Medicare Claims Processing Manual

Chapter 22 - Remittance Advice

Table of Contents

10 - Background

(Rev.)

A-01-57, B3-7030, AB-03-026

Intermediaries, carriers, and Durable Medical Equipment Regional Carriers (DMERCs) send to providers, physicians, and suppliers, as a companion to claim payments, a notice of payment, referred to as the Remittance Advice (RA). RAs explain the payment and any adjustment(s) made. For each claim or line item payment, reduction, or denial, there is an associated remittance advice item. Payment for multiple claims can be reported on one transmission of the remittance advice. RA notices can be produced and transferred in either paper or electronic format.

Carriers and DMERCs also send informational RAs to physicians that do not accept assignment (acceptance of direct Medicare payments instead of billing the patient), unless the beneficiary or physician requests that the remittance notice be suppressed. An informational RA is identical to other RAs, but must carry a standard message to notify physicians that do not accept assignment that they do not have appeal rights beyond those afforded when limitation on liability (rules regulating the amount of liability that an entity can accrue because of medical services which are not covered by Medicare) applies. Suppliers that do not accept assignment may not be sent an RA.

In order to implement the Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification provisions for Electronic Remittance Advice (ERA) transactions, the Secretary of Health and Human Services has established an implementation guide for a HIPAA compliant version of the X12N 835 (Health Care Claim/Payment Advice). An implementation guide is a reference document governing the implementation of an electronic format, it contains all information necessary to use the subject format, e.g., instructions and structures. This HIPAA compliant 835 has been established as a national standard for use by all health plans in the United States, including Medicare intermediaries, carriers, and DMERCs. Medicare requires the use of this format exclusively for ERAs. Medicare has also established paper formats that must be used by carriers, DMERCs and intermediaries.

The HIPAA compliant version of the 835 includes some significant changes from earlier versions of the 835 supported by Medicare. See appendix D of the 835 version 4010 implementation guide for a summary of these changes. Implementation guides may be

downloaded without charge from http://www.wpc-edi.com/HIPAA. Anyone wanting to download this file is required to set up a user name and password for this site. Follow the instructions on the site to setup a new account and download this file.

Addenda to the implementation guides have also been published, these addenda can be found at http://hipaa.wpc-edi.com/HIPAAAddenda_40.asp.

By January 2, 2002, intermediaries, carriers, and DMERCs had to be able to issue HIPAA compliant 835 version 4010 transactions in production mode to any provider or clearinghouse that requested production data in that version. Here after, all contractors must upgrade to most current versions as directed by program memoranda. HIPAA requires CMS policy to change such that only one version of electronic formats will be maintained, not the version and previous version as before HIPAA.

Effective October 2002, unless a provider has requested that Medicare revert to issuance of Standard Paper Remittance (SPR) only, non-HIPAA compliant 835, National Standard Format (NSF), and Uniform Billing 92 (UB-92) remittance recipients are automatically sent production HIPAA compliant 835 transactions.

20 - General Remittance Completion Requirements

(Rev.)

A3-3750

The following general field completion and calculation rules apply to both paper and electronic versions of the remittance advice, except as otherwise noted. See the current implementation guide for specific requirements:

- Any adjustment applied to the submitted charge and/or units must be reported in the claim and/or service adjustment segments with the appropriate group, reason, and remark codes explaining the adjustments. Every provider level adjustment must likewise be reported in the provider level adjustment section of the remittance advice. Intermediary RAs do not report service line adjustment data, only summary claim level adjustment information.

- The computed field "Net" must include "ProvPd" (Calculated Pmt to Provider, CLP04 in the 835) and interest, late filing charges and previously paid amounts.

- The Medicare contractor reports only the name of the immediately subsequent payer on the remittance advice, even if coordination of benefits (COB) information is sent to more than one payer. (The current HIPAA compliant version does not have the capacity to report more than one crossover carrier.)

- The check amount is the sum of all claim-level payments, including claims and service-level adjustments, less any provider level adjustments.

- Positive adjustment amounts reduce the amount of the payment and negative adjustment amounts increase it.

- The contractor does not issue an RA for a voided or cancelled claim. It issues an RA for the adjusted claim with "Previously Paid" (CLP04 in the 835) showing the amount paid for the voided claim.

30 - Remittance Balancing

(Rev.)

A-01-57, AB-02-067, A-02-070, B-01-35

The principles of remittance balancing are the same for both paper and electronic remittance formats. Balancing requires that the total paid is equal to the total billed plus or minus payment adjustments for a single 835 remittance in accordance with the rules of the 835 format. Specific instructions for each electronic version are included in the implementation guides.

Every HIPAA compliant X12 835 transaction issued by an intermediary or carrier/DMERC must comply with the implementation guide (IG) requirements, i.e., these remittances must balance at the service, claim and transaction levels. Back end validation must be performed to ensure that these conditions are met.

Although issuance of out-of-balance RAs is not encouraged, providers have indicated that receipt of an out-of-balance RA is preferable to not receiving any RA to explain payment. It is permissible on an exception basis for carriers to issue an 835 that does not balance as long as immediate action is initiated to correct the problem that created the out-of-balance situation. However, these out-of-balance 835s must be rare exceptions, and not the rule. If an out-of-balance 835 is issued, affected physicians, suppliers and clearinghouses must be notified of the problem and the expected date of correction . Carrier shared system software will treat production of an out-of-balance 835 as a priority problem, and will work closely with the carriers and CMS to fix the problem as soon as possible.

Intermediary shared systems must make forced balancing adjustments at the line, claim and/or transaction level as applicable to make each 835 transaction balance. Intermediary shared systems must report the amount by which a line or claim is out of balance with adjustment reason code A7 (Presumptive Payment Adjustment) at the line or claim level. The intermediary shared systems must report the amount by which a transaction is out-of-balance with reason code CA (manual claim adjustment) as a provider level adjustment (PLB). PLB Medicare composite reason code CS/CA will be reported in this situation.

A7 and CA may only be used by intermediaries on a temporary exception basis, pending intermediary diagnosis of the source of the balancing problem and intermediary shared system programming to correct that problem. Intermediaries must notify effected providers and clearinghouses of the problem and the expected date of correction whenever A7 or CA is used to force 835s to balance. The shared systems will treat production of an out-of-balance 835 as a priority problem, and will work closely with the fiscal intermediaries and CMS to fix the problem as soon as possible.

40 - Electronic Remittance Advice

(Rev.)

A3-3750

Electronic Remittance Advice (ERA) transactions must be produced in the current HIPAA compliant Accredited Standards Committee (ASC) X12 835 format. Directions for version updates are posted when necessary in program memoranda issued by CMS. Refer to http://www.wpc-edi.com/HIPAA for implementation guides, record formats, and data dictionaries for the 835.

Shared systems maintainers must provide appropriate provider file structures and switching mechanisms so that contractors can select and generate the abbreviated 835 and/or the automated clearing house (ACH) format when electronic funds transfer (EFT) applies. See the implementation guides for further information on the abbreviated 835 and use of the 835 for EFT.

Changes to content and format of ERAs may not be made by individual contractors. Changes will be made only by shared system maintainers, and then, only as directed by CMS.

40.1 - ANSI ASC X12 835

(Rev.)

A3-3750, AB-02-067, A-02-070

The 835 is a variable-length record designed for wire transmission and is not suitable for use in application programs. Therefore, shared systems generate a flat file version of the 835. Contractors must translate that flat file into the variable length 835 record for transmission to providers or their billing services. See Chapter 24 for technical information about transmission of the 835.

Contractors are required to:

- Send the remittance data directly to providers or their designated billing services;
- Provide sufficient security to protect beneficiaries' privacy. At the provider's request, the contractor may send the 835 through the banking system if its Medicare bank and the provider's bank have that capability. The contractor does not allow any party to view beneficiary information, unless authorized by specific instructions from CMS see §40.1 for additional information;
- Issue the remittance advice specifications and technical interface specifications to all requesting providers within three weeks of their request. Interface specifications must contain sufficient detail to enable a reasonably knowledgeable provider to interpret the RA, without the need to pay the contractor or an

associated business under the same corporate umbrella for supplemental services or software;

- Contractors send the 835 to providers over a wire connection. They do not use tapes or diskettes;
- Intermediaries allow providers to receive a hard copy remittance in addition to the 835 during the first 30 days of receiving ERAs and during other testing. After that time, intermediaries do not send a hard copy version of the 835, in addition to the electronic transmission, in production mode. They should contact CMS if this requirement causes undue hardship on a particular intermediary provider;
- Contractors may release an ERA prior to the payment date, but never later than the payment date;
- Ensure that their provider file accommodates the data necessary to affect EFT, either through use of the ACH or the 835 format. The abbreviated 835 contains no beneficiary-specific information; therefore, it may be used to initiate EFT and may be carried through the banking networks.
- Pay the costs of transmitting EFT through their bank to the ACH. Payees are responsible for the telecommunications costs of EFT from the ACH to their bank, as well as the costs of receiving 835 data once in production mode; and
- Provide for sufficient back-up to allow for retransmission of garbled or misdirected transmissions.

