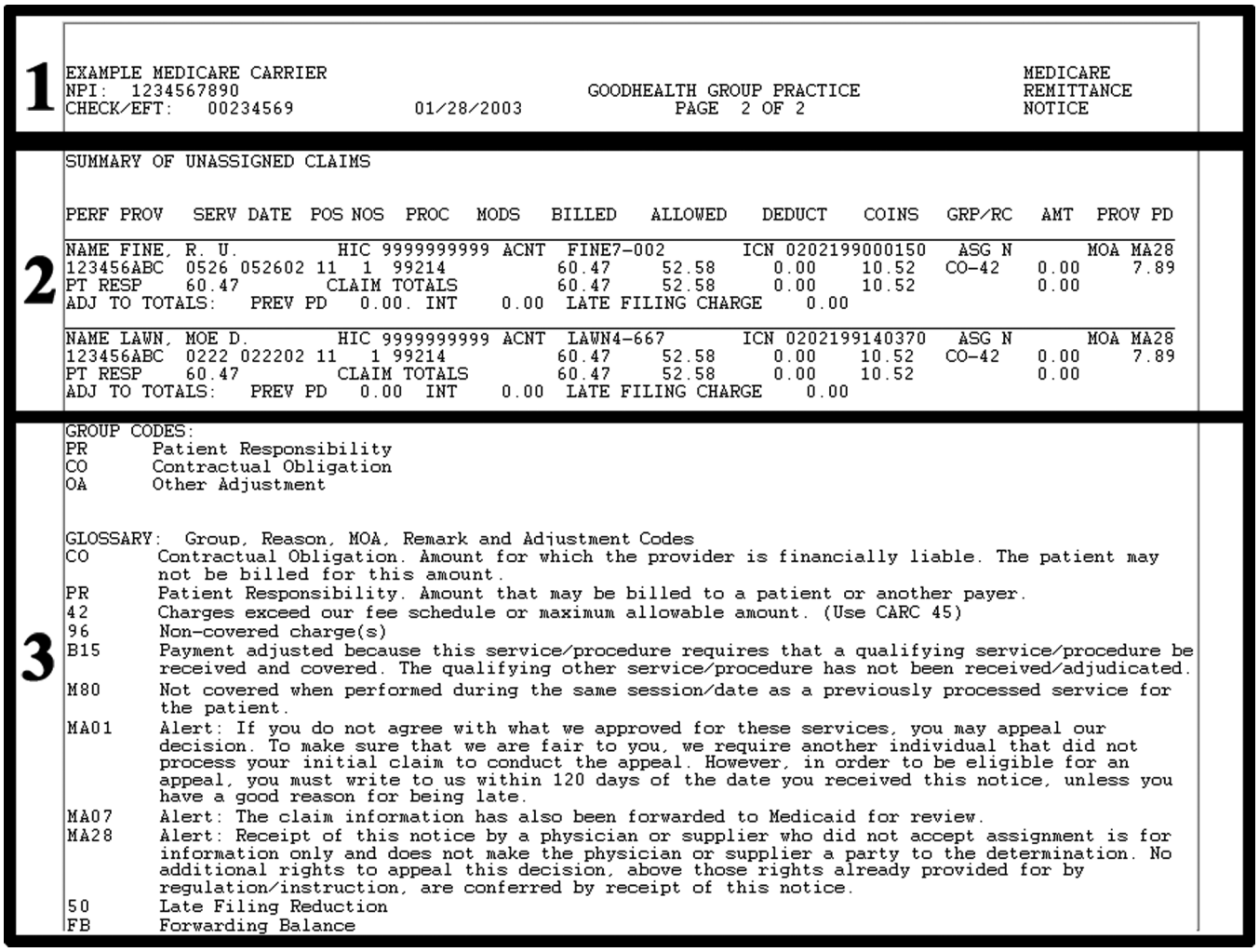
```
PERF PROV   SERV DATE  POS NOS  PROC   MODS   BILLED   ALLOWED   DEDUCT   COINS  GRP/RC   AMT   PROV PD
-----------------------------------------------------------------------------------------------------------------
NAME FISCHER, BENNY      HIC 9999999999 ACNT  FISC6123133-01  ICN 0202199306840   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 FISCHER, BENNY      HIC 9999999999 ACNT  FISC6123133-01  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 HURT, I. M.         HIC 9999999999 ACNT  HURT5-329       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 MARLOWE, PHILIP     HIC 9999999999 ACNT  MARLO861-316    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 RAP, JACK           HIC 9999999999 ACNT  RAP33-721       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 4-11. Example of a Professional SPR - Page 1



1

