



Medicare Remittance Advice

Published July 2010



Part B



IMPORTANT



The information provided in this manual was current as of June 2010. Any changes or new information superseding the information in this manual, provided in newsletters/eBulletins, MLN articles, listserv notices, Local Coverage Determinations (LCDs) or CMS Internet-Only Manuals with publication dates after June 2010, are available at:

<http://www.trailblazerhealth.com/Medicare.aspx>

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INTRODUCTION

Every day, Medicare Fee-for-Service (FFS) contractors send thousands of Remittance Advices (RAs) to Medicare providers, each containing information that may affect a provider's Medicare business.

Providers receive a Medicare Remittance Advice (MRA) once a claim has been received and processed. The MRA provides claims processing decisions regarding payments, adjustments, denials, missing or incorrect data, refunds and claims withholding due to Medicare Secondary Payer (MSP) or penalty situations.

Adjustments can include a denied claim, zero payment, partial payment, reduced payment, penalty applied, additional payment and supplemental payment.

WHAT ARE THE USES FOR THE RA?

Providers use the RA to post payments and 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 that include Group Codes, Claim Adjustment Reason Codes and RA Remark Codes.

WHAT ARE THE DIFFERENT TYPES OF THE RA?

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.

The ERA is produced in the Health Insurance Portability and Accountability Act of 1966 (HIPAA)-compliant Accredited Standards Committee (ASC) X12N 835 format. The RA is also known as the ANSI ASC X12N 835.

WHY RECEIVE THE ERA?

There are several advantages to receiving the ERA. These advantages include:

- Faster communication and payment notification.
- Faster account reconciliation through electronic posting.
- Automation of follow-up action.
- Paperwork reduction.
- Detailed information.
- Access to data in a variety of formats through free, Medicare-supported software (Medicare Remit Easy Print (MREP) software).

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WHO IS ANSI?

American National Standards Institute (ANSI) is a private, non-governmental association (of which CMS is a member) that sets standards for not only health care transactions, but also for banking, transportation, appliances and a wide range of other items and services.

Several codes have been developed for the provider remittance advice. The three major code sets are:

- Group codes.
- Claim Adjustment Reason Codes (CARCs).
- Remittance Advice Remark Codes (RARCs).

CARCs and RARCs are updated three times a year. The latest codes may be viewed on the Washington Publishing Company's Web site at:

<http://www.wpc-edi.com/codes>

Group Codes

Group codes identify the financially responsible party or the general category of payment adjustment. A group code must always be used in conjunction with a CARC.

Group codes are codes that will always be shown with a reason code to indicate when a provider may or may not bill a beneficiary for the non-paid balance of the services furnished.

Payment Adjustment Category Description

- PR (Patient Responsibility).
- CO (Contractual Obligation).
- OA (Other Adjustment).
- CR (Correction or Reversal to a prior decision).

Group Code PR

All denials or reductions from the billed amount with group code PR are the financial responsibility of the beneficiary or his supplemental insurer (if it covers that service).

Due to the frequency of their use, separate columns have been set aside for reporting of deductible and coinsurance, both of which are also the patient's responsibility.

PR amounts, including deductible and coinsurance, are totaled in the Patient Responsibility field at the end of each claim.

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Group Code OA

Group code OA is used when neither PR nor CO applies, such as with the reason code message that indicates the bill is being paid in full.

Group Code CR

Group code CR is used when there is a change to the decision on a previously adjudicated claim, perhaps as the result of a subsequent reopening.

Reminder: Group code CR explains the reason for change and is always used in conjunction with PR, CO or OA to show revised information.

Group Code CO

Group code CO is always used to identify excess amounts for which the law prohibits Medicare payment and absolves the beneficiary of any financial responsibility, such as:

- Participation agreement violation amounts.
- Limiting charge violations.
- Late filing penalties.
- Amounts for services not considered being reasonable and necessary.

Claim Adjustment Reason Codes (CARCs)

These codes provide financial information about claim decisions. *CARCs communicate an adjustment or why a claim (or service line) was paid differently than it was billed. If there is no adjustment to a claim/service line, then there is no need to use a CARC.* The numeric code will appear after the group code. These codes can be found in the ADJ REASON CODES field on the ERA and the RC field on the SPR.