Every X12 835 transaction issued by an intermediary or carrier/DMERC must comply with the implementation guide (IG) requirements (see §40.4), i.e., each required segment must be reported, each required or applicable situational data element in a required or situational segment must be reported, and the data in a data element must meet the minimum length and data attribute (AN, ID, R, etc.) specifications in the implementation guide.

Back end validation must be performed to ensure that these conditions are met. Carriers, DMERCs, and intermediaries are not required to validate codes maintained by their standard systems, such as Healthcare Common Procedure Coding System (HCPCS), that are issued in their standard system's flat file for use in the body of an 835, but they are required to validate data in the 835 envelope as well as the codes that they maintain, such as claim adjustment reason codes, that are reported in the 835. Medicare contractors do not need to re-edit codes or other data validated during the claim adjudication process during this back end validation. Valid codes are to be used in the flat file, unless:

- A service is being denied or rejected using an 835 for submission of an invalid code, in which case the invalid code must be reported on the 835;
- A code was valid when received, but was discontinued by the time the 835 is issued, in which case, the received code must be reported on the 835; or

- A code is received on a paper claim or a pre HIPAA compliant or any other electronic claim, and does not meet the required data attribute(s) for the HIPAA compliant 835, in which case, "gap filling" would be needed if it were to be inserted in a compliant 835.

40.2 - Generating an ERA if Required Data is Missing or Invalid

(Rev.)

AB-02-067, A-02-070

A. Carriers/DMERCs

The X12 835 IG contains specific data requirements, which must be met to build a HIPAA compliant ERA. A claim could be received on paper, or in a pre HIPAA compliant X12 835 or other electronic format that lacks data or has data that does not meet the data attributes or length requirements for preparation of a HIPAA-compliant ERA. If not rejected as a result of standard or IG level editing, a carrier/DMERC must either send an SPR advice or a "gap filled" ERA to avoid noncompliance with HIPAA.

For example, if a procedure code is sent with only four characters and the code set specified in the IG includes five character codes in the data element, and the code is not rejected by the front end and/or pre-pass edits, the claim would be denied due to the invalid procedure code. Preparation of an ERA with too few characters though would not comply with the IG requirements. The noncompliant ERA could be rejected by the receiver.

The shared system maintainers, working in conjunction with their contractors, must decide whether to generate an SPR, which is not covered by HIPAA, or to "gap fill" in this situation, depending on system capability and cost. Except in some very rare situations, "gap filling" would be expected to be the preferred solution. To "gap fill", the shared systems must enter meaningless characters to meet the data element minimum length requirements in any outgoing X12 transaction if insufficient data is available for entry in a required data element. Shared system maintainers must work with their respective users to determine which characters will be used to gap fill required data elements. The selected meaningless character(s) must also meet the data requirements of the data elements where used, e.g., be alphanumeric (AN), decimal (R), identifier (ID), date (DT), or another data type as appropriate. The values may not include any special characters, low values, high values, or all spaces since this could result in translation problems. The contractors must notify the trading partners, if and when their files are affected, as to when and why these characters will appear in an 835.

40.3 - Electronic Remittance Advice Data Sent to Banks

A3-3751, A-01-057, A-02-070, AB-02-067, B-01-35

(Rev.)

Under the HIPAA Privacy requirements, U.S. health care payers are prohibited from sending table two 835 data (portion of 835 containing protected patient health care information) (or protected patient health care information in any other paper or electronic format) to a bank (see §40.5.1), unless:

- That bank also functions as a health care data clearinghouse;
- The provider has authorized the bank as a health care data clearinghouse to receive that data; and
- The bank has signed an agreement to safeguard the privacy and security of the data.

The definition of a financial clearinghouse, as used by banks for transfer of funds, differs from the definition of health care data clearinghouse as used by HIPAA. The HIPAA definition must be met if a bank is to be authorized for receipt of table two or equivalent patient health care data.

Table two contains protected patient information that is not approved for release to a bank that is not an authorized health care data clearinghouse. A nonhealth data clearinghouse bank cannot receive 835 data, except as provided in table one.

40.4 - Medicare Standard Electronic PC-Print Software

A3-3751, A-01-57

(Rev.)

PC-Print software enables providers to print remittance data transmitted by Medicare. Intermediaries are required to make PC-Print software available to providers at no charge. This software must be able to operate on Windows-95, 98, 2000/Me, and Windows NT platforms, and include self-explanatory loading and use information for providers. It should not be necessary to furnish providers training for use of PC-Print software.

Intermediaries must supply providers with PC-Print software within three weeks of request. The Fiscal Intermediary Shared System (FISS) maintainer will supply PC-Print software and a user's guide for all intermediaries. The FISS maintainer must assure that the PC-Print software is modified as needed to correspond to updates in the ERA and SPR formats.

Providers are responsible for any telecommunication costs associated with receipt of the 835, but the software itself is provided at no cost.

The PC-Print software enables providers to:

- Receive, over a wire connection, an 835 electronic remittance advice transmission on a personal computer (PC) and write the 835 file in American National Standard Code for Information Interchange (ASCII) to the provider's 'A:' drive;
- Print 835 claims and provider payment summary information;
- View and print remittance information for a single claim; and
- View and print a sub-total by bill type.

The receiving PC always writes an 835 file in ASCII. The providers may choose one or more print options, e.g., the entire transmission, a single claim, a summary by bill type, or a provider payment summary. Since the software performs limited functions, malfunctions should rarely occur. If software malfunctions are detected, they are to be corrected through the FISS maintainer. Individual intermediaries or data centers may not modify the PC-Print software.

Effective with use of HIPAA compliant versions of the 835, carriers and DMERCs are not required to issue PC-Print software to providers. A survey of carriers indicated limited use of the NSF versions of PC-Print previously developed. Providers realize the most significant benefits of the 835, such as automatic posting of patient records and maintenance of accounts receivables, when they process the data electronically. When providers use the 835 as intended by the designers, they should rarely need hard copies of 835 data. Since providers still receive, or can request, SPRs, most carriers and DMERCs did not consider it cost effective, to continue to support PC-Print.

Carriers and DMERCs who consider there to be a local need for PC-Print software as an 835 marketing tool, to retain current 835 customers, or to respond to other demonstrated provider needs have the option to continue to generate PC-Print software. However, carriers and DMERCs who elect to continue to support PC-Print software, must be able to demonstrate that the benefits generated from the software exceed their cost to support the software. If they elect to continue to support PC-Print software, the software must operate on Windows 95, 98, 2000, and Windows NT platforms and be made available to providers free or at cost.

40.5 - 835 Implementation Guide

PM A-01-57, Date: April 30, 2001

(Rev.)

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires that Medicare, and all other health insurance payers in the United States, comply with the electronic data interchange standards for health care as established by the Secretary of Health and Human Services. The X12N 835 implementation guide has been established as the standard for compliance for remittance advice transactions. The implementation

guide for the current HIPAA compliant version of the 835 is available electronically at http://www.wpc-edi.com/hipaa.

Although that implementation guide contains requirements for use of specific segments and data elements within the segments, the guide was written for use by all health benefit payers, and not specifically for Medicare. However, a Companion Document was prepared by CMS to clarify when conditional data elements and segments must be used for Medicare reporting, and identify those codes and data elements that never apply to Medicare and which may not be used in Medicare remittance advice transactions.

Section 40.5.1 is a copy of the "Medicare X12N 835 Version 4010.A.1 HIPAA Companion Document." This document itemizes the Medicare requirements for use of specific segments, data elements, and codes in the 835, and maps the flat file to the corresponding 835 version 4010/4010.A.1 segments and data elements. For information about the structure of the X12N format (i.e., definitions of segments, loops, and elements) or definitions for specific codes see the Implementation Guide.

When reviewing the Companion Document, keep in mind the following information about loop usage (e.g., required, not used, and situational definitions). For additional information on this subject see the Implementation Guide:

- Loop usage within ASC X12 transactions and their implementation guides can be confusing. Care must be used to read the loop requirements in terms of the context or location within the transaction. The usage designator of a loop's beginning segment indicates the usage of the loop. Segments within a loop cannot be sent without the beginning segment of that loop.

- If the first segment is Required, the loop must occur at least once unless it is nested in a loop that is not being used. A note on the Required first segment of a nested loop will indicate dependency on the higher-level loop.

- If the first segment is Situational, there will be a Segment Note addressing use of the loop. Any required segments in loops beginning with a Situational segment only occur when the loop is used. Similarly, nested loops only occur when the higher-level loop is used.

40.5.1 - Medicare 835 HIPAA Companion Document - Intermediaries

(Rev.)

AB-02-067, A-02-070, AB-01-149, AB-01-159, AB-01-79, A-03-005

This companion document supplements, but does not contradict any requirements in the 835 version 4010.A.1 implementation guide.