```
EXAMPLE MEDICARE CARRIER                                                    MEDICARE
NPI:  1234567890                          GOODHEALTH GROUP PRACTICE         REMITTANCE
CHECK/EFT:   00234569          01/28/2003          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 FINE, R. U.          HIC 9999999999 ACNT  FINE7-002       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 LAWN, MOE D.         HIC 9999999999 ACNT  LAWN4-667       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.
50      Late Filing Reduction
FB      Forwarding Balance
```

Figure 4-12. Example of a Professional SPR - Page 2

4.4.1 Header Information (Professional SPR)

Section 1 of Figures 4-11 and 4-12 shows the header information that appears on all pages of a Professional SPR. This section contains provider and Medicare Contractor information for the SPR. The fields provided in this header information are listed in this section. Some fields in the header information do not contain labels. **These unlabeled fields are designated with an asterisk (*) on the following page.** Figure 4-12 shows the second page of an example SPR.

The following data appears on the left side of the page in the header section. See Figure 4-13 for a closer view of this portion of the SPR.

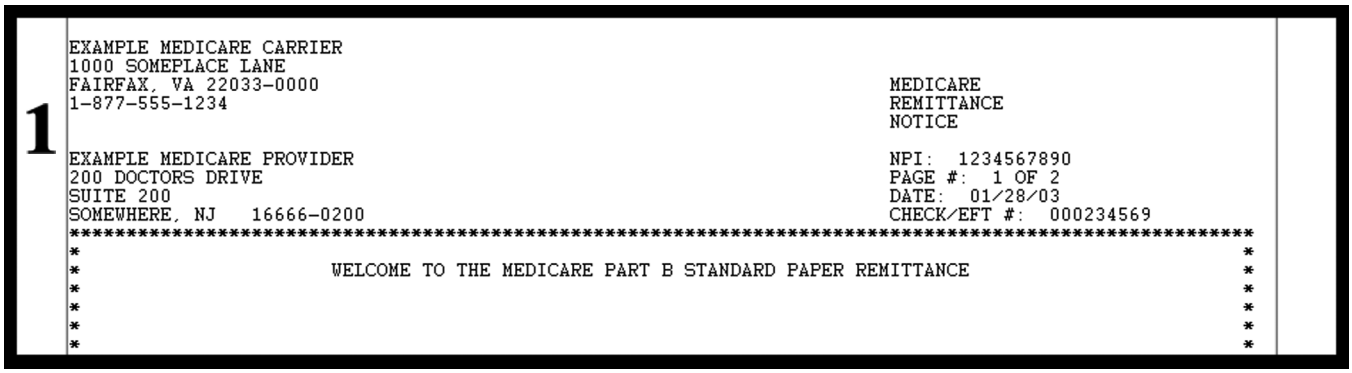


Figure 4-13. Introductory Information on Page 1 of the Example Professional SPR

MEDICARE CARRIER NAME - This field displays the name of the Medicare Contractor that processed the claim(s) and produced the SPR.

STREET ADDRESS* - This field displays the street address of the Medicare Contractor.

CITY* - This field displays the city in which the Medicare Contractor is located.

STATE* - This field displays the state in which the Medicare Contractor is located.

ZIP CODE* - This field displays the Zip code of the Medicare Contractor.

TEL #* - This field displays the telephone number of the Medicare Contractor.

PROVIDER NAME* - This field displays the name of the provider that submitted the claims addressed on the SPR.

STREET ADDRESS* - This field displays the street address of the provider.

CITY* - This field displays the city in which the provider is located.

STATE* - This field displays the state in which the provider is located.

ZIP CODE* - This field displays the Zip code of the provider.

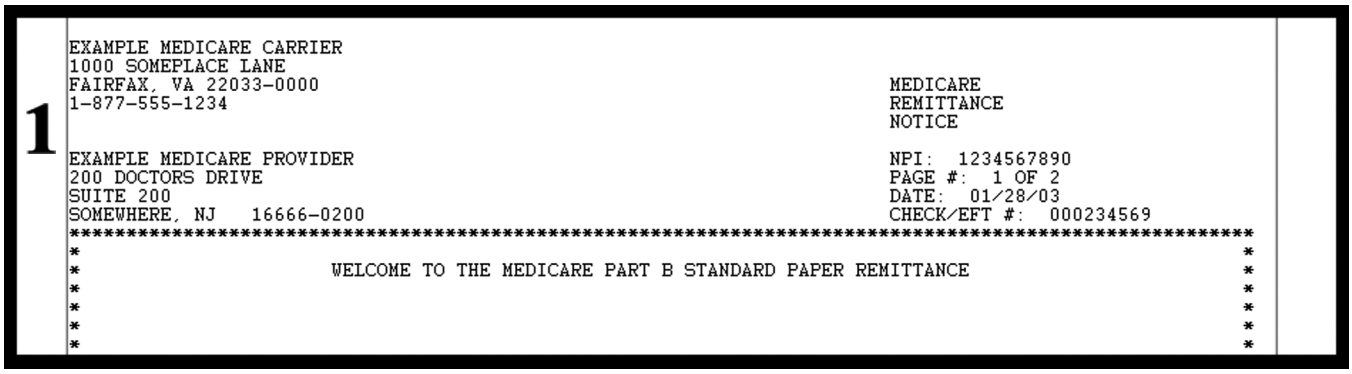
The following information appears on the right side of the page. See Figure 4-13 for a closer view of this portion of the SPR.

MEDICARE REMITTANCE NOTICE - This text appears on the right side of the SPR as a document title.

NPI - This field displays the National Provider Identifier (NPI) of the facility receiving the SPR. The NPI is the number assigned to the facility for billing and identification purposes. For more information about the NPI, visit http://www.cms.gov/NationalProvIdentStand on the CMS website.

PAGE # - This field indicates the current page number and total number of pages in the SPR.

DATE - This field indicates the date that the SPR was issued.



CHECK/EFT # - This field indicates the check or EFT transaction number through which payment was issued. If a paper check is issued, this field contains the check number. The RA number is inserted if no payment is issued.

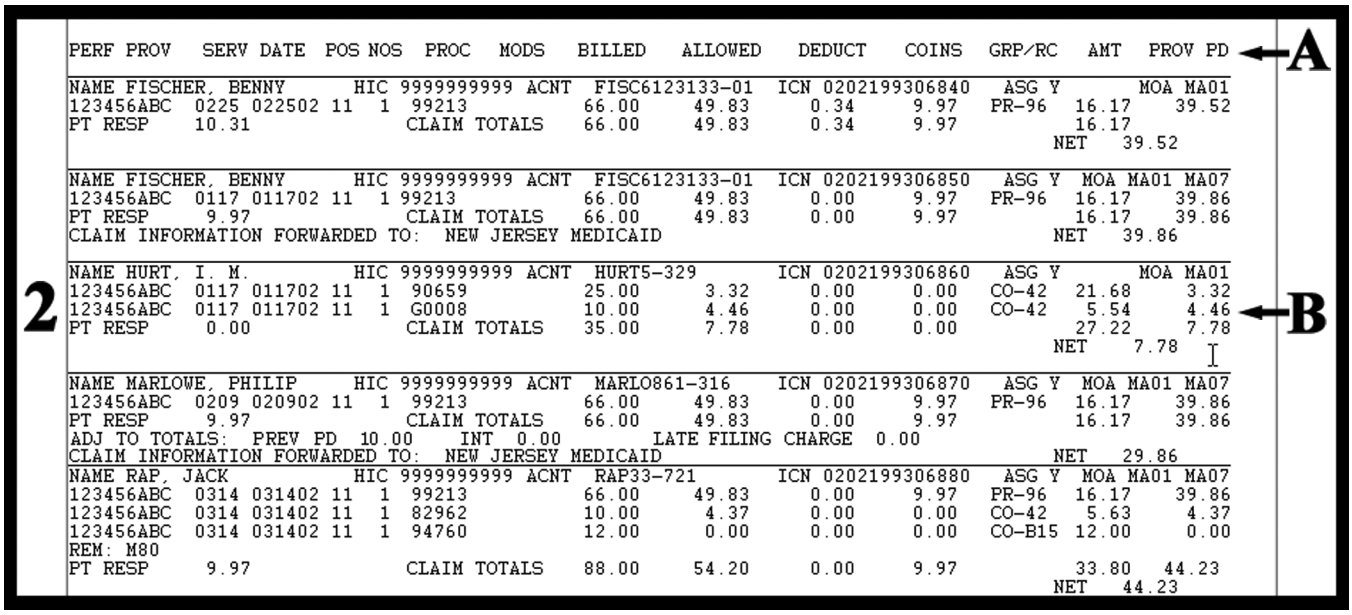
The final area of the header information is the bulletin board section. This area, boxed in with asterisks, contains Medicare Contractor-specific information for the provider. The bulletin board section is only provided on the first page of the SPR.

MREP Information

On a paper remittance printed from the MREP software, the bulletin board section is omitted.

4.4.2 Assigned Claims (Professional SPR)

Figure 4-14 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 4-14) provides a reference for the service-line-level and claim-level data that are displayed for each claim in the assigned claims section.



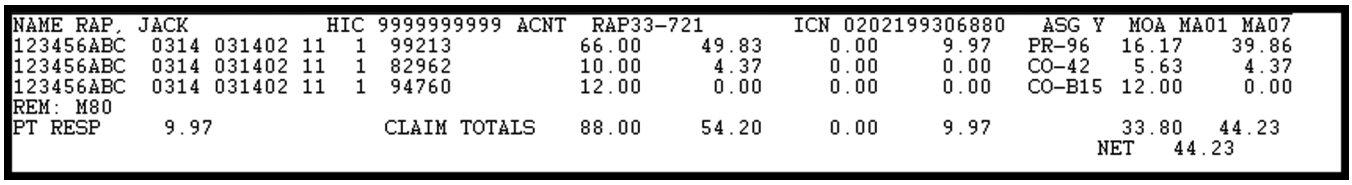
```
PERF PROV   SERV DATE  POS NOS  PROC   MODS   BILLED   ALLOWED   DEDUCT   COINS  GRP/RC   AMT   PROV PD  <-A
NAME FISCHER, BENNY       HIC 9999999999 ACNT  FISC6123133-01  ICN 0202199306840   ASG Y        MOA MA01
123456ABC  0225 022502 11  1  99213          66.00     49.83     0.34     9.97  PR-96  16.17     39.52
PT RESP    10.31             CLAIM TOTALS   66.00     49.83     0.34     9.97         16.17
                                                                                 NET   39.52
NAME FISCHER, BENNY       HIC 9999999999 ACNT  FISC6123133-01  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 HURT, I. M.          HIC 9999999999 ACNT  HURT5-329       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 MARLOWE, PHILIP      HIC 9999999999 ACNT  MARLO861-316    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 RAP, JACK            HIC 9999999999 ACNT  RAP33-721       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
```

2

Figure 4-14. The Assigned Claims Section of the Professional SPR

After the header row, claims are listed individually (shown in Section B of Figure 4-14). 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. Names displayed on the Professional SPR are in alphabetical order by last name.

Figure 4-15 shows a single claim from the assigned claims section. The fields displayed for each claim are described in the following sections.



```
NAME RAP, JACK            HIC 9999999999 ACNT  RAP33-721       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 4-15. Information for an Individual Claim

4.4.2.1 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. The fields in the first line (that apply to the claim as a whole) are described in this section.

NAME - This field contains the last name and first name of the beneficiary for whom the claim was processed. If a claim was submitted by the provider using the name Jane Smith, but during processing Medicare records indicate the name of record for that beneficiary is listed as Jane Jones on the Common Working File (CWF), a file that contains beneficiary entitlement and history records, then the SPR shows the name “Jones, Jane” in this field.

```
NAME RAP, JACK           HIC 9999999999 ACNT  RAP33-721       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
```

HIC - This field indicates the Health Insurance Claim (HIC) number of the beneficiary for whom the claim was processed. For example, a claim was submitted by the provider using the HIC number 123456789A. If the beneficiary's HIC number was changed to 987654321B on the CWF, then the SPR shows the HIC number 987654321B in this field.

ACNT - This field contains any internal number assigned to the individual electronic claim by the provider. A zero appears if no internal number is submitted with the claim.

ICN - This field contains the Internal Control Number (ICN). The 13-digit ICN is a unique number assigned to the claim at the time it is received by the Medicare Contractor. It is used to track and monitor the claim.

ASG - This field indicates whether the provider has accepted assignment for these claims. This field contains either a "Y" or an "N".

MOA - This field contains Remittance Advice Remark Codes (RARCs) at the claim level. These codes and their meanings are listed in the glossary section at the end of the SPR. *RARCs are used to convey appeal information and other claim-specific information providing additional explanation for claim-level adjustments. A complete listing of these codes can be found at http://www.wpc-edi.com/codes on the Internet.*

4.4.2.2 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 4-15, there are three separate service lines. These columns correspond to the headers shown in Figure 4-16. These fields are described in this section.