Examples of CARCs:

Code	Financial Information
1	Deductible amount
2	Coinsurance amount
3	Copayment amount
4	The procedure code is inconsistent with the modifier used or a required modifier is missing.
5	The procedure code/bill type is inconsistent with the place of service.
6	The procedure/revenue code is inconsistent with the patient's age.

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Remittance Advice Remark Codes (RARCs)

RARCs are used in conjunction with CARCs on an RA to further explain an adjustment or to indicate if and what appeal rights apply. Additionally, there are some RARCs that are used to relay informational messages even when there is not an adjustment. RARCs are maintained by CMS. Any RARC may be reported at the service-line level or the claim level, as applicable, on any ERA or SPR.

Examples of RARCs

Code	Description
M42	The medical necessity form must be personally signed by the attending physician.
MA02	If you do not agree with this determination, you have the right to appeal. You must file a written request for an appeal within 180 days of the date you receive this notice.
MA18	The claim information is also being forwarded to the patient's supplemental insurer. Send any questions regarding supplemental benefits to them.

MREP SOFTWARE

In an effort to advance toward an electronic environment, CMS has developed software called MREP that enables physicians and suppliers to view and print Health Insurance Portability and Accountability Act of 1996 (HIPAA)-compliant 835s from their own computer. Remittance advices printed from the MREP software mirror the current SPR format. Providers must have access to the Internet.

MREP software is free and available for viewing and printing the HIPAA-compliant ERA. The MREP software enables providers and suppliers to:

- View MREP RAs.
- Search MREP RAs.
- Print MREP RAs.
- Print reports about MREP RAs.
- MREP software can be installed on a personal computer or on a network.
- Utilize the MREP software. Providers will need to receive a HIPAA-compliant ERA. Call one of the two phone numbers below to find out more about MREP and/or for information on how to receive a HIPAA-compliant ERA.
 - All states:
 - (866) 528-1605.
 - (866) 528-1606.

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MREP Application Tips

- Part B providers must download the MREP software to convert the 835 ERA files into a readable SPR that can be printed.
- Providers should create a folder called HIPAA 835 files to store 835 files and make sure all users know the location.
- To start MREP, double-click the MREP shortcut.
- An Import window opens that allows providers to select the HIPAA 835 file.
- Select the HIPAA 835 file to import by double-clicking it.
- After the import is finished, the Remittance Advice List window displays.

Note: Part B providers who use the MREP software will need to download updated versions when they become available to use in conjunction with the RARC and CARC updated files.

Detailed information about MREP can be found on the CMS Web site at:

http://www.cms.gov/AccessToDataApplication/02_MedicareRemitEasyPrint.asp

ANSI RESOURCES

Under the standard format, only reason codes approved by ANSI and Medicare-specific supplemental messages approved by CMS may be used.

The X12.835 reason codes were designed to replace the large number of different coding systems used by health payers in this country and also to relieve the burden of providers interpreting each of the different coding systems.

The code lists are updated around April, August and December. The latest codes may be viewed at:

<http://www.wpc-edi.com/codes>

Providers can sign up for a broadcast service to receive code list update announcements. View e-mail by visiting:

<http://mailman.wpc-edi.com/mailman/listinfo/remarkcodesnotification>

TrailBlazer Health Enterprises[®] also alerts providers of updated codes through bulletins, appropriate listservs and/or its Web site.

PAID AND ADJUSTED AMOUNTS

Paid and adjusted amounts will be totaled at the end of the assigned claims listings to help providers balance the billed amounts against the Medicare payments and adjustments.

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UNASSIGNED CLAIMS INFORMATION

Information on any unassigned claims will be listed separately after the assigned claims to avoid the inadvertent use of unassigned claims information to balance accounts.

ABBREVIATIONS/TERMS

A number of abbreviations/terms are used in the RA. The following key defines the abbreviations/terms.