Table 1 - Header Data

Segment/ Data Elements	835 and Medicare Requirements/Notes
Envelope	
ISA	Required
ISA01	Required. Enter 00 pending establishment of HIPAA security requirements for transmissions. Translator Generated (TG)
ISA02	Required. Enter 10 blank spaces pending establishment of HIPAA security requirements. TG
ISA03	Required. Enter 00 pending establishment of HIPAA security requirements. TG
ISA04	Required. Enter 10 blank spaces pending establishment of HIPAA security requirements. TG
ISA05	Required. Enter ZZ as Medicare trading partners will always mutually decide on the interchange sender ID to be used. TG
ISA06	Required. Mapped to flat file (ff) record 1, field 1.
ISA07	Required. The type of number used for receiver identification is individually negotiated between trading partners. Enter 29 if using the NPI number, when effective, as the qualifier. Enter ZZ, mutually defined, if using an alternate locally defined qualifier. Alternately, one of the other qualifiers permitted in the IG can be used if trading partners choose one of those means of identification. TG
ISA08	Required. The number must be locally determined. TG
ISA09	Required. Enter the transmission date. TG
ISA10	Required. Enter the transmission time. TG
ISA11	Required. TG
ISA12	Required. TG
ISA13	Required. TG
ISA14	Required. Enter 0. TG
ISA15	Required. Mapped to ff record 1, field 13.
ISA16	Required. Locally determined, but “>” is recommended as the delimiter symbol. TG

IEA	Required.
IEA01	Required. TG
IEA02	Required. TG
GS	Required
GS01	Required. TG
GS02	Required. Mapped to ff record 1, field 1.
GS03	Required. The receiver's code is established in the trading partner agreement. It may be the provider # (mapped to ff record 1, field 3), the provider chain ID # (mapped to ff record 1, field 2), the VAN ID # (in local records, TG), or the EDI submitter # (in local records, TG).
GS04	Required. TG
GS05	Required. TG
GS06	Required. TG
GS07	Required. TG
GS08	Required. TG

Table 1, Header Data

ST	Required.
ST01	Required. Always enter "835." TG
ST02	Required. TG
BPR	Required.
BPR01	Required. Codes U and X do not apply to Medicare. Mapped to ff record 1, field 14.
BPR02	Required. Mapped to ff record 1, field 15.
BPR03	Required. Code D does not apply to Medicare. Mapped to ff record 1, field 16.
BPR04	Required. Codes BOP and FWT do not apply to Medicare. Mapped to ff record 1, field 17.
BPR05	Situational, but required for Medicare if ACH is entered in BPR04. Mapped to ff record 1, field 18.

BPR06	Situational, but required for Medicare if ACH in BPR04. Code 04 does not apply to Medicare. Mapped to ff record 1, field 19.
BPR07	Situational, but required for Medicare if ACH in BPR04. Mapped to ff record 1, field 20.
BPR08	Situational, but required for Medicare if ACH in BPR04. Mapped to ff record 1, field 21.
BPR09	Situational, but required for Medicare if ACH in BPR04. Mapped to ff record 1, field 22**.**
BPR10	Situational, but required for Medicare if ACH in BPR04. Mapped to ff record 1, field 23.
BPR11	Situational, but required for Medicare when BPR10 is used. Mapped to ff record 1, field 34. BPR11 and TRN04 must be identical.
BPR12	Situational, but required for Medicare if ACH in BPR04. Code 04 does not apply to Medicare. Mapped to ff record 1, field 24**.**
BPR13	Situational, but required for Medicare if ACH in BPR04. Mapped to ff record 1, field 25.
BPR14	Situational, but required for Medicare if ACH in BPR04. Mapped to ff record 1, field 26.
BPR15	Situational, but required if ACH in BPR04. Mapped to ff record 1, field 27.
BPR16	Required. Mapped to ff record 1, field 28.
BPR17-21	Not used.
TRN	Required.
TRN01	Required. Mapped to ff record 1, field 29.
TRN02	Required. If no payment is issued, insert the remittance advice number. Mapped to ff record 1, field 30 and 31.
TRN03	Required. TRN03 must =BPR10. Mapped to ff record 1, field 23.
TRN04	Situational, but required for Medicare when BPR10 is used. Mapped to ff record 1, field 34. BPR11 and TRN04 must be identical.
CUR	Situational, but does not apply to Medicare.
REF (060.A)	Situational, but required for Medicare if the 835 is being sent to any entity other than the payee.

REF01	Required. Always enter ”EV.” TG
REF02	Required. Must correspond to entry in ISA08. Mapped to ff record 1, field 2.
REF03-04	Not used.
REF (060.B)	Situational, but does not apply to Medicare intermediaries.
DTM (070)	Situational, but required for Medicare if the date of the 835 is different than the cutoff date for the adjudication action that generated the 835.
DTM01	Required. Mapped to ff record 1, field 32.
DTM02	Required. Mapped to ff record 1, field 33.
DTM03-06	Not used.
N1 (080.A)	Required for payer identification.
N101	Required. Mapped to ff record 10, field 13.
N102	Situational, but required for Medicare. Mapped to ff record 10, field 14.
N103	Situational. Always enter “XV” in this loop when the PlanID is effective, but not used prior to that date. Mapped to ff record 10, field 15.
N104	Situational, but required once the PlanID is effective. Mapped to ff record 10, field 16.
N105-106	Not used.
N3 (100)	Required for payer identification.
N301	Required. Mapped to ff record 10, field 17.
N302	Situational in the 835, but required by Medicare if there is more than 1 address line for the payer, such as for a suite number. Mapped to ff record 10, field 18.
N4 (110)	Required for payer identification.
N401	Required. Mapped to ff record 10, field 19.
N402	Required. Mapped to ff record 10, field 20.
N403	Required. Mapped to ff record 10, field 21.
N404-406	Not used.

REF (120.A)	Situational. Required for Medicare prior to the effective date of the PlanID. After that date, a Medicare payer may use at its option in addition to the PlanID in the 060 REF.
REF01	Required. Enter 2U; EO, HI, and NF do not apply to Medicare. Mapped to ff record 10, field 22.
REF02	Required. Mapped to ff record 10, field 23.
REF03-04	Not used.
PER (130)	Situational, but will not be used by Medicare.
N1 (080.B)	Required to identify the payee.
N101	Required. Mapped to ff record 15, field 13.
N102	Situational, but reporting of the payee's name is required for Medicare prior to the effective date of the NPI. Mapped to ff record 15, field 14.
N103	Required. Always enter "FI" until the NPI is effective. After that date, always enter "XX." Mapped to ff record 15, field 15.
N104	Required. Payee's TIN for qualifier FI mapped to ff record 15, field 24. NPI, when effective, mapped to ff record 15, field 16.
N105-106	Not used.
N3 (100.B)	Situational, but required for Medicare if data reported in the N1 segment for this loop.
N301	Required. Mapped to ff record 15, field 17.
N302	Situational, but required if this segment is used and there is a second payee address line. Mapped to ff record 15, field 18.
N4 (110.B)	Situational, but required for Medicare if data reported in the N1 segment of this loop.
N401	Required. Mapped to ff record 15, field 19.
N402	Required. Mapped to ff record 15, field 20.
N403	Required. Mapped to ff record 15, field 21.
N404	Situational. Only required if the address is other than the U. S. Mapped to ff record 15, field 22.
N405-406	Not used.

REF (120.B) Situational, but will be required for Medicare to report the Taxpayer Identification Number (TIN) when the National Payer Identifier (NPI) is effective. The TIN will be reported in N104 until that date.

REF01	Required. Always enter "TJ" in this loop when the NPI is effective. Prior to that date, use PQ (Payee Identification) for Medicare. 0B, 1A, 1B, 1C, 1D, 1E, 1F, 1G, 1H, D3, G2, and N5 do not apply to Medicare intermediaries. TJ mapped to ff record 15, field 23. PQ mapped to ff record 15, field 25.
REF02	Required. TJ (TIN) mapped to ff record 15, field 24. PQ mapped to ff record 15, field 26.
REF03-04	Not used.

Table 2, Detail Data

LX	Situational, but required for Medicare.
LX01	Required. Mapped to ff record 20, field 13.
TS3	Situational, but required for intermediaries when applicable.
TS301	Required. Mapped to ff record 20, field 3.
TS302	Required. Mapped to ff record 20, field 5.
TS303	Required. Mapped to ff record 20, field 4.
TS304	Required. Mapped to ff record 20, field 14.
TS305	Required. Mapped to ff record 20, field 15.
TS306	Situational, but required for Medicare if there have been any covered charges for this provider for this fiscal period. The covered charge allowable by Medicare is the submitted charge minus the noncovered charges. Mapped to ff record 20, field 16.
TS307	Situational, but required for Medicare if there have been any noncovered charges for this provider for this fiscal period. Mapped to ff record 20, field 17.
TS308	Situational, but required for Medicare if there have been any denied charges for this provider for this fiscal period. Mapped to ff record 20, field 18.
TS309	Situational, but required for Medicare if there have been any payments to this provider for this fiscal period. Includes total interest. The amount can be less than zero. Mapped to ff record 20, field 19.

TS310 Situational, but required for Medicare if there have been any interest payments to this provider for this fiscal period. Mapped to ff record 20, field 20.

TS311 Situational but required for Medicare if there have been any A2 contractual adjustments for this provider for this fiscal period. Mapped to ff record 20, field 21.

TS312 Situational, but required for Medicare if there have been any Gramm-Rudman reductions for this provider for this fiscal period. Mapped to ff record 20, field 22.

TS313 Situational, but required for Medicare if there have been any payments made by payer(s) primary to Medicare for claims processed by Medicare for this type of bill for this fiscal period. This includes any coinsurance and deductible amounts another payer paid for a beneficiary. Mapped to ff record 20, field 23.

