https://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/Remittance.html

Health Care Payment and Remittance Advice

Electronic Remit Advice (ERA) and Standard Paper Remit (SPR)

After Medicare processes a claim, either an ERA or an SPR is sent with final claim adjudication and payment information. One ERA or SPR usually includes adjudication decisions about multiple claims. Itemized information is reported within that ERA or SPR for each claim and/or line to enable the provider to associate the adjudication decisions with those claims/lines as submitted by the provider. The ERA or SPR reports the reason for each adjustment, and the value of each adjustment. Adjustments can happen at line, claim or provider level. In case of ERA the adjustment reasons are reported through standard codes. For any line or claim level adjustment, 3 sets of codes may be used:

1. Claim Adjustment Group Code (Group Code)
2. Claim Adjustment Reason Code (CARC)
3. Remittance Advice Remark Code (RARC)

Group Codes assign financial responsibility for the unpaid portion of the claim balance e.g., CO (Contractual Obligation) assigns responsibility to the provider and PR (Patient Responsibility) assigns responsibility to the patient. Medicare beneficiaries may be billed only when Group Code PR is used with an adjustment. CARCs provide an overall explanation for the financial adjustment, and may be supplemented with the addition of more specific explanation using RARCs. Medicare beneficiaries are sent Medicare Summary Notice that indicates how much financial responsibility the beneficiary has.

At the provider level, adjustments are usually not related to any specific claim in the remittance advice, and Provider Level Balance (PLB) reason codes are used to explain the reason for the adjustment. Some examples of provider level adjustment would be: a) an increase in payment for interest due as result of the late payment of a clean claim by Medicare; b) a deduction from payment as result of a prior overpayment; c) an increase in payment for any provider incentive plan. The SPR also reports these standard codes, and provides the code text as well. One check or electronic funds transfer (EFT) is issued when payment is due; representing all benefits due from Medicare for the claims itemized in that ERA or SPR.

There are a number of advantages of ERA over SPR. The amount payable for each line and/or claim as well as each adjustment applied to a line or claim can be automatically posted to accounting or billing applications from an ERA, eliminating the time and cost for staff to post this information manually from an SPR. ERAs generally contain more detailed information than the SPR. Please see the separate page in this EDI section for further information on the benefits of acceptance of EFT for Medicare claim payments.

All ERAs sent by Medicare contractors are currently in the Accredited Standards Committee (ASC) X12N 835 version 5010 format adopted as the national HIPAA ERA standard. There is a link below to this version of the ERA.

Medicare provides free software to read the ERA and print an equivalent of an SPR using the software. Institutional and professional providers can get PC Print and Medicare Easy Print (MREP) respectively from their contractors. These software products enable providers to view and print remittance advice when they're needed, thus eliminating the need to request or await mail delivery of SPRs. The MREP software also enables providers to view, print, and export special reports to Excel and other application programs they may have.

See the Medicare Claims Processing Manual, (Pub.100-04), Chapters 22 and 24 for further remittance advice information.

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