ACNT	Patient account number assigned by the provider. A zero appears if no internal number is submitted with the claim.
ADJS	Adjustments.
ALLOWED	Allowed amount (prior to deductions or offsets).
ASG	Whether the provider has accepted assignment for the claim (Y or N).
BILLED	The amount the provider billed for the service(s).
COINS	Coinsurance amount due by the beneficiary (or other insurer, if applicable).
Check/EFT #	Check or Electronic Funds Transfer (EFT) transaction number through which payment was issued.
DEDUCT	Deductible amount due by the beneficiary (or other insurer, if applicable).
GRP/RC	Group codes and Claim Adjustment Reason Codes (CARCs).
FCN	Financial Control Number of prior claims that contributed to the overpayment or that explains the reason for the offset
HIC	Medicare Health Insurance Claim number of the beneficiary for whom the claim was processed.
ICN	Internal Control Number – The 13-digit ICN is a unique number assigned to the claim at the time it is received by the Medicare contractor.
INT	Interest amount.
MOA	Remittance Advice Remark Codes (RARCs) at the claim level. These codes and their meanings are listed in the glossary at the end of the MRA.
MOD	Modifiers billed with the specified procedure.
MSP	Medicare Secondary Payer. The amount paid by an insurer primary to Medicare.
NET	The net amount Medicare owes the provider for the claim.
NOS	Number of services rendered.
OTHER	Other claim level adjustments that apply
PERF PROV	Performing/rendering provider for the service line.
POS	Place of service.
PREV PD	Previous paid amount on this claim.
PROC	HCPCS/CPT procedure code.

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PROV PD AMT	Total paid amount for claims before any provider adjustments are applied.
PT RESP	Patient responsibility – The total amount the beneficiary owes the provider for this claim.
Total RC AMT	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.
REM	Remittance Advice Remark Codes.
SERV DATE	Date of service.
# of Claims	The total number of claims listed in the assigned claims section.

SUMMARY

CMS has responded to provider requests for simplification, standardization and less paper. CMS continues to strive to deliver accurate and consistent information that will help providers better understand the Medicare program and effectively file claims by delivering and making available the most up-to-date means of capturing important data via the latest technology.

CMS has developed an excellent desk reference that providers will find beneficial:

*The CMS Medicare Learning Network (MLN) offers a Web-Based Training (WBT) to educate professional providers and suppliers, as well as their billing staffs, with general RA information. To enroll in this or any other MLN training, go to <http://www.cms.gov/MLNProducts> on the MLN Web site and select **Web-Based Training Modules** under the Related Links Inside CMS section.*

OTHER RESOURCES

TrailBlazerSM has created a Reason Code Search tool. This tool offers users the ability to view the narrative for a specific reason code. The database contains the most common reason codes or those that have received the most calls to Customer Service. This is not an all-inclusive listing and additional reason codes will be added as they are identified. Users can choose to view the narrative for a specific reason code or a complete listing of reason codes/narratives.

The Reason Code Search tool can be accessed on the Self-Service Tools Web page, which can be found under Customer Service in the left navigation menu of the TrailBlazer Web site. Following is a direct link to the Reason Code Search tool:

<http://www.trailblazerhealth.com/Tools/ReasonCodeSearch.aspx>

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ANYTOWN LIVING WELL FAMILY PRACTICE		1		2		PROVIDER #: #####
YOUR STREET						PAGE #: 1 OF 2
ANYTOWN, TX #####-0001						DATE: 08/21/10
						CHECK/EFT #: 880000000

Section 1

Provider information is displayed, including name and complete address of the provider who submitted the claim.

Section 2

Provider # – This field displays the National Provider Identifier (NPI) of the facility receiving the SPR.

Page # – Indicates the current page number and total number of pages in the RA.

Date – Indicates the date the RA was issued.

Check/EFT # – Indicates the check or EFT transaction number through which payment was issued.

	PERF PROV	SERV DATE	POS	NOS	PROC	MODS	BILLED	ALLOWED	DEDUCT	COINS	GRP/RC-AMT	PROV PD
3A	NAME DOE, JANE				HIC #####X	ACNT	XXXXXXXXXXXXXXXXXX	ICN	2910000000000	ASG Y	MOA MA01	
	#####	0803 080310	11	1	99214		93.00	85.09	0.00	17.02	CO-45	7.91 68.07
	#####	0803 080310	11	1	3095F		0.01	00.00	0.00	0.00	CO-96	0.01 0.00
	REM: N365											
	PR RESP	17.02			CLAIMS TOTALS		93.01	85.09	0.00	17.02		7.92 68.07
												68.07 NET

Section 3A

PERF PROV – Displays the NPI of the performing/rendering provider for this service line.