TS314 Situational but required for Medicare if any blood deductible amounts have applied to this provider for this type of bill for this fiscal period. Mapped to ff record 20, field 24.

TS315 Situational, but required for Medicare if there have been payments made using the clinical lab or orthotics and prosthetics fee schedules. Equals the total covered charges minus sum of charges for line items paid on either the clinical lab or orthotics and prosthetics fee schedules. Mapped to ff record 20, field 25.

TS316 Situational, but required for Medicare if any coinsurance was due to this provider for this type of bill summary for this fiscal period. Mapped to ff record 20, field 26.

TS317 Situational, but required for Medicare if provider billed for HCPCS line items payable on either clinical lab or orthotics and prosthetics fee schedules for this type of bill for this fiscal period. Mapped to ff record 20, field 27.

TS318 Situational, but required for Medicare if benefits allowed for HCPCS line items covered by the clinical lab or orthotics and prosthetics fee schedules for this provider for this fiscal period. Mapped to ff record 20, field 28.

TS319 Situational, but required for Medicare if any cash deductible applied for this provider for this type of bill for this fiscal period. Mapped to ff record 20, field 29.

TS320 Situational, but required for Medicare if any professional component amounts were paid to this provider for this type of bill for this fiscal period. Mapped to ff record 20, field 30.

TS321	Situational, but required for Medicare if other payers satisfied the patient liability amounts (reason codes in the PR group) for this provider for this type of bill for this fiscal period. Mapped to ff record 20, field 31.
TS322	Situational, but required if any refund made to patients by Medicare on behalf of this provider for this type of bill for this fiscal period. Mapped to ff record 20, field 32.
TS323	Situational, but required for Medicare if this provider was on PIP for any portion of this fiscal period. Mapped to ff record 20, field 33.
TS324	Situational, but required for Medicare if this provider was on PIP for any portion of this fiscal period. Mapped to ff record 20, field 34.
TS2	Situational, but required for Medicare if there have been inpatient PPS payments to this provider for this type of bill for this fiscal period.
TS201	Required. Mapped to ff record 21, field 13.
TS202	Situational, but required for Medicare if any federal-specific operating DRG amounts have been paid. Mapped to ff record 21, field 14.
TS203	Situational, but required for Medicare if any hospital-specific operating DRG amounts have been paid. Mapped to ff record 21, field 15.
TS204	Situational, but required for Medicare if any disproportionate share payments have been paid. Mapped to ff record 21, field 16.
TS205	Situational, but required for Medicare if capital payments, other than capital outliers, have been paid. Mapped to ff record 21, field 17.
TS206	Situational, but required for Medicare if any indirect medical education payments made. Mapped to ff record 21, field 18.
TS207	Situational, but required for Medicare if any day outlier payments made. Mapped to ff record 21, field 19.
TS208	Situational, but required for Medicare if any day outlier payments made. Mapped to ff record 21, field 20.
TS209	Situational, but required for Medicare if any cost outlier payments made. Mapped to ff record 21, field 21.
TS210	Situational, but required for Medicare if DRG payments made. This is the arithmetic average length of stay for DRGs for this interchange transmission. Mapped to ff record 21 field 22.
TS211	Situational, but required for Medicare when there have been discharges. Mapped to ff record 21, field 23.

TS212	Situational, but required for Medicare if there have been cost report days. append to ff record 21, field 24.
TS213	Situational, but required for Medicare if there have been covered days. Mapped to ff record 21, field 25.
TS214	Situational, but required for Medicare if there have been any noncovered days. Mapped to ff record 21, field 26.
TS215	Situational, but required for Medicare if MSP pass-through amounts applied. Mapped to ff record 21, field 27.
TS216	Situational, but required for Medicare if DRG payments made. Mapped to ff record 21, field 28.
TS217	Situational, but required for Medicare if any PPS Capital FSP DRG payment made. Mapped to ff record 21, field 29.
TS218	Situational, but required for Medicare if any PPS capital HSP DRG payment made. Mapped to ff record 21, field 30.
TS219	Situational, but required for Medicare if any PPS DSH DRG payment made. Mapped to ff record 21, field 31.
CLP	Required.
CLP01	Required. Mapped to ff record 30, field 13.
CLP02	Required. Mapped to ff record 30, field 14. (Codes 5-17, 25 and 27 do not apply to Medicare.)
CLP03	Required. Mapped to ff record 30, field 15.
CLP04	Required. Mapped to ff record 30, field 16.
CLP05	Situational, but does not apply to intermediaries.
CLP06	Required. Intermediaries must always enter “MA.” None of the other 835 codes apply to Medicare intermediaries. Mapped to ff record 30, field 17.
CLP07	Situational, but required for Medicare. Mapped to ff record 30, field 7.
CLP08	Situational, but required for Medicare. Mapped to ff record 30, field 18.
CLP09	Situational, but required for Medicare intermediaries. Mapped to ff record 30, field 19.
CLP10	Not used.
CLP11	Situational, but required for intermediaries if DRG payments made. Mapped to ff record 30, field 20.

CLP12	Situational, but required for Medicare if DRG payment made. Mapped to ff record 30, field 21.
CLP13	Situational, but required for Medicare if discharge fraction was a factor in payment to an institution. Mapped to ff record 30, field 22.
CAS (020)	Situational. May only be used if there are claim level adjustments. Adjustments reported at the service level may not be reported again, individually or in total, at the claim level. Unlike prior 835 versions, version 4010 does not require entry of an OA 93 message in a claim level CAS when there are no claim level adjustments. **Payers, including Medicare, are prohibited from use of any reason code that is not valid for use with version 4010 in the official reason code compendium maintained at** http://www.wpc-edi.com/**. This list is updated 3 times a year in the months following the X12 meetings – in March, July and November.** See the service level CAS segment for more information on Medicare use of the CAS.
CAS01	Required. Medicare contractors are limited to use of the CO, CR, OA, and PR group codes. PI may not be used for Medicare. Mapped to ff record 31, field 13. (If 2nd loop, mapped to ff record 31, field 32.)
CAS02	Required. Mapped to ff record 31, field 14. (If 2nd loop, mapped to field 33.)
CAS03	Required. Mapped to ff record 31, field 15. (If 2nd loop, mapped to field 34.)
CAS04	Situational. Mapped to ff record 31, field 16. (If 2nd loop, mapped to field 35.)
CAS05	Situational, but required for Medicare if a second claim level adjustment applies to this group code. Mapped to ff record 31, field 17. (If 2nd loop, mapped to field 36.)
CAS06	Situational, but required for Medicare if a second claim level adjustment applies to this group code. Mapped to ff record 31, field 18. (If 2nd loop, mapped to field 37.)
CAS07	Situational, but required for Medicare if a second claim level adjustment applies to this group code. Mapped to ff record 31, field 19. (If 2nd loop, mapped to field 38.)
CAS08	Situational, but required for Medicare if a third claim level adjustment applies to this group code. Mapped to ff record 31, field 20. (If 2nd loop mapped to field 39.)

CAS09 Situational, but required for Medicare if a third claim level adjustment applies to this group code. Mapped to ff record 31, field 21. (If 2nd loop, mapped to field 40.)

CAS10 Situational, but required for Medicare if a third claim level adjustment applies to this group code. Mapped to ff record 31, field 22. (If 2nd loop, mapped to field 41.)

CAS11 Situational, but required for Medicare if a fourth claim level adjustment applies to this group code. Mapped to ff record 31, field 23. (If 2nd loop, mapped to field 42.)

CAS12 Situational, but required for Medicare if a fourth claim level adjustment applies to this group code. Mapped to ff record 31, field 24. (If 2nd loop, mapped to field 43.)

CAS13 Situational, but required for Medicare if a fourth claim level adjustment applies to this group code. Mapped to ff record 31, field 25. (If 2nd loop, mapped to field 44.)

CAS14 Situational, but required for Medicare if a fifth claim level adjustment applies to this group code. Mapped to ff record 31, field 26. (If 2nd loop, mapped to field 45.)

CAS15 Situational, but required for Medicare if a fifth claim level adjustment applies to this group code. Mapped to ff record 31, field 27. (If 2nd loop, mapped to field 46.)

CAS16 Situational, but required for Medicare if a fifth claim level adjustment applies to this group code. Mapped to ff record 31, field 28. (If 2nd loop, mapped to field 47.)

CAS17 Situational, but required for Medicare if a sixth claim level adjustment applies to this group code. Mapped to ff record 31, field 29. (If 2nd loop, mapped to field 48.)

CAS18 Situational, but required for Medicare if a sixth claim level adjustment applies to this group code. Mapped to ff record 31, field 30. (If 2nd loop, mapped to field 49.)

CAS19 Situational, but required for Medicare if a sixth claim level adjustment applies to this group code. Mapped to ff record 31, field 31. (If 2nd loop, mapped to field 50.)

NM1 (030.A) Required to report patient-related information.

NM101 Required. Mapped to ff record 40, field 13.

NM102 Required. Mapped to ff record 40, field 14.

NM103 Required. Mapped to ff record 40, field 15.

NM104 Required. Mapped to ff record 40, field 16.

NM105 Situational, but required for Medicare when a middle name or initial is available for the patient. Mapped to ff record 40, field 17.

NM106 Not used.