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

Figure 4-16. Header for Service-Line Data

PERF PROV - This field displays the NPI of the performing/rendering provider for this service line. The NPI is the number assigned to the rendering provider for billing and identification purposes. If there is more than one provider, only the first is included. For more information about the NPI, visit http://www.cms.gov/NationalProvIdentStand on the CMS website.

SERV DATE - This field displays the date(s) of service.

POS - This field indicates the two-digit Place of Service (POS) code. A list of POS codes is available at http://www.cms.gov/manuals/downloads/clm104c26.pdf on the CMS website.

NOS - This field displays the number of services rendered.

PROC - This field indicates the Healthcare Common Procedure Coding System (HCPCS) procedure code. Information on HCPCS codes (including a list of Level II HCPCS codes) may be found at http://www.cms.gov/HCPCSReleaseCodeSets on the CMS website.

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

NOTE: When an SPR is used to report the results of adjudication of a retail drug claim submitted in the National Council for Prescription Drug Programs (NCPDP) format adopted by HIPAA, the longer length National Drug Code (NDC) number begins in the PROC field and ends in the MODS field.

MODS - This field displays all modifiers billed with the specified procedure.

BILLED - This field displays the amount that the provider billed for the service.

ALLOWED - This field displays the Medicare-allowed amount for the service.

DEDUCT - This field displays the amount of any deductible applied to the claim. If an amount is displayed in this field, this is the amount that the beneficiary (or other insurer, if applicable) is responsible for paying the provider.

- For 2010, there is a yearly deductible of $155.00 for professional services. Some supplemental insurance plans may cover the deductible amount.

NOTE: Deductible amounts are subject to change annually.

COINS - This field displays the coinsurance amount. If an amount is displayed in this field, this is the amount that the beneficiary (or other insurer, if applicable) is responsible for paying the provider.

- For Part B coinsurance, the beneficiary is responsible for 20 percent of the allowed charges. Some beneficiaries have insurance that pays this 20 percent.

NOTE: Coinsurance amounts are subject to change annually.

GRP/RC - This field contains any Group Codes and Claim Adjustment Reason Codes (CARCs) associated with this service line. There are four possible Group Codes for Medicare. See Table 2-1 in Chapter 2 of this Guide for a list of Group Codes.

Codes listed for a service line of a claim are listed along with their definitions in the glossary section of the SPR. A complete listing of CARCs can be found at http://www.wpc-edi.com/codes on the Internet.

AMT - This field contains the amount of any adjustment that was made based on the preceding Group Code and CARC.

PROV PD - This field contains the total amount that the provider was paid for the service.

Some claims have additional Remittance Advice Remark Codes (RARCs) that apply to the claim at a service-line level. These codes are displayed immediately under that service line. An example of this is the “REM: M80” text as shown in Figure 4-17.

NAME RAP, JACK			HIC 9999999999 ACNT	RAP33-721		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 4-17. Information for an Individual Claim

```
NAME RAP, JACK           HIC 9999999999 ACNT  RAP33-721       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
```

4.4.2.3 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 4-17 for a closer view of this portion of the SPR. These fields are described in this section.

PT RESP - This field indicates the total amount that the beneficiary owes the provider for this claim.

CLAIM TOTALS - The claim totals section provides the totals of all service-line-level amounts. The dollar amounts here fall under the BILLED, ALLOWED, DEDUCT, COINS, AMT, and PROV PD column headers.

CLAIM INFORMATION FORWARDED TO: - Some claims, such as that shown in Figure 4-18, show this 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.