SERV DATE – Displays the date of service.

POS – Indicates the two-digit Place of Service (POS) code that references where the service was rendered.

NOS – Indicates the number of services rendered.

PROC – Displays the procedure code(s) billed on the claim.

MODS – Displays all modifiers billed with the specified procedure.

BILLED – Indicates the amount the provider billed for the service.

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ALLOWED – Displays the Medicare allowed amount for the service.

DEDUCT – Indicates the amount of any deductible applied to the claim.

COINS – Indicates the coinsurance amount. This is the amount the beneficiary (or other insurer) is responsible for paying the provider.

GRP/RC – This field contains any group codes and CARCs associated with this service line. These combinations of codes are defined in the glossary section of the RA.

AMT – Contains the amount of any adjustment that was made based on the preceding group code and CARC.

PROV PD – Displays the total amount that the provider was paid for the service.

PERF	PROV	SERV DATE	POS	NOS	PROC	MODS	BILLED	ALLOWED	DEDUCT	COINS	GRP/RC-AMT	PROV PD	
	NAME DOE, JANE		HIC #####X	ACNT	XXXXXXXXXXXXXXXXXX	ICN	2910000000000	ASG Y	MOA	MA01			
	##### 0803 080310 11		1	99214			93.00	85.09	0.00	17.02	CO-45	7.91	68.07
	##### 0803 080310 11		1	3095F			0.01	00.00	0.00	0.00	CO-96	0.01	0.00
	REM: N365												
	PR RESP	17.02			CLAIMS TOTALS		93.01	85.09	0.00	17.02		7.92	68.07
													68.07 NET

Section 3B

NAME – Displays the name of the beneficiary.

HIC – This field displays the health insurance claim number of the beneficiary for whom the claim was processed.

ACNT – Contains any internal number assigned to the individual electronic claim by the provider. A zero appears if no internal number is submitted on the claim.

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

ASG – This field indicate whether the provider has accepted assignment for these claims. The field contains either a “Y” or an “N.”

MOA – This field contains Remittance Advice Remark Codes (RARCs) at the claim level (e.g., “MA01” shown in the above example). RARCs are used to convey appeal information and other claim-specific information. These codes and their meanings are listed in the glossary section at the end of the RA.

REM – Remark codes – This field indicates any RARCs associated with the claim. Some claims have additional RARCs that appear immediately under that service line level (e.g., “REM N365” shown in the above example). These codes and their meanings

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are listed in the glossary section at the end of the RA.

PERF	PROV	SERV DATE	POS	NOS	PROC	MODS	BILLED	ALLOWED	DEDUCT	COINS	GRP/RC-AMT	PROV PD
NAME	DOE, JANE				HIC #####X	ACNT	XXXXXXXXXXXXXXXXXX	ICN	2910000000000	ASG Y	MOA	MA01
#####	0803	080310	11	1	99214		93.00	85.09	0.00	17.02	CO-45	7.91 68.07
#####	0803	080310	11	1	3095F		0.01	00.00	0.00	0.00	CO-96	0.01 0.00
REM:	N365											
PR RESP		17.02			CLAIMS TOTALS		93.01	85.09	0.00	17.02		7.92 68.07
												68.07 NET

Section 3C

PT RESP – Indicates the total amount that the beneficiary owes the provider for this claim.

CLAIM TOTALS – This field 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.

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

PERF	PROV	SERV DATE	POS	NOS	PROC	MODS	BILLED	ALLOWED	DEDUCT	COINS	GRP/RC-AMT	PROV PD
NAME	DOE, JANE				HIC #####X	ACNT	XXXXXXXXXXXXXXXXXX	ICN	2910000000000	ASG Y	MOA	MA01
#####	0803	080310	11	1	99214		93.00	85.09	0.00	17.02	CO-45	7.91 68.07
#####	0803	080310	11	1	3095F		0.01	0.00	0.00	0.00	CO-96	0.01 0.00
REM:	N365											
PT RESP		17.02			CLAIMS TOTALS		93.01	85.09	0.00	17.02		7.92 68.07
												NET 68.07

Section 4 – PQRI

This claim indicates it is a Provider Quality Reporting Initiative (PQRI) claim because of the procedure code and the billed amount. Additional comments can be found in the glossary section of the RA.