NM107 Situational, but will not be used by Medicare.

NM108 Situational, but required for Medicare. Always enter "HN" for Medicare until notified that the HIPAA Individual Identifier is effective, at which point enter "II" in this data element. None of the other qualifiers apply to Medicare. Mapped to ff record 40, field 18.

NM109 Situational, but required for Medicare if reported on the incoming claim. Mapped to ff record 40, field 19.

NM110-111 Not used.

NM1 (030.B) Situational, but the loop is intended for information on an insured when different than the patient. This situation does not apply in Medicare.

NM1 (030.C) Situational, but required for Medicare when the HIC number has been corrected.

NM101 Required. For Medicare purposes, the insured is the patient. Mapped to ff record 40, field 20.

NM102 Required. Code 2 does not apply to Medicare. Mapped to ff record 40, field 21.

NM103 Situational, but not used by Medicare.

NM104 Situational, but not used by Medicare.

NM105 Situational, but not used by Medicare.

NM106 Not used.

NM107 Situational, but not used for Medicare.

NM108 Situational, but required for Medicare if the patient's ID # has been corrected. Mapped to ff record 40, field 22.

NM109 Situational, but required for Medicare if the patient's ID # as been corrected. Mapped to ff record 40, field 23.

NM110-111 Not used.

NM1 (030.D) Situational, but does not apply to Medicare intermediaries.

NM1 (030.E) Situational, but required for Medicare if claim data is being transferred to another payer under a coordination of benefits (COB) agreement with that payer.

NOTE: Although Medicare may send claim and payment information to multiple secondary payers, the 835 does not permit identification of more than one of those secondary payers. When COB transmissions are sent to more than one secondary payer for the same claim, report remark code N89 in a claim level remark code data element.

NM101 Required. Mapped to ff record 41, field 13.

NM102 Required. Mapped to ff record 41, field 14.

NM103 Required. Mapped to ff record 41, field 15.

NM104-107 Not used.

NM108 Required. Until the PlanID is effective, enter "PI" for Medicare if another or no ID number is available for the payer. When PlanID is effective, enter "XV." AD, FI, NI, and PP do not apply to Medicare. Mapped to ff record 41, field 16.

NM109 Required. Enter the PlanID when effective. Prior to that date, enter the other number if available with PI, or if no ID number is available, enter 00 with PI. Mapped to ff record 41, field 17.

NM110-111 Not used.

NM1 (030.F) Situational, but required for Medicare when a claim is denied or rejected due to the need for processing by a primary payer. That primary payer must be identified in the remittance advice. This segment notifies the provider whom to bill first. Do not use when NM1 segment 030.E applies.

NM101 Required. Mapped to ff record 41, field 18. (If 2nd loop, mapped to field 23.)

NM102 Required. Mapped to ff record 41, field 19. (If 2d loop, mapped to field 24.)

NM103 Required. Mapped to ff record 41, field 20. (If 2nd loop, mapped to field 25.)

NM104-107 Not used.

NM108 Required. Until the PlanID is effective, always enter "PI" for Medicare in this loop. When effective, always enter "XV" for Medicare. AD, FI, NI, and PP do not apply to Medicare. Mapped to ff record 41, field 21. (If 2nd loop, mapped to field 26.)

NM109	Required. Enter the PlanID when effective. Prior to that date, enter 00. Mapped to ff record 41, field 22. (If 2nd loop, mapped to field 27.)
NM110-111	Not used.
MIA	Situational, but required for Medicare when there has been inpatient care.
MIA01	Required. Always enter zero. Mapped to ff record 42, field 13.
MIA02	Situational, but required for Medicare if there has been an operating outlier payment. Mapped to ff record 42, field 14.
MIA03	Situational, but required for Medicare if lifetime psychiatric days used. Mapped to ff record 42, field 15.
MIA04	Situational, but required for Medicare if DRG payment made. Mapped to ff record 42, field 16.
MIA05	Situational, but required for Medicare if at least one claim level remark code applies. Mapped to ff record 42, field 17.
MIA06	Situational, but required for Medicare if a disproportionate share amount is paid. Mapped to ff record 42, field 18.
MIA07	Situational, but required for Medicare if an MSP pass-through amount paid. Mapped to ff record 42, field 19.
MIA08	Situational. But required for Medicare if PP capital amount paid. Mapped to ff record 42, field 20.
MIA09	Situational, but required for Medicare if PPS capital FSP DRG amount paid. Mapped to ff record 42, field 21.
MIA10	Situational, but required for Medicare if PPS capital HSP DRG amount paid. Mapped to ff record 42, field 22.
MIA11	Situational, but required for Medicare if PPS capital DSH DRG amount paid. Mapped to ff record 42, field 23.
MIA12	Situational, but required for Medicare if old capital amount paid. Mapped to ff record 42, field 24.
MIA13	Situational, but required for Medicare if PPS capital IME amount paid. Mapped to ff record 42, field 25.
MIA14	Situational, but required for Medicare if PPS operating HSP DRG amount paid. Mapped to ff record 42, field 26.
MIA15	Situational, but required for Medicare if cost report days apply. Mapped to ff record 42, field 27.

MIA16	Situational, but required for Medicare if PPS operating FSP DRG amount paid. Mapped to ff record 42, field 28.
MIA17	Situational, but required for Medicare if PPS outlier amount paid. Mapped to ff record 42, field 29.
MIA18	Situational, but required for Medicare if indirect teaching amount paid. Mapped to ff record 42, field 30.
MIA19	Situational, but required for Medicare if professional component amount billed but not payable by this provider. Mapped to ff record 42, field 31.
MIA20	Situational but required for Medicare if a second claim level remark code applies. Mapped to ff record 42, field 32.
MIA21	Situational but required for Medicare if a third claim level remark code applies. Mapped to ff record 42, field 33.
MIA22	Situational but required for Medicare if a fourth claim level remark code applies. Mapped to ff record 42, field 34.
MIA23	Situational but required for Medicare if a fifth claim level remark code applies. Mapped to ff record 42, field 35.
MIA24	Situational but required for Medicare if a PPS capital exception amount paid. Mapped to ff record 42, field 36.
MOA	Situational, but required for Medicare intermediaries if there has been other than inpatient care and at least one claim level remark code applies for that noninpatient care.
MOA01	Situational, but required for Medicare if reimbursement rate reporting applies. Mapped to ff record 43, field 13.
MOA02	Situational, but required for Medicare if any line items paid on a fee schedule basis. Mapped to ff record 43, field 14.
MOA03	Situational, but required for Medicare if at least one claim level remark code applies. Mapped to ff record 43, field 15.
MOA04	Situational, but required for Medicare if a second claim level remark code applies. Mapped to ff record 43, field 16.
MOA05	Situational, but required for Medicare if a third claim level remark code applies. Mapped to ff record 43, field 17.
MOA06	Situational, but required for Medicare if a fourth claim level remark code applies. Mapped to ff record 43, field 18.
MOA07	Situational, but required for Medicare if a fifth claim level remark code applies. Mapped to ff record 43, field 19.

MOA08 Situational, but required for Medicare if ESRD payment made. Mapped to ff record 43, field 20.

MOA09 Situational, but required for Medicare if professional component amount billed but not payable to this provider. Mapped to ff record 43, field 21.

REF (040.A) Situational, but required for Medicare if provider submitted a proprietary identification number on the claim.

REF01 Required. Only "EA" applies to Medicare. Mapped to ff record 44, field 13.

REF02 Required. Mapped to ff record 44, field 14.

REF03-04 Not used.

REF (040.B) Situational, but does not apply to Medicare intermediaries.

DTM (050) Situational, but multiple loops required for Medicare.

DTM01 Required. "050" mapped to ff record 44, field 15. "232" mapped to ff record 44, field 17. "233" mapped to ff record 44, field 19.

DTM02 Required. Mapped to ff record 44, field 16 for 050. Mapped to ff record 44, field 18 for 232. Mapped to ff record 44, field 20 for 233.

DTM03-06 Not used.

PER (060) Situational, but not used by Medicare.

AMT (062) Situational, but required for Medicare if any of the qualifiers in AMT01 apply to the claim.

AMT01 Required. Use multiple loops if more than 1 qualifier applies. DY mapped to ff record 44, field 21; NL mapped to ff record 44, field 23; ZK for hemophilia add on to ff record 44, field 25; F5 to ff record 44, field 27; I to ff record 44, field 29; ZZ for inpatient outlier payment to ff record 44, field 31; AU to ff record 44, field 33. The other qualifiers do not apply to Medicare at this time.

NOTE: Pre-4010, NJ was reported in the AMT segment to report the gross amount of payment made by the primary payer on the claim. NJ is not approved for use in 4010. In 4010, primary payment reporting will be limited to the use of claim adjustment reason code 23 to convey the amount of the primary payment that impacted the Medicare payment calculation. This may be less than the gross payment made by the primary payer. Since Medicare would be primary in this instance, the provider would already have been notified of the gross amount of the primary's payment by that payer. This is not considered an essential data element for a secondary payer's remittance advice.