NET - This field indicates the net amount Medicare owes the provider for this claim.

```
NAME MARLOWE, PHILIP     HIC 9999999999 ACNT  MARLO861-316    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 4-18. Information for an Individual Claim

4.4.2.4 Assigned Claims - Adjustments Line (Professional SPR)

The adjustments line appears for assigned claims, if applicable. These fields are described in this section.

ADJ TO TOTALS - The unassigned claim section contains an additional line for adjustments. This line can contain the following fields.

PREV PD - This field displays the amount previously paid for the rendered services. This field contains a value only when the claim is an adjusted claim.

INT - This field displays the interest amount.

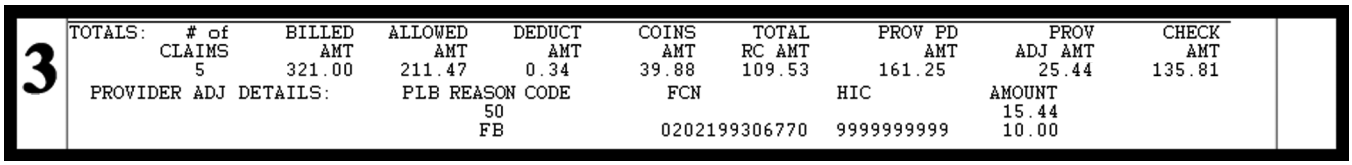
LATE FILING CHARGE - This field displays the late filing charge.

MREP Information

Paper remittances printed from the MREP software handle adjusted claims differently than the SPR.

When the Medicare Contractor generates an SPR, it nets the amount paid on the original claim to the amount paid on the adjusted claim. The NET amount for the claim reflects the original and the adjusted claim.

On a paper remittance generated 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 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 4-19. Totals for the Assigned Claims and Provider Adjustment Details Sections

4.4.2.5 Assigned Claims - Totals For All Assigned Claims (Professional SPR)

The assigned claims section of the SPR includes the totals line shown in Figure 4-19. These totals are for all assigned claims. These fields are described in this section.

MREP Information

On paper remittances generated from the MREP software, this totals section includes totals for all claims, assigned and unassigned.

 # OF CLAIMS - This field displays the total number of claims listed in the assigned claims section.

BILLED AMOUNT - This field displays the total amount billed for all claims listed in the assigned claims section.

ALLOWED AMOUNT - This field displays the total amount allowed for all claims listed in the assigned claims section.

DEDUCT AMOUNT - This field displays the total amount applied to beneficiaries' deductibles for all claims listed in the assigned claims section.

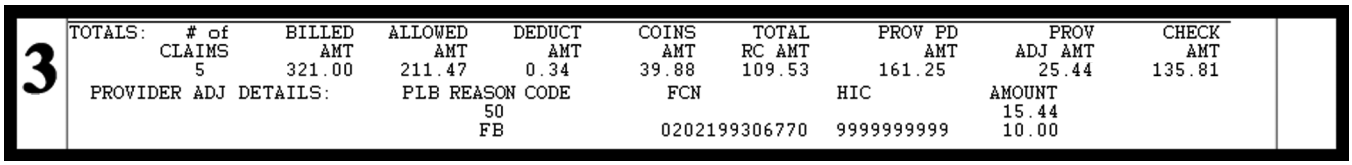
COINS AMT - This field indicates the total coinsurance amount for all claims that are the beneficiaries' responsibility.

TOTAL RC AMT - This field indicates the total amount of adjustments made to assigned claims due to Claim Adjustment Reason Codes (CARCs) listed on each service line. This excludes interest, late filing charges, deductibles, and amounts previously paid for rendered services.

PROV PD AMT - This field displays the total payment amount for claims before any provider adjustments are applied.

PROV ADJ AMT - This field is a total of all provider-level adjustments (see Section 4.4.2.6), and any values in the "ADJ TO TOTALS" section for any claims that contain this information (see Section 4.4.2.4).

CHECK AMT - This field contains the amount of the check or EFT that the provider receives.



4.4.2.6 Assigned Claims - Provider-Level Adjustment Details (Professional SPR)

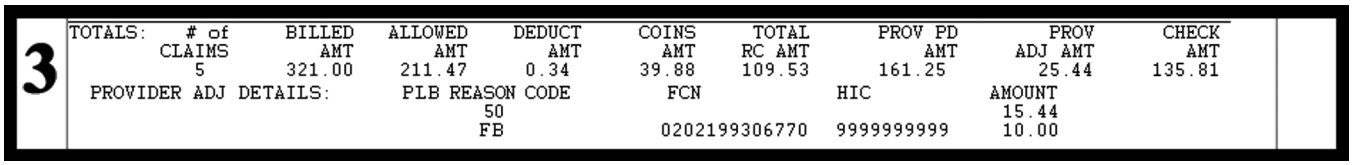
Below the claim totals is a section that lists provider-level adjustment details. This section is used to show adjustments that are not specific to a particular claim or service on this SPR. These are shown as an adjustment from the provider's payment at the summary level. These fields are described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

PLB REASON CODE - This field indicates the provider-level adjustment reason code. Table 4-2 lists the various Provider-Level Adjustment Reason Codes that may be used on a Professional SPR. For a complete listing of Provider-Level Adjustment Codes, see Chapter 3, Table 3-9 of this Guide or refer to the *ASC X12N 835 Implementation Guide: Health Care Claim Payment/Advice*, available at http://www.wpc-edi.com/hipaa on the Internet.

NOTE: 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.

Table 4-2. Professional SPR Provider-Level Adjustment Reason Code Definitions

Provider-Level Adjustment Reason Code	Definition	Use
50	Late Charge	Used to identify Late Claim Filing Penalty.
72	Authorized Return	Used to identify a refund adjustment to a provider (from a previous overpayment). Code "PR" appears on an Institutional RA (e.g., 72/PR). This adjustment should be a negative value and always be offset by some other provider-level adjustment referring to the original refund request or reason.
AP	Acceleration of Benefits	Used to reflect accelerated payment amounts or withholdings. A positive value represents a withholding. A negative value represents a payment.
B2	Rebate	Used for the refund adjustment.
CS	Adjustment	Used to provide supporting identification. Code "RI" is used on a Professional RA for a Reissued Check Amount (e.g., CS/RI).
FB	Forwarding Balance	A negative value represents a balance moving forward to a future payment advice. A positive value represents a balance being applied from a previous payment advice. A reference number (the original ICN and HIC) is applied for tracking purposes.
IR	Internal Revenue Service Withholding	Used for Internal Revenue Service withholdings.



3									
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	

Provider-Level Adjustment Reason Code	Definition	Use
J1	Nonreimbursable	Used to offset claim or service level data that reflects what could be paid if not for demonstration programs or other limitation that prevents issuance of payment. For example, this is used to zero balance provider payment for Centers of Excellence and Medicare Advantage RAs.
L6	Interest Owed	Used for the interest paid on claims on an RA.
LE	Levy	Used for IRS Levy.
SL	Student Loan Repayment	Used to represent a student loan repayment.
WO	Overpayment Recovery	Used to recover previous overpayment. A reference number (the original ICN and HIC) is applied for tracking purposes.

FCN - This field indicates the Financial Control Number (FCN) that this adjustment relates to when the adjustment refers to a claim that appeared on a previous SPR. This usually matches the ICN field of the previous claim. If the adjustment in question does not relate to a specific claim, this field is blank.

HIC - This field indicates the HIC number of the beneficiary when the adjustment refers to a claim that appeared on a previous SPR. If the adjustment in question does not relate to a specific claim, this field is blank.

AMOUNT - This field indicates the amount of the provider-level adjustment. These adjustments can either decrease the payment (a positive number) or increase the payment (a negative number).

4.4.3 Unassigned Claims (Professional SPR)

Figure 4-20 shows the unassigned claims section of a Professional SPR. Unassigned claims are listed separately in this section. All claims in this section display an “N” in the ASG field. Claims and service-line-level information are listed in the same manner as in the assigned claims section. The Remittance Advice Remark Code (RARC) for unassigned claims always displays an MA28 code.

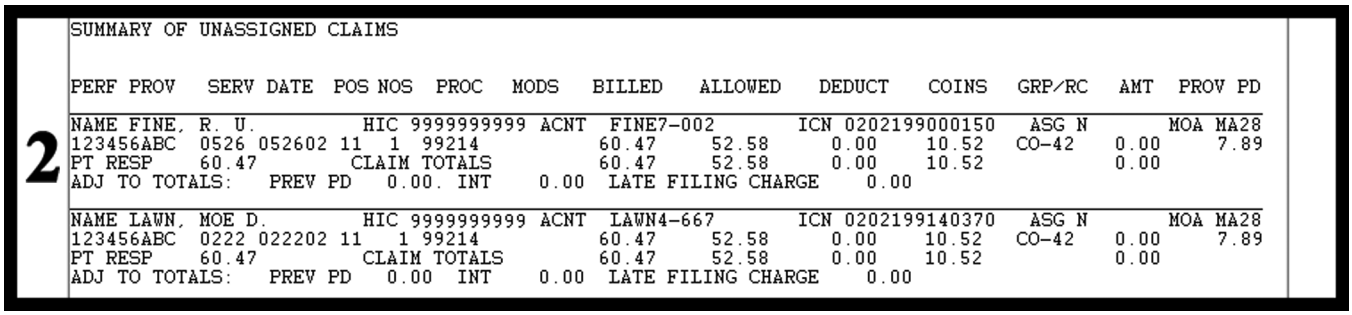


Figure 4-20. The Unassigned Claims Section of a Professional SPR

4.4.3.1 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. These fields are described in this section.

ADJ TO TOTALS - The unassigned claim section contains an additional line for adjustments. This line can contain the following fields.

PREV PD - This field displays the amount previously paid for the rendered services. This field contains a value only when the claim is an adjusted claim.

INT - This field displays the interest amount.

LATE FILING CHARGE - This field displays the late filing charge.

4.4.4 The Glossary Section (Professional SPR)

The glossary section of a Professional SPR contains a list of all Group Codes, Remittance Advice Remark Codes (RARCs), Claim Adjustment Reason Codes (CARCs), and Provider-Level Adjustment Reason Codes used on the SPR (see Figure 4-21). Each code is listed with its appropriate text. Providers should look at this section for an explanation regarding the adjustments made on the SPR. *All RARCs and CARCs may be found at http://www.wpc-edi.com/codes on the Internet.* Table 4-1 provides a listing of Provider-Level Adjustment Reason Codes that may be found on the Professional SPR. For a complete listing of Provider-Level Adjustment Codes, see Chapter 3, Table 3-9 of this Guide or refer to the *ASC X12N 835 Implementation Guide: Health Care Claim Payment/Advice*, available at http://www.wpc-edi.com/hipaa on the Internet.

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.
50      Late Filing Reduction
FB      Forwarding Balance
```

Figure 4-21. The Glossary Section of a Professional SPR

4.5 BALANCING A PROFESSIONAL REMITTANCE ADVICE (RA)

Remittance balancing reconciles differences between payment amounts shown on the Remittance Advice (RA) with the amounts actually billed by the provider. Balancing requires that the total paid is equal to the total billed, plus or minus any payment adjustments. According to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), every electronic transaction issued by a Medicare Contractor must balance at the service-line, claim, and transaction levels.

DISCLAIMER

The examples included in this section are for demonstration purposes only. The field names may vary depending on the software the provider/receiver uses to view the RA.

4.5.1 What Are the General Rules for Remittance Balancing?

The following Electronic Remittance Advice (ERA) field completion and calculation rules apply to the corresponding fields in the Standard Paper Remittance Advice (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 is reported in the claim or service adjustment segments with the appropriate Group Codes, Claim Adjustment Reason Codes (CARCs), and Remittance Advice Remark Codes (RARCs) explaining the adjustments. The same adjustment may not be reported at both the claim and the service-line level of an RA. Every provider-level adjustment is reported 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 (e.g., deductible paid by the beneficiary) reduce the provider's amount of payment from Medicare; and
- Any negative adjustments (e.g., interest on a clean claim that is paid after the 30th day from receipt) increase the amount of the payment from Medicare. Any adjustment reported with a negative sign reflects an increase in Medicare payment.

4.5.2 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. Providers 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)

4.5.2.1 On a Professional ERA

Providers 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.

4.5.2.2 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 4-22). The sum of total provider paid adjustment amounts is found in the PROV ADJ AMT field.

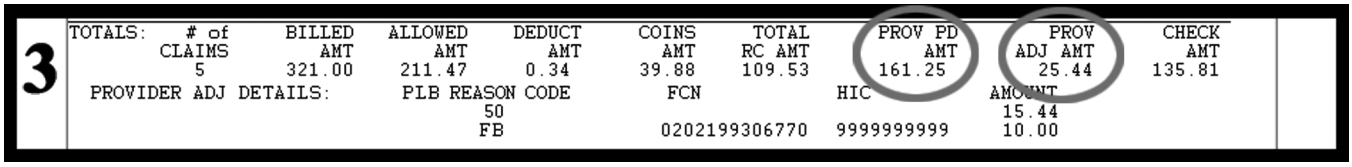


Figure 4-22. Highlighted Claim Segments and Fields Used for Transaction-Level Balancing on a Professional SPR

Table 4-3 shows the figures that are used to balance the SPR shown at the transaction level in Figure 4-22.

Table 4-3. 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.

4.5.3 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. The same adjustment cannot be taken 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

4.5.3.1 On a Professional ERA

Providers 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.