PERF	PROV	SERV DATE	POS	NOS	PROC	MODS	BILLED	ALLOWED	DEDUCT	COINS	GRP/RC-AMT	PROV PD
NAME	DOE, JANE				HIC #####X	ACNT	XXXXXXXXXXXXXXXXXX	ICN	2910000000000	ASG Y	MOA	MA130 MA112
#####	0329	032910	22	1	99213		77.00	0.00	0.00	0.00	CO-16	77.00 0.00
REM:	N77											
PT RESP		0.00			CLAIMS TOTALS		77.00	0.00	0.00	0.00		77.00 0.00
												NET 0.00

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Section 5 – REJECTED

The CO-16 message along with the RARC (MOA codes) indicates the claim has been rejected by Medicare. The REM code (e.g., "N77" in the above example) explains what is missing/incomplete or invalid. These claims must be refiled with the missing/incomplete or invalid information. These codes and their meanings are further explained in the glossary section at the end of the RA.

PERF	PROV	SERV DATE	POS	NOS	PROC	MODS	BILLED	ALLOWED	DEDUCT	COINS	GRP/RC-AMT	PROV PD	
NAME	SMITH, MARY			HIC	#####X	ACNT	XXXXXXXXXXXXXXXXXX	ICN	2910000000000	ASG	Y	MOA	MA01
#####	0601	060110	11	1	99213		80.00	60.85	60.85	0.00	CO-45	19.15	0.00
											OA-23	31.89	
											PR-23	-31.89	
#####	0601	060110	11	1	73140		50.00	27.74	27.74	0.00	CO-45	22.26	0.00
											OA-23	22.31	
											PR-23	-22.31	
PT RESP	34.39					CLAIMS TOTALS	130.00	88.59	88.59	0.00		41.41	
											NET		0.00

Section 6 – MSP

Example of a Medicare Secondary Payer (MSP) claim. Claim scenario: Primary payer processed the claim with payment and Medicare processed the claim and applied the allowed amounts to the patient's 2010 Part B deductible.

Primary allowed	\$61.89	Medicare allowed	\$60.85
	<u>\$22.31</u>		<u>\$27.74</u>
	\$84.20		\$88.59

Primary paid	\$31.89 (OA-23)	Part B deductible	
	<u>\$22.31</u> (OA-23)	withheld	\$88.59
	\$54.20		

*Patient responsibility	\$30.00	Medicare paid	\$00.00
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*This amount should not be collected up front from the patient. Refer to the MRA for final patient responsibility.

Does the patient have any financial responsibility after the primary payer determination and the Medicare determination?

Medicare allowed	\$88.59
Minus any Medicare payment(s)	- \$00.00
<u>Minus any primary payment(s)</u>	<u>- \$54.20</u>
Patient responsibility	\$34.39

Provider should collect \$34.39 from patient.

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PERV PROV	SERV DATE	POS	NOS	PROC	MODS	BILLED	ALLOWED	DEDUCT	COINS	GRP/RC/AMT	PROV PD		
NAME	DOE, JANE			HIC	#####X	ACNT	XXXXXXXXXXXX	ICN	671000000000	ASG Y	MOA	MA67	
#####	0223	022310	11	1	73030	RT	65.00	0.00	0.00	0.00	CO-109	65.00	0.00
REM:	MA59	MA101											
#####	0223	022310	11	1	99213		100.00	66.45	0.00	13.29	CO-45	33.55	53.16
PT RESP:	13.29				CLAIM TOTALS		165.00	66.45	0.00	13.29		98.55	53.16
ADJS:	PREV PD	76.40		INTEREST	0.00			LATE FILING CHARGE	0.00			NET	0.00
OVERPAYMENT/ADJUSTMENT													

Section 7 – OVERPAYMENT/ADJUSTMENT

ADJS – Adjustment.

PREV PD – Displays the amount the provider was previously paid on this claim.