AMT02 Required. Inpatient or partial hospitalization per diem amount (DY) mapped to ff record 44, field 22. NL mapped to ff record 44, field 24. Hemophilia add on (ZK) mapped to ff record 44, field 26. F5 mapped to ff record 44, field 28. I mapped to ff record 44, field 30. Any inpatient outlier payment (ZZ) mapped to ff record 44, field 32. AU mapped to ff record 44, field 34. The other qualifiers do not apply to Medicare at this time.

AMT03 Not used.

QTY (064) Situational, but required for Medicare if any of the QTY01 qualifiers apply. Use multiple loops if more than 1 qualifier applies.

QTY01 Required. CA mapped to ff record 44, field 35; NA mapped to ff record 44, field 37; LA to ff record 44, field 39; CD to ff record 44, field 41; ZK mapped to ff record 44, field 43; and OU mapped to ff record 44, field 45.

QTY02 Required. CA mapped to ff record 44, field 36. NA mapped to ff record 44, field 38. LA mapped to ff record 44, field 40. CD mapped to ff record 44, field 42. ZK is mapped to ff record 44, field 44. OU is mapped to ff record 44, field 46. The other qualifiers in the implementation guide do not apply to Medicare at this time.

NOTE 1: VS, visits, had been reported at the service level for covered and noncovered HHA visits prior to version 4010. With HH PPS, it will only be necessary to report HHA visits if there are 4 or fewer visits during an episode. In version 4010, the number of visits, when 4 or less, will be reported as the line adjustment quantity (SVC level CAS04, 07, 10, 13, 16, or 19) for the final HHA bill for the episode. The HHA will still be paid on a per visit basis in that situation.

NOTE 2: Pre-4010, FL was used to report the approved units for hemophilia add on. FL is not available for use in the 4010 implementation guide. Use ZK to report the hemophilia covered units in version 4010. SVC Situational, but required for Medicare when service level detail included on the incoming claim. A separate loop is required for each procedure.

SVC

SVC01-1 Required. Only HC, NU, N4 and ZZ apply to Medicare intermediaries. HC mapped to ff record 50, field 13; NU mapped to ff record 50, field 13; ZZ mapped to ff record 50, field 13; N4 mapped to ff record 50, field 15. HC and ZZ would not apply to the same line, but NU and HC or NU and ZZ could apply to the same line. When more than one applies to the same line, enter the HC or ZZ in SVC01-1 and the NU in SVC04. ZZ will be used to report HIPPS codes if used in SNF or HHA billing. (Contrary to

the implementation guide note which only mentions SNF billing.) N4 will not be used until Medicare begins usage of NDC codes for drugs.

SVC01-2 Required. HC mapped to ff record 50, field 14. NU mapped to ff record 50, field 14. ZZ mapped to ff record 50, field 14. N4 mapped to ff record 50, field 16.

NOTE: When a service is being denied due to submission of an invalid HCPCS, HIPPS, NDC or revenue code, the invalid submitted code must be entered in this data element. This is a necessary exception to the HIPAA requirement for use of valid medical codes.

SVC01-3 Situational, but required for Medicare if HC applies and at least one modifier was reported on the claim for the service. Modifiers do not apply to and may not be reported for other procedure code types. Mapped to ff record 50, field 17.

SVC01-4 Situational, but required for Medicare if HC applies and a second modifier was reported on the claim for the service. Mapped to ff record 50, field 18.

SVC01-5 Situational, but required for Medicare if HC applies and a third modifier was reported on the claim for the service. Mapped to ff record 50, field 19.

SVC01-6 Situational, but required for Medicare if HC applies and a fourth modifier was reported on the claim for the service. Mapped to ff record 50, field 20.

SVC01-7 Situational, but Medicare will not report text language in a remittance advice.

SVC02 Required. Mapped to ff record 50, field 21.

SVC03 Required. Mapped to ff record 50, field 22.

SVC04 Situational, but required for Medicare if both a HCPCS or NDC, and a revenue code, were reported on the claim for the same service. Mapped to ff record 50, field 23.

SVC05 Situational, but required for Medicare. Mapped to ff record 50, field 24.

SVC06-1 Situational, but required if the procedure or drug code has been changed during adjudication. Mapped to ff record 50, field 25 if HC, if N4 is field 27.

SVC06-2 Required. HC mapped to ff record 50, field 26. N4 mapped to ff record 50, field 28. Medicare would not change a NU (revenue code) or ZZ (HIPPS code) during adjudication.

SVC06-3	Situational, but required for Medicare if the first modifier was changed during adjudication. Mapped to ff record 50, field 29.
SVC06-4	Situational, but required for Medicare if the second modifier was changed during adjudication. Mapped to ff record 50, field 30.
SVC06-5	Situational, but required for Medicare if the third modifier was changed during adjudication. Mapped to ff record 50, field 31.
SVC06-6	Situational, but required for Medicare if the fourth modifier was changed during adjudication. Mapped to ff record 50, field 32.
SVC06-7	Situational, but text will not be reported by Medicare.
SVC07	Situational, but required for Medicare if the paid units of service is different than the billed units of service. Mapped to ff record 50, field 33.
DTM (080)	Situational, but required for Medicare when service level data is reported on the claim.
DTM01	Required. Only 472 applies to intermediaries. 472 mapped to ff record 50, field 34.
DTM02	Required. Mapped to ff record 50, field 35.
DTM03-06	Not used.
CAS (090)	Situational, but required for Medicare whenever the amount paid for a service does not equal the amount billed. Medicare intermediaries are required to separately report every adjustment made to a service. It is necessary to use separate loops if more than 1 group code applies, or if there are more than 6 adjustment codes per group.
CAS01	Required. PI does not apply to Medicare. Mapped to ff record 51, field 13.
CAS02	Required. Mapped to ff record 51, field 14.
CAS03	Required. Mapped to ff record 51, field 15.
CAS04	Situational, but required for Medicare. Mapped to ff record 51, field 16.
CAS05	Situational, but required for Medicare if there is a second service level adjustment. Mapped to ff record 51, field 17.
CAS06	Situational, but required for Medicare if there is a second service level adjustment. Mapped to ff record 51, field 18.
CAS07	Situational, but required for Medicare if there is a second service level adjustment. Mapped to ff record 51, field 19.

CAS08	Situational, but required for Medicare if there is a third service level adjustment. Mapped to ff record 51, field 20.
CAS09	Situational, but required for Medicare if there is a third service level adjustment. Mapped to ff record 51, field 21.
CAS10	Situational, but required for Medicare if there is a third service level adjustment. Mapped to ff record 51, field 22.
CAS11	Situational, but required for Medicare if there is a fourth service level adjustment. Mapped to ff record 51, field 23.
CAS12	Situational, but required for Medicare if there is a fourth service level adjustment. Mapped to ff record 51, field 24.
CAS13	Situational, but required for Medicare if there is a fourth service level adjustment. Mapped to ff record 51, field 25.
CAS14	Situational, but required for Medicare if there is a fifth service level adjustment. Mapped to ff record 51, field 26.
CAS15	Situational, but required for Medicare if there is a fifth service level adjustment. Mapped to ff record 51, field 27.
CAS16	Situational, but required for Medicare if there is a fifth service level adjustment. Mapped to ff record 51, field 28.
CAS17	Situational, but required for Medicare if there is a sixth service level adjustment. Mapped to ff record 51, field 29.
CAS18	Situational, but required for Medicare if there is a sixth service level adjustment. Mapped to ff record 51, field 30.
CAS19	Situational, but required for Medicare if there is a sixth service level adjustment. Mapped to ff record 51, field 31.
REF (100.A)	Situational, but required for Medicare if any of the qualifiers apply. Multiple loops required if more than 1 qualifier applies.
REF01	Required. 1S mapped to ff record 50, field 36; RB mapped to ff record 50, field 36. 1S and RB would not apply to the same line simultaneously. 6R does not apply to Medicare intermediaries, as indicated in the implementation guide note for the standard, this situational segment "is used to provide additional information used in the process of adjudicating this service." Since intermediary claims are not subject to splitting, provider control number is not used for Medicare adjudication and is not needed by providers to re-associate lines for split claims. None of the other qualifiers currently apply to intermediaries.

REF02 Required. 1S mapped to ff record 50, field 37. RB mapped to ff record 50, field 38 when a rate code factored in the payment. The APC number will only be reported with the first HCPCS, and not for subsequent HCPCS, in that APC.

REF03-04 Not used.

REF (100.B) Situational, but does not apply to Medicare intermediaries.

AMT (110) Situational, but required for Medicare intermediaries if any of the qualifiers apply. Multiple loops must be used if more than 1 qualifier applies.

AMT01 Required. Only DY and B6 currently apply to Medicare intermediaries. DY mapped to ff record 50, field 39. B6 mapped to ff record 50, field 41.

AMT02 Required. DY mapped to ff record 50, field 40. B6 mapped to ff record 50, field 42.

AMT03 Not used.

QTY Situational, but does not apply to Medicare intermediaries in version 4010. Used to report covered and noncovered HHA visits in prior versions. Most HHA care will now be paid under HH PPS. In those cases where individual HHA visit payments are made, the number of covered visits will be reported in SVC05, the quantity data element for the HHA visits HCPCS ad with the VS qualifier in a claim level QTY segment. The number of noncovered visits will be shown as a quantity adjustment in the CAS segment for the HHA visits HCPCS.