4.5.3.2 On a Professional SPR

The information necessary to perform claim-level balancing on a Professional SPR is found on the CLAIM TOTALS field (in the middle left-hand side of the SPR in Figure 4-23). This field horizontally lists the total BILLED, DEDUCT, COINS, AMT, and PROV PD amounts for a single claim (see Figure 4-23). 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 MARLOWE, PHILIP      HIC 9999999999 ACNT  MARLO861-316    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 4-23. Highlighted SPR Fields Page Used for Claim-Level Balancing on a Professional SPR

Table 4-4 shows the figures that are used to balance the SPR shown in Figure 4-23 at the claim level.

Table 4-4. 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.

4.5.4 Service-Line-Level Balancing a Professional RA

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

The service-line-level balancing formula is:

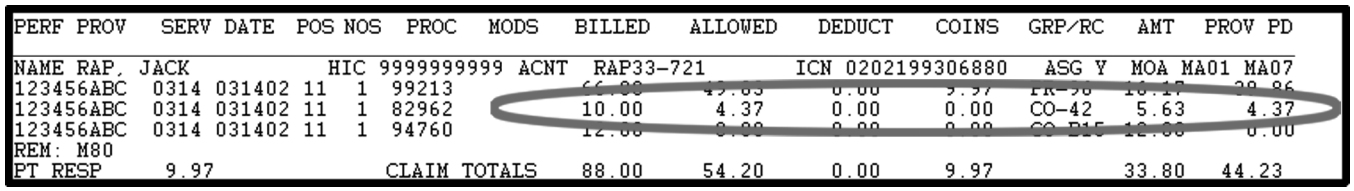
Submitted charge for this service
– Monetary adjustment amount applied to this service
Paid Amount for this Service

4.5.4.1 On a Professional ERA

Providers 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.

4.5.4.2 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 provider was paid (found in the PROV PD column). See Figure 4-24.



PERF PROV	SERV DATE	POS	NOS	PROC	MODS	BILLED	ALLOWED	DEDUCT	COINS	GRP/RC	AMT	PROV PD
NAME RAP, JACK			HIC 9999999999		ACNT	RAP33-721		ICN 0202199306880		ASG Y	MOA MA01 MA07	
123456ABC	0314 031402	11	1	99213		[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
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		[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
REM: M80												
PT RESP	9.97			CLAIM TOTALS		88.00	54.20	0.00	9.97		33.80	44.23

Figure 4-24. Highlighted Fields Used for Service-Line-Level Balancing on a Professional SPR

Table 4-5 shows the figures that are used to balance the SPR shown in Figure 4-24 at the service-line level for a selected service line (the example is based on the service line with PROC 82962).

Table 4-5. 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.

Notes

Reference A: Acronyms

This list contains acronyms used throughout this Guide.

Acronym	Description
A/R	Accounts Receivable
AC	All Claims
ADA	American Dental Association
AHIP	America's Health Insurance Plan
AMA	American Medical Association
APC	Ambulatory Payment Classification
ASC	Accredited Standards Committee
ASC	Ambulatory Surgical Center
BCBSA	Blue Cross/Blue Shield Association
BS	Bill Type Summary
CAH	Critical Access Hospital
CARC	Claim Adjustment Reason Code
CDC	Centers for Disease Control and Prevention
CDT-4	Current Dental Terminology - Fourth Edition
CMHC	Community Mental Health Center
CMS	Centers for Medicare & Medicaid Services
COB	Coordination of Benefits
CORF	Comprehensive Outpatient Rehabilitation Facility
CPT-4	Current Procedural Terminology - Fourth Edition
CRNA	Certified Registered Nurse Anesthetist
CWF	Common Working File
DFARS	Defense Federal Acquisition Regulation System
DME	Durable Medical Equipment
DMEPOS	Durable Medical Equipment, Prosthetics, Orthotics, and Supplies
DME MAC	Durable Medical Equipment Medicare Administrative Contractor
DRG	Diagnosis Related Group
EDI	Electronic Data Interchange
EFIO	Electronic File Interchange Organization
EFT	Electronic Funds Transfer
EOMB	Explanation of Medicare Benefits
ERA	Electronic Remittance Advice
ESRD	End Stage Renal Disease
FARS	Federal Acquisition Regulation System

Acronym	Description
FFS	Medicare Fee-For-Service Program
FI	Fiscal Intermediary
FL	Form Locator
FPE	Fiscal Period End
FQHC	Federally Qualified Health Center
FY	Fiscal Year
FYE	Fiscal Year End
GHP	Group Health Plan
HCPCS	Healthcare Common Procedure Coding System
HHA	Home Health Agency
HHPPS	Home Health Prospective Payment System
HHS	Department of Health & Human Services
HIC	Health Insurance Claim
HICN	Health Insurance Claim Number
HIPAA	Health Insurance Portability and Accountability Act of 1996
HIPPS	Health Insurance Prospective Payment System
HIQA	Health Insurance Query A
HIQH	Health Insurance Query for Home Health Agencies
ICD-9-CM	International Classification of Diseases, 9th Revision, Clinical Modification
ICF	Intermediate Care Facility
ICN	Internal Control Number
IHS	Indian Health Service
IRF	Inpatient Rehabilitation Facility
LTCH	Long Term Care Hospital
LUPA	Low Utilization Payment Adjustment
MAC	Medicare Administrative Contractor
MCR	Medicare Cost Report
MLN	Medicare Learning Network®
MPFS	Medicare Physician Fee Schedule
MR	Medical Review
MREP	Medicare Remit Easy Print
MREP SPR	Medicare Remit Easy Print Standard Paper Remittance Advice
MRN	Medical Record Number
MS	Medical Social
MSN	Medicare Summary Notice
MSP	Medicare Secondary Payer

Acronym	Description
NA	Nurses Aide
NCHS	National Center for Health Statistics
NCPDP	National Council for Prescription Drug Programs
NDC	National Drug Code
NPI	National Provider Identifier
NUCC	National Uniform Claim Committee
OPPS	Outpatient Prospective Payment System
OPT	Outpatient Physical Therapy
OT	Occupational Therapy
PCN	Patient Control Number
PIP	Periodic Interim Payment
POS	Place of Service
PPS	Prospective Payment System
PS	Provider Payment Summary
PT	Physical Therapy
RA	Remittance Advice
RAP	Request for Anticipated Payment
RARC	Remittance Advice Remark Code
RDF	Renal Dialysis Facility
RHC	Rural Health Clinic
RHHI	Regional Home Health Intermediary
RUG	Resource Utilization Group
SC	Single Claim
SCHIP	State Children's Health Insurance Program
SN	Skilled Nursing
SNF	Skilled Nursing Facility
SPR	Standard Paper Remittance Advice
ST	Speech Therapy
TOB	Type of Bill
TOP	Transitional Outpatient Payment
WBT	Web-Based Training
WHO	World Health Organization
WPC	Washington Publishing Company

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Reference B: Glossary

This list contains terms used throughout this Guide.

835 - the Health Care Claim Payment/Advice (835) transaction set is designed for the payment of claims and transfer of remittance information of the Health Care Industry. The transaction set can be used to make a payment, send an Explanation of Benefit (EOB) remittance service, or make a payment and send an EOB remittance and advice from a health care payer to health care provider, or their agent, either directly or through a depository financial institution. Commonly referred to as "the 835" in this Guide is the Accredited Standards Committee (ASC) X12N 835 version 004010A1 adopted under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This is a variable-length record designed for wire (electronic) transmission of remittance data.

A

Adjudication - the process of determining whether a Medicare claim is paid or denied, based on the information submitted and the eligibility of the recipient.

Adjusted Claim - a new claim affected by an original claim that was processed and later reprocessed. The Medicare Remit Easy Print (MREP) software displays the original claim that was processed with negative dollar amounts (reversing the original payment amount if present) and the new adjusted claim (usually assigned a new ICN) displaying the current amounts that have been approved for the claim.

Adjustment - an additional payment or reduction in payment at the line, claim, or provider level of a Remittance Advice (RA) that corresponds to a Claim Adjustment Reason Code (CARC) explaining the adjustment. Additional information may be provided by a Remittance Advice Remark Code (RARC). Provider-level adjustments may be accompanied by a provider-level adjustment reason code.

Allowed Amount - the allowable reimbursement amount for the covered services, which may include any deductible for which the beneficiary is responsible.

American Medical Association (AMA) - a national association that develops and promotes medical practice, research, and education on behalf of patients and physicians. A professional organization for physicians. The AMA is the secretariat of the National Uniform Claim Committee (NUCC), which has a formal consultative role under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The AMA also maintains the Current Procedural Terminology (CPT-4) medical code set.

Appeal - a special kind of complaint that the provider may be entitled to make if he or she disagrees with a decision to deny or reduce payment for an item or service that he or she provided to a Medicare beneficiary.

Assigned Claim - a claim submitted to Medicare by a professional provider who agrees to accept the Medicare-approved charges as payment in full for the rendered services.