INTEREST – Interest amount.

LATE FILING CHARGE – Amount charged to the provider for filing a claim past the claim filing time limits.

TOTALS	# OF CLAIMS	BILLED AMT	ALLOWED AMT	DEDUCT AMT	COINS AMT	TOTAL RC-AMT	PROV PD AMT	PROV ADJ AMT	CHECK AMT
8	4	300.01	173.68	88.59	17.02	-179.49	14.91	29.41	38.66

Section 8 – TOTALS

of CLAIMS – Displays the total number of claims listed on the SPR.

BILLED AMT – Indicates the total amount billed for all claims listed on the SPR. The billed amount does not include the dollar amounts for adjusted claims.

ALLOWED AMT – Provides the total amount allowed for all new claims. On previously processed claims, only the allowed amounts affected by the adjustment are included.

DEDUCT AMT – Displays the total amount applied to the beneficiaries' deductibles for all claims listed on the SPR.

COINS AMT – Provides the total coinsurance amount for all claims that are the beneficiaries' responsibility. On previously processed claims, only the coinsurance amount(s) affected by the adjustment is included.

TOTAL RC-AMT – Indicates the total amount of adjustments made due to CARCs listed on each service line. The total reason code amount is determined by adding the coinsurance amount, the provider paid amount and the deductible amount (if applicable) together and subtracting that amount from the total billed amount.

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PROV PD AMT – The provider paid amount is the total net amount (the amount Medicare owes the provider for this claim) minus any Forwarding Balance (FB).

PROV ADJ AMT – The provider adjustment amount is the total amount of any Withholding (WO) amounts. Provides the amount the check has been adjusted from the provider's paid amount.

CHECK AMT – The check amount is the total net amount minus any WO amounts.

PROVIDER ADJ DETAILS:	PLB REASON CODE	FCN	AMOUNT	CHECK AMOUNT
9	WO	4510000000000000	29.41	
	FB	6710000000000000	53.16	

Section 9 – PROVIDER ADJ DETAILS

The provider-level adjustment details section is used to show adjustments that are not specific to a particular claim or service on this SPR.

PLB REASON CODE – This field indicates the various provider-level adjustment reason codes that may be used. A complete listing can be found on the Washington Publishing Web site at: <http://www.wpc-edi.com/hipaa>. Examples include:

- **50** – Late charge – Used to identify Late Claim Filing Penalty.
- **L6** – Interest owed – Used for the interest paid on claim on an RA.
- **WO** – Withholding – Used to recover **previous** overpayments. A reference number (the original ICN) is applied for tracking purposes. The WO amount is subtracted from the check amount.
- **FB** – Forwarding Balance – Reflects the difference in the payment between the original claim and the overpayment/adjustment to the original claim. An FB will be on an RA any time a claim has been overpaid/adjusted. This amount does not reflect a withholding on this claim. Providers should receive a letter requesting this amount and instructions for refund. If the refund is not received in approximately 45 days, the amount will be reflected as a “WO” on a future remittance.

When the adjustment shows a corrected payment of less than the original claim payment, an FB reflects a negative amount. When the adjustment shows a corrected payment of more than the original claim payment, the FB reflects a positive amount.

The RA will identify the associated FB with the FCN (ICN).

FCN – 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

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matches the ICN field of a previous claim. If the adjustment in question does not relate to a previous claim, this field is left 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).*

REVISION HISTORY

Date	Description
January 2008	<ul style="list-style-type: none">• Revised and updated MREP information.• Inserted an up-to-date MRA example.
March 2008	Corrected beneficiary name in MRA example and language in MRA legend.
November 2008	Updated ERA contact numbers.
July 2009	<ul style="list-style-type: none">• Updated ERA phone numbers.• Added note for providers using MREP to download updated versions.• Updated Abbreviations and added Terms.• Added information about the Reason Code Search tool.• Updated dates on the SPR example.
<i>June 2010</i>	<ul style="list-style-type: none">• <i>Added information on the different types of RAs.</i>• <i>Added WPC name and Web site under “Who Is ANSI?”</i>• <i>Added additional information on CARCs.</i>• <i>Updated example of RA.</i>• <i>Updated glossary.</i>