LQ Situational, but required for Medicare whenever any service level remark codes apply. Multiple loops must be used if more than 1 service level remark code applies. The flat file can record up to 19 remark codes per service.

LQ01 Required. Only "HE" applies to Medicare intermediaries. 1st HE mapped to ff record 50, field 43; 2nd to field 45; 3rd to field 47; 4th to field 49; 5th to field 51; 6th to field 53; 7th to field 55; 8th to field 57; and 9th to field 59.

LQ02 Required. 1st mapped to ff record 50, fields 44, and succeeding to fields 46, 48, 50, 52, 54, 56, 58, and 60 respectively.

Table 3, Summary Data

PLB Situational, but required for Medicare whenever there have been any provider-level adjustments.

PLB01 Required. Mapped to ff record 60, field 3.

PLB02 Required. Mapped to ff record 60, field 4.

PLB03-1 Required. The X12N provider adjustment reason code must be reported in 03-1, and the Medicare provider adjustment identifier code in 03-2. The first X12N provider adjustment reason code is mapped to ff record 60, field 13.

NOTE: Outpatient PPS instructions had directed intermediaries to identify Transitional Outpatient Payments (TOPs) with BN in this data element, but some providers associate BN with managed care only and not with fee for service payments. For Medicare's use of version 4010, report TOPs with IS, interim settlement, in PLB03-1 and IR in the first 2 positions of PLB03-2.

PLB03-2 Situational, but required for Medicare. Positions 1-2=the first Medicare provider adjustment code (mapped to ff record 60, field 14). Contrary to the misphrased note in the implementation guide, intermediaries should not report any additional data in positions 3-30 of this data element. Nor may intermediaries report anything other than the Medicare provider adjustment code in positions 1-2 of this data element.

PLB04 Required. Mapped to ff record 60, field 15.

PLB05-1 Situational, but required if there is a second provider level adjustment. Mapped to ff record 60, field 16.

PLB05-2 Situational, but required for Medicare if there is a second provider level adjustment. Mapped to ff record 60, field 17.

PLB06 Situational, but required for Medicare if there is a second provider level adjustment. Mapped to ff record 60, field 18.

PLB07-1 Situational, but required if there is a third provider level adjustment. Mapped to ff record 60, field 19.

PLB07-2 Situational, but required for Medicare if there is a third provider level adjustment. Mapped to ff record 60, field 20.

PLB08 Situational, but required for Medicare if there is a third provider level adjustment. Mapped to ff record 60, field 21.

PLB09-1 Situational, but required if there is a fourth provider level adjustment. Mapped to ff record 60, field 22.

PLB09-2 Situational, but required for Medicare if there is a fourth provider level adjustment. Mapped to ff record 60, field 23.

PLB10 Situational, but required for Medicare if there is a fourth provider level adjustment. Mapped to ff record 60, field 24.

PLB11-1	Situational, but required for Medicare if there is a fifth provider level adjustment. Mapped to ff record 60, field 25.
PLB11-2	Situational, but required for Medicare if there is a fifth provider level adjustment. Mapped to ff record 60, field 26.
PLB12	Situational, but required for Medicare if there is a fifth provider level adjustment. Mapped to ff record 60, field 27.
PLB13-1	Situational, but required for Medicare if there is a sixth provider level adjustment. Mapped to ff record 60, field 28.
PLB13-2	Situational, but required for Medicare if there is a sixth provider level adjustment. Mapped to ff record 60, field 29.
PLB14	Situational, but required for Medicare if there is a sixth provider level adjustment. Mapped to ff record 60, field 30.
GE	Required.
GE01	Required. TG
GE02	Required. Must equal GS06. TG
SE	Required.
SE01	Required. The transaction segment count is computed by the carrier system. TG
SE02	Required. Must equal ST02. TG

40.5.2 - Medicare 835 HIPAA Companion Document - Carriers

(Rev.)

AB-02-067, AB-01-149, AB-01-159, AB-01-79, B-01-10, AB-01-132

This companion document supplements, but does not contradict any requirements in the 835 version 4010 implementation guide.

Table 1 - Header Data

Segment/ Data Elements	835 and Medicare Requirements/Notes
ST	Required.
ST01	Required. Always enter “835.”
ST02	Required.

BPR	Required.
BPR01	Required. Codes U and X do not apply to Medicare.
BPR02	Required.
BPR03	Required. Code D does not apply to Medicare.
BPR04	Required. Codes BOP and FWT do not apply to Medicare.
BPR05	Situational, but required for Medicare if ACH is entered in BPR04.
BPR06	Situational, but required for Medicare if ACH in BPR04. Code 04 does not apply to Medicare.
BPR07	Situational, but required for Medicare if ACH in BPR04.
BPR08	Situational, but required for Medicare if ACH in BPR04.
BPR09	Situational, but required for Medicare if ACH in BPR04.
BPR10	Situational, but required for Medicare if ACH in BPR04.
BPR11	Situational, but does not apply to Medicare and should not be reported.
BPR12	Situational, but required for Medicare if ACH in BPR04. Code 04 does not apply to Medicare.
BPR13	Situational, but required for Medicare if ACH in BPR04.
BPR14	Situational, but required for Medicare if ACH in BPR04.
BPR15	Situational, but required if ACH in BPR04.
BPR16	Required.
BPR17-21	Not used.
TRN01	Required.
TRN02	Required.
TRN03	Required.
TRN04	Situational, but does not apply to Medicare.
CUR	Situational, but does not apply to Medicare.
REF (060.A)	Situational, but required for Medicare if the 835 is being sent to any entity other than the provider.
REF01	Required.

REF02	Required.
REF03-04	Not used.
REF (060.B)	Situational, but required for Medicare to identify a local version number for the implementation. Sometimes a local version number is needed to identify a post-implementation modification in programming, such as to correct a programming error. The local version number could be needed to answer a provider inquiry related to the programming modification.
REF01	Required.
REF02	Required. The version number is assigned locally.
REF03-04	Not used.
DTM (070)	Situational, but required for Medicare if the date of the 835 is different than the cutoff date for the adjudication action that generated the 835.
DTM01	Required.
DTM02	Required.
DTM03-06	Not used.
N1 (080.A)	Required for payer identification.
N101	Required.
N102	Situational, but required for Medicare.
N103	Situational. Always enter "XV" in this loop when the PlanID is effective, but not used prior to that date.
N104	Situational, but required once the PlanID is effective.
N105-106	Not used.
N3 (100)	Required for payer identification.
N301	Required.
N302	Situational, but required by Medicare if there is more than 1 address line for the payer, such as for a suite number.
N4 (110)	Required for payer identification.
N401	Required.
N402	Required.
N403	Required.

N404-406	Not used.
REF (120.A)	Situational. Required for Medicare prior to the effective date of the Plan ID. After that date, a Medicare payer may use at its option in addition to the Plan ID in the 060 REF.
REF01	Required. Only 2U applies to Medicare.
REF02	Required.
REF03-04	Not used.
PER (130)	Situational. Recommended for use for Medicare, but reporting of contact information in an 835 is at the option of individual Medicare contractors.
PER01	Required.
PER02	Situational. Optional for Medicare but recommended if this segment is used.
PER03	Situational, but required for Medicare if this segment is used.
PER04	Situational, but required for Medicare if there is an entry in PER03.
PER05	Situational. May be used at the option of a Medicare contractor to report a second contact.
PER06	Situational, but required if there is an entry in PER05.
PER07	Situational, but required for Medicare if segment is used and it is necessary to report a telephone extension number.
PER08-09	Not used.
N1 (080.B)	Required to identify the payee.
N101	Required.
N102	Situational, but required for Medicare prior to the effective date of the NPI.
N103	Required. Always enter “FI” until the NPI is effective. After that date, always enter “XX.”
N104	Required.
N105-106	Not used.
N3 (080)	Situational, but required for Medicare.
N301	Required.

N302	Situational, but required if there is a second payee address line.
N4 (100.B)	Situational, but required for Medicare.
N401	Required.
N402	Required
N403	Required.
N404	Situational. Only required if the address is other than the U. S.
N405	Not used.
N406	Not used.
REF (120.B)	Situational, but required for Medicare.
REF01	Required. Always enter "TJ" in this loop when the NPI is effective. Prior to that date, use 1C (Medicare provider number) or 1G (UPIN) for Medicare. 0B, 1A, 1B,1D, 1E, 1F, 1H, D3, G2, N5 and PQ do not apply to Medicare.
REF02	Required.
REF03-04	Not used.

Table 2 - Detail Data

LX	Situational, but required for Medicare.
LX01	Required.
TS3	Situational. Not used by Medicare carriers, only by intermediaries.
TS2	Situational. Not used by Medicare carriers, only by intermediaries.
CLP	Required.
CLP01	Required.
CLP02	Required. Codes 25 and 27 do not apply to Medicare and are not in the flat file.
CLP03	Required.
CLP04	Required.
CLP05	Situational, but required for Medicare if there is any patient financial responsibility for amounts not paid by Medicare.