Assignment - a category that indicates that a provider agrees to accept Medicare's fee as full payment. The beneficiary may be responsible for coinsurance and/or deductible amounts.

B

Beneficiary - a person eligible to receive Medicare or Medicaid payment and/or services.

Benefit Maximum - the maximum benefit allowed under the insurance plan. Examples include annual or lifetime dollar coverage limits.

Blue Cross and Blue Shield Association (BCBSA) - a non-profit corporation representing the Blue Cross and Blue Shield plans on a national level as a coordinating agency in marketing, government relations, and other system wide initiatives. Also owns the Blue Cross Blue Shield mark and sets approval standards. The BCBSA serves as the administrator for the Health Care Code Maintenance Committee and also helps maintain the Healthcare Common Procedure Coding System (HCPCS) Level II Codes.

C

Carrier - a non-governmental organization or agency that contracts to serve as the fiscal agent and claim processor between professional providers and suppliers and the Federal Government.

Centers for Medicare & Medicaid Services (CMS) - the Federal agency that administers the Medicare Program, and works in partnership with the States to administer Medicaid, the State Children's Health Insurance Program (SCHIP), and health insurance portability standards. CMS is responsible for the quality standards in health care facilities through its survey and certification activity. CMS is responsible for oversight of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) administrative simplification transaction and code sets, health identifiers, and security standards. CMS also maintains the Healthcare Common Procedure Coding System (HCPCS) medical code set and the Remittance Advice Remark Codes (RARCs) administrative code set.

Claim Adjustment Reason Code (CARC) - a national administrative code set that identifies the reasons for any differences, or adjustments, between the original provider charge for a claim or service and the payer's payment for it. This code set is maintained by the Claim Adjustment Status Code Maintenance Committee.

Claim Level - the section of a Remittance Advice (RA) that provides information about individual claims.

Claim Withholding - a specific type of claim-level adjustment on an institutional provider Remittance Advice (RA) to indicate that a prior payment (e.g., home health first 60-day advance payment) requires adjustment after processing.

Clean Claim - a claim that does not require Medicare Contractors (Fiscal Intermediaries [FIs], Regional Home Health Intermediaries [RHHIs], Carriers, Part A/B Medicare Administrative Contractors [MACs] or Durable Medical Equipment Medicare Administrative Contractors [DME MACs]) to investigate or develop them outside of their Medicare operations on a prepayment basis.

Code - a data element that represents a standardized definition, reason, or condition that relates to the claim or service.

Common Working File (CWF) - a database containing Medicare eligibility and usage data for each beneficiary. The file helps reduce claims overpayment and provides the most current and accurate data on Medicare beneficiaries.

Community Mental Health Center (CMHC) - a facility that provides outpatient mental health services to individuals residing within a specific geographic area.

Comprehensive Outpatient Rehabilitation Facility (CORF) - a facility that provides comprehensive rehabilitation services under the supervision of a physician to outpatients with physical disabilities. Services include physical therapy, occupational therapy, and speech-language pathology services.

Contractor - see Medicare Contractor.

Coordination of Benefits (COB) - the process for determining the respective responsibilities for a medical claim of two or more health plans or insurance policies that cover the same benefits. If one of the plans is a Medicare health plan, Federal law may determine which plan pays first.

Critical Access Hospital (CAH) - a facility that provides limited outpatient and inpatient hospital services to individuals in rural areas.

Current Procedural Terminology (CPT-4) Codes - a uniform coding system that consists of descriptive terms and identifying codes that are used primarily to identify medical services and procedures furnished by providers and is maintained by the American Medical Association (AMA).

D

Denial - the nonpayment of a processed claim for an identified coverage or medical necessity reason.

Department of Health & Human Services (HHS) - the agency that administers many of the "social" programs at the Federal level regarding the health and welfare of the citizens of the U.S. It is the "parent" of the Centers for Medicare & Medicaid Services (CMS).

Diagnosis Related Group (DRG) - a classification system that groups patients according to diagnosis, type of treatment, age, and other relevant criteria.

Durable Medical Equipment (DME) - any reusable medical equipment ordered by a physician for use in a beneficiary's home (e.g., walker, wheelchair, hospital bed).

Durable Medical Equipment Medicare Administrative Contractor (DME MAC) - a Medicare Contractor that provides claims processing and payment of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) for a designated region of the country.

E

Electronic Funds Transfer (EFT) - an electronic transfer of payments directly to a provider's financial institution.

Electronic Remittance Advice (ERA) - a Remittance Advice (RA) transmitted in an electronic format.

End Stage Renal Disease (ESRD) - a condition of permanent kidney failure that is severe enough to require lifetime dialysis or a kidney transplant.

Explanation of Medicare Benefits (EOMB) - this has been replaced by the Medicare Summary Notice (MSN). See Medicare Summary Notice (MSN).

F

Fee Schedule - a complete listing of fees used by health plans to pay doctors or other providers.

Field - the location in the Remittance Advice (RA) that represents specific claim processing data.

Fiscal Intermediary (FI) - a non-governmental organization or agency (including Regional Home Health Intermediaries [RHHIs]) that contracts to serve as the fiscal agent and claim processor between institutional providers and the Federal Government.

Flat File - this term usually refers to a file that consists of a series of fixed-length records that include some sort of record type code. In this Guide, it refers to the original transmitted Electronic Remittance Advice (ERA) file received before it is deciphered by software.

G

Group Codes - this is a standard code set used to identify either the financially responsible party or the general category of payment adjustment. A group code must always be used in conjunction with a Claim Adjustment Reason Code (CARC).

Group Health Plan (GHP) - a health insurance plan sponsored by either a patient's (or the spouse's) employer where a single employer of 20 or more employees is the sponsor and/or contributor to the GHP, or two or more employers are sponsors and/or contributors and at least one of them has 20 or more employees.

H

Healthcare Common Procedure Coding System (HCPCS) - a uniform method for providers and suppliers to report professional services, procedures, and supplies. HCPCS includes Current Procedural Terminology (CPT-4) codes (Level I) and national alphanumeric codes (Level II).

Healthcare Common Procedure Coding System (HCPCS) Modifier - a two-digit alphanumeric code used in conjunction with a procedure code to provide additional information about the service.

Health Insurance Portability and Accountability Act of 1996 (HIPAA) - the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA, Title II) require the Department of Health & Human Services to establish national standards for electronic health care transactions and national identifiers for providers, health plans, and employers. It also addresses the security and privacy of health data.

Home Health Agency (HHA) - a public or private organization that specializes in giving in-home skilled nursing and other therapeutic services, such as physical therapy.

Hospital - an institution with organized medical staff that is primarily engaged in providing diagnostic, therapeutic, and/or rehabilitation services to inpatients (injured, disabled, or sick persons).

I

Informational RA - a Remittance Advice (RA) sent to providers who do not accept assignment, and is not accompanied by payment (providers who do not accept assignment must bill the beneficiaries to obtain payment). An informational RA is identical to other RAs. However, an informational RA contains a Remittance Advice Remark Code (RARC) indicating that the provider does not have appeal rights.

Inpatient Rehabilitation Facility (IRF) - a hospital that provides specialized care for patients recovering from specified conditions that require intensive inpatient rehabilitation therapy. It may be a freestanding facility or a distinct part of a hospital complex.

Institutional Provider - a facility-based health care organization (including hospitals, Skilled Nursing Facilities [SNFs], Home Health Agencies [HHAs], hospices, and others) that submits claims to Fiscal Intermediaries (FIs) and Regional Home Health Intermediaries (RHHIs).

International Classification of Diseases 9th Edition Clinical Modification (ICD-9-CM) Codes - a medical code set maintained by the World Health Organization (WHO). The primary purpose of this code set was to classify causes of death. A U.S. extension, maintained by the National Center for Health Statistics (NCHS) within the Centers for Disease Control and Prevention (CDC), identifies morbidity factors, or diagnoses. The ICD-9-CM codes have been selected for use in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) transactions. These codes rarely appear on a Remittance Advice (RA).

L

Long Term Care Hospital (LTCH) - a facility that generally treats patients who require hospital-level care for greater than 25 days. It may be a freestanding facility or a separate and distinct part of a hospital complex.

M

Maximum Allowed - the maximum benefit allowed for a particular medical service.

Medical Code Sets - any clinical codes used in transactions to identify what procedures, services, and diagnoses pertain to a patient encounter.

Medicare Administrative Contractor (MAC) - the contracting organization that is responsible for the receipt, processing, and payment of Medicare claims. In addition to providing core claims processing, operations for both Medicare Part A and Part B, they perform functions related to: Beneficiary and Provider Service, Appeals, Provider Outreach and Education (also referred to as Provider Education and Training), Financial Management, Program Evaluation, Reimbursement, Payment Safeguards, and Information Systems Security.

Medicare Contractor - a private health Insurer that processes Medicare claims and makes payments to providers of services and to beneficiaries. See also Carrier, Durable Medical Equipment Medicare Administrative Contractor (DME MAC), Fiscal Intermediary (FI), Medicare Administrative Contractor (MAC), and Regional Home Health Intermediary (RHHI).

Medicare Contractor Standard Paper Remittance Advice (SPR) - a Standard Paper Remittance Advice (SPR) generated by a Medicare Contractor and sent to a provider.

Medicare Remit Easy Print (MREP) - a software program developed by the Centers for Medicare & Medicaid Services (CMS) that enables professional providers/suppliers to read and print Health Insurance Portability and Accountability Act of 1996 (HIPAA)-compliant 835s.

Medicare Secondary Payer (MSP) - the term used when Medicare is not responsible for paying first on a claim; some individuals have other insurance or coverage that must pay before Medicare pays for some services (e.g., Group Health Plan [GHP]).

Medicare Summary Notice (MSN) - a notice that is sent to a Medicare beneficiary after the provider files a claim for Part A or Part B services under the Original Medicare Plan. This notice explains what the provider billed for, the Medicare-approved amount, how much Medicare paid, and what the Medicare beneficiary may pay (formerly Explanation of Medicare Benefits [EOMB]).

N

National Provider Identifier (NPI) - the NPI is a standard unique identifier assigned to health care providers for billing and identification purposes. For more information about the NPI, visit http://www.cms.gov/NationalProvIdentStand on the Centers for Medicare & Medicaid Services (CMS) website.

Non-Assigned Claim - a type of claim that may only be filed by a non-participating Medicare physician or applicable non-physician practitioner. When a non-assigned claim is filed, the beneficiary is reimbursed directly.

Non-Clinical Code Sets - a group of codes that characterize a general administrative situation, rather than a medical condition or service (also referred to as non-medical code sets).

Non-Covered Charges - the charges not covered by the payer. This may be Medicare, Medicaid, or private health insurance.

Non-Medical Code Sets - a group of codes that characterize a general administrative situation, rather than a medical condition or service (also referred to as non-clinical code sets).

Non-Participating Provider - a provider who does not accept direct Medicare payments and bills the beneficiary instead.

O

Offset - the recovery by Medicare of a (non-Medicare) debt by reducing present or future Medicare payments and applying the amount withheld to the previous debt.

Outpatient Physical Therapy (OPT) - a rehabilitation facility that provides outpatient services to help the beneficiary recover from an illness or an injury (also known as Other Rehabilitation Facility). This provider type is limited to the provision of physical therapy, occupational therapy, and speech-language pathology services.

P

Part A - referred to as “Hospital Insurance”, helps cover services and supplies related to inpatient hospital stays; Skilled Nursing Facility (SNF) care following a related, covered three-day hospital stay; some home health care; and hospice care for the terminally ill.

Part B - referred to as “Medical Insurance”, helps cover doctors’ services, certain medical items, and outpatient care. Also covers medical services such as outpatient physical therapy. Part B covers home health care when the beneficiary qualifies for the home health benefit, but does not qualify for payment under Part A.

Participating Provider - a provider who agrees to accept assignment on all Medicare claims. The provider may bill the beneficiary only for Medicare deductible and/or coinsurance amounts.

PC-Print - a software program developed by the Centers for Medicare & Medicaid Services (CMS) that enables institutional providers to read and print Health Insurance and Accountability Act of 1996 (HIPAA)-compliant 835s.

Penalty Withholding - a specific type of claim-level adjustment on a Remittance Advice (RA) indicating the act of withholding payment benefits due to a penalty that has been imposed.

Physician - an individual licensed under State law to practice medicine or osteopathy.

Professional Provider - an individual physician or other recognized health care practitioner, or a group of such individuals, or a supplier that submits claims to Carriers, Part B Medicare Administrative Contractors (MACs), and Durable Medical Equipment Medicare Administrative Contractors (DME MACs).

Provider - a physician, health care professional, hospital, or health care facility approved to furnish care to beneficiaries and to receive payment from Medicare or other health insurers.

Provider-Level Adjustment - an adjustment that is not specific to a particular claim or service on the Remittance Advice (RA). These adjustments are generally explained by a Provider-Level Adjustment Reason Code.

R

Refund - an adjustment made at the provider level of the current payment to indicate changes that Medicare is making on a prior payment. For example, a provider requested by a Medicare Contractor to refund an overpayment could choose to have the overpayment taken out of the next payment.

Regional Home Health Intermediary (RHHI) - an organization that contracts with Medicare to pay home health and hospice bills and to audit home health agencies.

Rejected Claim - a claim that is rejected due to technical errors, including missing or erroneous required data elements. These claims are not processed and do not generate a Remittance Advice (RA).

Remittance - for the purposes of this Guide, the payment of a Medicare claim by a Medicare Contractor.

Remittance Advice (RA) - a document that explains the reimbursement decision made by the Medicare Contractor; this explanation may include the reasons for payments, denials, and/or adjustments for processed claims. Also serves as a companion to claim payments.

Remittance Advice Remark Code (RARC) - a code used within Remittance Advice (RA) to convey information about remittance processing or to provide a supplemental explanation for an adjustment already described by a Claim Adjustment Reason Code (CARC).

Remittance Balancing - the act of reconciling (or settling) differences between payments shown on the Remittance Advice (RA) as compared to amounts actually billed by the provider.

Remittance Notice - the previous term for a Remittance Advice (RA). It is a summarized statement for providers, including payment information for one or more beneficiaries. See also Remittance Advice (RA).

Rural Health Clinic (RHC) - an outpatient facility that is primarily engaged in furnishing physicians' and other medical services that meets other requirements designated to ensure the health and safety of individuals served by the clinic. The clinic must be located in a medically underserved area that is not urbanized as defined by the U.S. Bureau of Census.

S

Service-Line Level - the section of a Remittance Advice (RA) that provides information about individual services billed on a claim.

Skilled Nursing Facility (SNF) - an institution or distinct part of an institution that has a transfer agreement with one or more hospitals. This facility is primarily engaged in providing inpatient skilled nursing care or rehabilitation services but does not provide the level of care or treatment available in a hospital.

Standard Paper Remittance Advice (SPR) - a Remittance Advice (RA) transmitted in a standardized paper format.

Supplier - an entity that provides Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS), including drugs.

T

Transaction Level - this section provides information about provider-level adjustments. Within the transaction, the sum of all the claim payments minus the sum of all provider-level adjustments must equal the total payment amount.

Translator Software - any software application that converts an electronic flat file to a user-friendly format on the provider's computer screen (see PC-Print and Medicare Remit Easy Print).

U

Unassigned Claim - a claim submitted to Medicare by a professional provider who has not agreed to accept the Medicare-approved charges as payment in full for the services rendered. Providers collect payment for unassigned claims directly from the beneficiary.

Unbundling - an act that occurs when a service that is considered part of the basic allowance of another procedure, is billed separately to Medicare. Medicare does not allow billing for incorrectly unbundled services.

W

Withholding - an act that occurs when a percentage of payment or set dollar amounts are deducted (adjusted) from the payment to the provider during claim processing that may or may not be returned depending on specific predetermined factors. The Remittance Advice (RA) contains Claim Adjustment Reason Codes (CARCs) explaining the reason for the withholding adjustment.

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Reference C: Websites and Phone Numbers

Please note that all of the following information was accurate at the time of printing; however, information is subject to change.

WEB PAGE REFERENCES

Resource	Website
Centers for Medicare & Medicaid Services (CMS) Home Page	http://www.cms.gov
CMS Health Insurance Portability and Accountability Act of 1996 (HIPAA) Transactions and Code Sets Standards	http://www.cms.gov/TransactionCodeSetsStands
CMS Medicare Claims Processing Manual	http://www.cms.gov/Manuals/IOM/list.asp
CMS Medicare Contracting Reform (MCR)	http://www.cms.gov/MedicareContractingReform
CMS Medicare Coordination of Benefits (COB) General Information	http://www.cms.gov/COBGeneralInformation
CMS Medicare Electronic Billing and Electronic Data Interchange (EDI) Transactions	http://www.cms.gov/ElectronicBillingEDITrans
CMS Medicare Fee-For-Service Provider Resource Center	http://www.cms.gov/center/provider.asp
CMS Medicare Healthcare Common Procedure Coding System (HCPCS) General Information and Code Sets	http://www.cms.gov/MedHCPCSGenInfo http://www.cms.gov/HCPCSReleaseCodeSets
CMS Medicare Learning Network®	http://www.cms.gov/MLNGenInfo
CMS Medicare Physician Fee Schedule Look-up	http://www.cms.gov/apps/physician-fee-schedule/overview.aspx
CMS Medicare Remit Easy Print Software	http://www.cms.gov/AccesstoDataApplication/02_MedicareRemitEasyPrint.asp
CMS National Provider Identifier (NPI) Standard	http://www.cms.gov/NationalProvIdentStand
CMS Paper Forms & Billing Instructions	http://www.cms.gov/CMSForms http://www.cms.gov/ElectronicBillingEDITrans/15_1450.asp http://www.cms.gov/ElectronicBillingEDITrans/16_1500.asp

Resource	Website
CMS Physician Fee Schedule	http://www.cms.gov/PhysicianFeeSched
CMS Place of Service Codes	http://www.cms.gov/manuals/downloads/clm104c26.pdf
Accredited Standards Committee (ASC) X12 Implementation Guide Interpretation Website	http://www.x12.org
Washington Publishing Company Code Lists	http://www.wpc-edi.com/codes
Washington Publishing Company Health Insurance Portability and Accountability Act of 1996 (HIPAA) Implementation Guides	http://www.wpc-edi.com/HIPAA

ADDRESS AND PHONE NUMBER REFERENCES

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Contact information for entities such as Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), Carriers, Part A/B Medicare Administrative Contractors (MACs), and Durable Medical Equipment Medicare Administrative Contractors (DME MACs) is available at http://www.cms.gov/MLNProducts/Downloads/CallCenterTollNumDirectory.zip on the CMS website.

Submitting Medicare Claims

Contacts Database
http://www.cms.gov/apps/contacts

Medicare Coordination of Benefits (COB) Contractor

http://www.cms.gov/COBGeneralInformation/03_ContactingtheCOBContractor.asp
Toll free: 800-999-1118
Toll free TTY: 800-318-8782

Reporting Fraud, Waste, and Abuse Matters

Office of the Inspector General (Department of Health & Human Services)
Attn: HOTLINE
330 Independence Avenue, SW
Washington, DC 20201

Toll free: 800-447-8477
Toll free TTY: 800-377-4950
Fax: 800-223-8164
E-mail: HHSTIPS@OIG.HHS.GOV

Medicare Beneficiary Help Line
http://www.medicare.gov
Toll free: 800-MEDICARE (800-633-4227)
Toll free TTY/TDD: 877-486-2048

Introduction to the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

HIPAA General Information & Hotline
http://www.cms.gov/HIPAAGenInfo
Toll free: 866-282-0659
Toll free TTY: 877-326-1166

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Reference D: Resources

The following resources were used to compile this Guide. Please note that all information was accurate at the time of printing; however, information is subject to change.

Resource	Location
Manuals	The CMS Online Manual System http://www.cms.gov/manuals *Medicare Claims Processing Manual*, Chapters 1, 22, 23, 24, 25, 26, and 31 http://www.cms.gov/Manuals/IOM/list.asp *Medicare Program Integrity Manual* http://www.cms.gov/Manuals/IOM/list.asp
Medicare Learning Network®	MLN Matters Articles - National articles helping Providers understand new or changed Medicare policy. http://www.cms.gov/MLNMattersArticles MLN Matters Article # MM 6897, April 30, 2010 MLN Matters Article # MM 6870, April 8, 2010 MLN Matters Article # SE0627, April 21, 2006 MLN Matters Article # SE0408, January 1, 2004
Websites	CMS Home Page: http://www.cms.gov CMS Acronyms: http://www.cms.gov/apps/acronyms CMS Forms: http://www.cms.gov/CMSForms CMS Glossary: http://www.cms.gov/apps/glossary CMS Healthcare Common Procedure Coding System (HCPCS) and Code Sets: http://www.cms.gov/MedHCPCSGenInfo http://www.cms.gov/HCPCSReleaseCodeSets Medicare Paper Claims Forms (CMS-1500, CMS-1450) and Billing Instructions: http://www.cms.gov/CMSForms http://www.cms.gov/ElectronicBillingEDITrans/15_1450.asp http://www.cms.gov/ElectronicBillingEDITrans/16_1500.asp Physician's Resource Center: http://www.cms.gov/center/physician.asp
Additional Documents	CMS HIPAA Information Series: 4. Overview of Electronic Transactions & Code Sets, May 2003 http://www.cms.gov/EducationMaterials/Downloads/Whateelectronictransactionsandcodesets-4.pdf

Resource	Location
External Resources	Claim Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs) http://www.wpc-edi.com/codes *004010X091, 835 Implementation Guide* http://www.wpc-edi.com/HIPAA

Index

This index features general key terms and concepts presented throughout this Guide. Field references were not included in this index. To search page references for specific RA fields and section headers, refer to the Field Index for Institutional RAs or refer to the Field Index for Professional RAs.

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Field Index For Institutional RAs

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All Claims (AC) Screen
Bill Type Summary (BS) Screen
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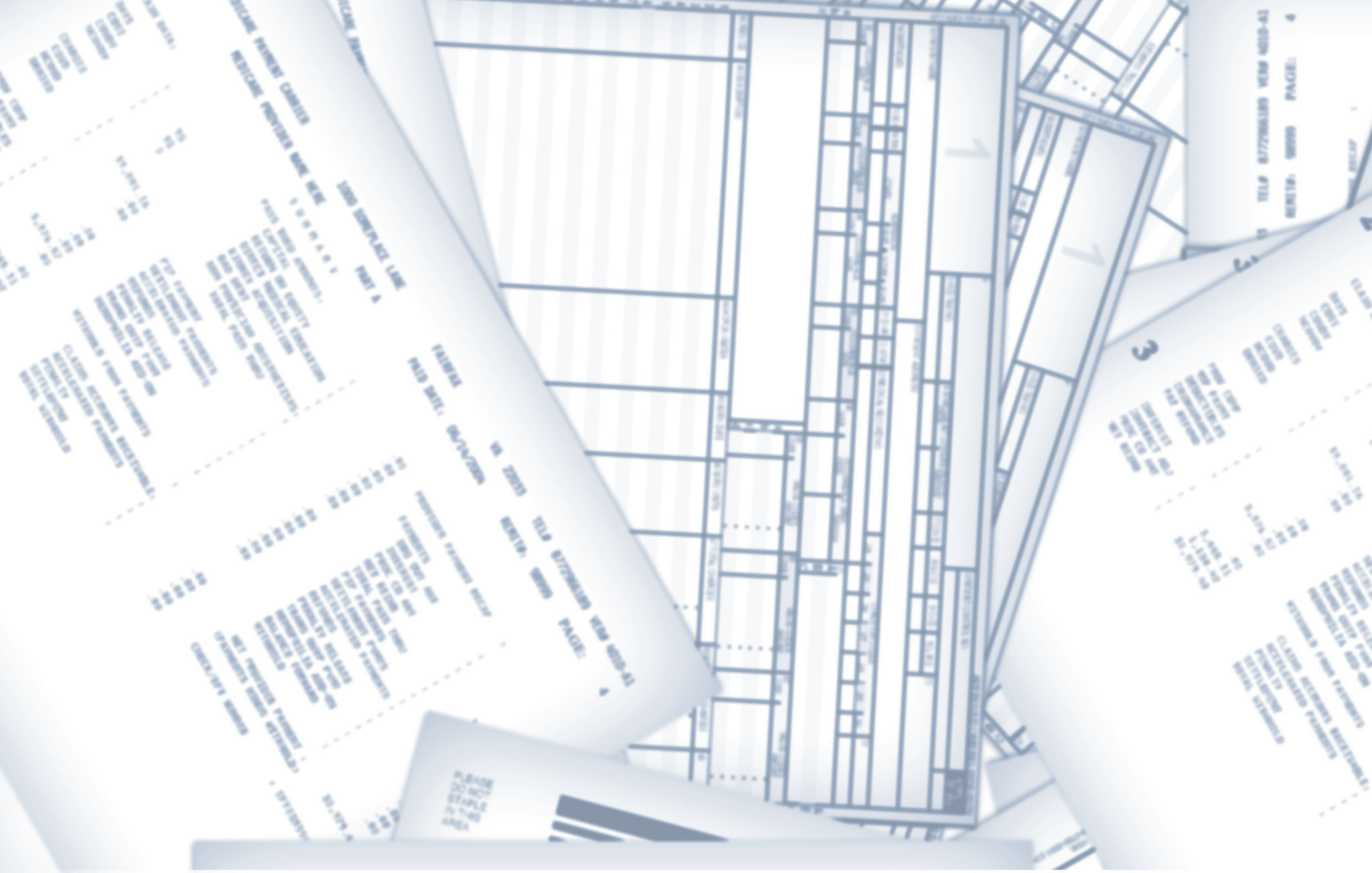

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