CLP06	Required. Carriers always enter “MB.” None of the other 835 codes apply to Medicare.
CLP07	Situational, but required for Medicare.
CLP08	Situational, but required for Medicare.
CLP09	Situational, but does not apply to Medicare carriers.
CLP10	Not used.
CLP11	Situational, but does not apply to carriers.
CLP12	Situational, but does not apply to carriers.
CLP13	Situational, but does not apply to carriers.
CAS (claim)	Situational, but does not apply to carriers. Adjustments for Medicare carriers should always be reported at the line level Unlike prior 835 versions, version 4010 does not require entry of an OA 93 message in a claim level CAS when there are no claim level adjustments.
NM1 (030.A)	Required to report patient-related information.
NM101	Required.
NM102	Required.
NM103	Required.
NM104	Required.
NM105	Situational, but required for Medicare when a middle name or initial is available for the patient.
NM106	Not used.
NM107	Situational, but will not be used for Medicare.
NM108	Situational, but required for Medicare. Always enter “HN” for Medicare, until notified that the HIPAA Individual Identifier is effective, at which point enter “II” in this data element. None of the other qualifiers apply to Medicare.
NM109	Situational, but required for Medicare if reported on the incoming claim.
NM110-111	Not used.
NM1 (030.B)	Situational, but the loop is intended for information on an insured when different than the patient. This situation does not apply in Medicare. Not used.

NM1 (030.C)	Situational, but is required for Medicare when the patient's name, as received on the claim, has been corrected.
NM101	Required. For Medicare purposes, the insured is the patient.
NM102	Required. Code 2 does not apply to Medicare.
NM103	Situational, but required for Medicare if the last name has been corrected.
NM104	Situational, but required for Medicare if the first name has been corrected.
NM105	Situational, and optional for Medicare carrier to report a corrected middle name or initial.
NM106	Not used.
NM107	Situational, but not used for Medicare.
NM108	Situational, but required for Medicare if the ID # has been corrected.
NM109	Situational, but required for Medicare if the ID # has been corrected.
NM110-111	Not used.
NM1 (030.D)	Situational, but required by the IG if the rendering provider is other than the payee. Rendering provider could vary by service. If the rendering provider for a service is different than reported at the claim level, the other rendering provider(s) must be identified at the service level. It is not necessary to repeat information for a rendering provider at the service level when the same as reported at the claim level. If there is more than one rendering provider other than the payee, enter either the identity of the provider who performed more of the services at the claim level, or if that would create programming difficulties, the identity of the first of the listed rendering providers.
NM101	Required.
NM102	Required. Code 2 does not apply to Medicare.
NM103	Situational, but do not report for Medicare. (Medicare reports only the number, not the name of the rendering provider.)
NM104	Situational, but do not report for Medicare. (Medicare reports only the number, not the name of the rendering provider.)
NM105	Situational, but do not report for Medicare. (Medicare reports only the number, not the name of the rendering provider.)
NM106	Not used.

NM107 Situational, but do not report for Medicare. (Medicare reports only the number, not the name of the rendering provider.)

NM108 Required. Until the NPI is effective, always enter "UP" for Medicare when there is a UPIN. If no UPIN, enter FI. When the NPI is effective, always enter "XX." BD, BS, MC, PC, and SL do not apply to Medicare.

NM109 Required.

NM110-111 Not used.

NM1 (030.E) Situational, but required for Medicare if claim data is being transferred to another payer under a coordination of benefits (COB) agreement with that payer. Note: Although Medicare may send claim and payment information to multiple secondary payers, the 835 does not permit identification of more than one of those secondary payers. When COB transmissions are sent to more than one secondary payer for the same claim, enter remark code N89 (see attachment 2) in a MOA segment remark code data element.

NM101 Required.

NM102 Required.

NM103 Required.

NM104-107 Not used.

NM108 Required. Until the PlanID is effective, always enter "PI" for Medicare; when effective, enter "XV." AD, FI, NI, and PP do not apply to Medicare.

NM109 Required.

NM110-111 Not used.

NM1 (030.F) Situational. Required for Medicare when a claim is denied or rejected due to the need for processing by a primary payer. That primary payer should be identified in the remittance advice.

NM101 Required.

NM102 Required.

NM103 Required.

NM104-107 Not used.

NM108 Required. Until the PlanID is effective, always enter "PI" for Medicare in this loop. When effective, always enter "XV" for Medicare. AD, FI, NI, and PP do not apply to Medicare.

NM109	Required. Enter the PlanID when effective. Prior to that date, zero-fill.
NM110-111	Not used.
MIA	Situational, but does not apply to Medicare carriers.
MOA	Situational, but required for Medicare whenever any claim level remark code applies, such as an appeal rights remark code or when there is more than one COB payer.
MOA01	Situational, but does not apply to Medicare carriers.
MOA02	Situational, but does not apply to Medicare carriers.
MOA03	Situational, but required for Medicare whenever at least one claim level remark code applies, such as for an appeal remark code.
MOA04	Situational, but required for Medicare if more than one claim level remark code applies.
MOA05	Situational, but required for Medicare if a third claim level remark code applies.
MOA06	Situational, but required for Medicare if a fourth claim level remark code applies.
MOA07	Situational, but required for Medicare if a fifth claim level remark code applies.
MOA08	Situational, but does not apply to Medicare carriers.
MOA09	Situational, but does not apply to Medicare carriers.
REF (040.A)	Situational, but does not apply to Medicare carriers.
REF (040.B)	Situational, but does not apply to Medicare. Carriers identify rendering providers, if different than billing providers, at the service level.
DTM (050)	Situational, but required for Medicare.
DTM01	Required. Always enter “050" for Medicare. This data element would only be used to report the date of receipt of the claim. Medicare carriers must report the start and end dates of care at the service level, and expiration of coverage information (036) does not apply to Medicare.
DTM02	Required.
DTM03-06	Not used.

PER	Situational, Medicare contractors may report contact information at their option, either in table 1, or table 2, but it should not be necessary to report contact information in both tables.
PER01	Required.
PER02	Situational, and optional for use by a Medicare carrier. If furnished, contact data must be supplied by the carrier rather than the standard system.
PER03	Situational, but required for Medicare if the segment is used. Contact data must be furnished by the carrier.
PER04	Situational, but required for Medicare if this segment is used. Carrier must furnish the data.
PER05	Situational, and optional for use by a Medicare carrier if the carrier would like to report additional contact information. If used, the data must be furnished by the carrier.
PER06	Situational, but required for Medicare if an entry in PER05. Data must be furnished by the carrier.
PER07	Situational, and optional for a carrier to use to report the extension number of any phone number reported in PER04 or 06. Data must be furnished by the carrier.
PER08	Situational, and optional for a carrier to use to report the extension number of any phone number reported in PER04 or 06. Data must be furnished by the carrier.
PER09	Not used.
AMT (062)	Situational, but required for Medicare if the claim reported the patient made any payment for the claim.
AMT01	Required. Only F5 and I apply to Medicare carriers. No other codes for this data element apply to Medicare.
AMT02	Required.
AMT03	Not used.
QTY	Situational, but does not apply to Medicare carriers.
SVC	Situational, but required for Medicare carriers. Note: The HCPCS, modifiers, and when applicable, NDC code reported on a claim for a service must be reported on the 835 for that service, including in situations where a service is being adjusted for submission of an invalid procedure code or modifier. This situation is considered an exception to the HIPAA

	requirement that standard transactions be limited to reporting of valid medical codes.
SVC01-1	Required. Only codes HC and N4 apply to Medicare carriers. A separate loop need for each service reported.
SVC01-2	Required.
SVC01-3	Situational, but required for Medicare if HC applies and at least one modifier was reported on the claim for the service.
SVC01-4	Situational, but required for Medicare if HC applies and a second modifier was reported on the claim for the service.
SVC01-5	Situational, but required for Medicare if HC applies and a third modifier was reported on the claim for the service.
SVC01-6	Situational, but required for Medicare if HC applies and a fourth modifier was reported on the claim for the service.
SVC01-7	Situational, but text language may not be reported for Medicare on a remittance advice.
SVC02	Required.
SVC03	Required.
SVC04	Situational, but does not apply to carriers.
SVC05	Situational, but required for carriers.
SVC06-1	Situational, but required if the procedure or drug code has been changed during adjudication. Only HC and N4 apply to Medicare carriers.
SVC06-2	Situational, but required if the procedure or drug code has been changed during adjudication.
SVC06-3--7	Situational, but required for Medicare if modifiers are changed.
SVC07	Situational, but required for Medicare if the paid units of service is different than the billed units of service.
DTM (080)	Situational, but required for Medicare.
DTM01	Required.
DTM02	Required.
DTM03-06	Not used.

CAS (svc)	Situational, but required for Medicare whenever the amount paid for a service does not equal the amount billed. Medicare carriers are required to separately report every adjustment made to a service.
CAS01	Required. PI does not apply to Medicare. Necessary to use separate loops if more than 1 group code applies, or if there are more than 6 procedure codes per group.
CAS02	Required.
CAS03	Required.
CAS04	Situational, but not used for Medicare.
CAS05	Situational, but required for Medicare if there is a second service level adjustment.
CAS06	Situational, but required for Medicare if there is a second service level adjustment.
CAS07	Situational, but not used for Medicare.
CAS08	Situational, but required for Medicare if there is a third service level adjustment.
CAS09	Situational, but required for Medicare if there is a third service level adjustment.
CAS10	Situational, but not used for Medicare.
CAS11	Situational, but required for Medicare if there is a fourth service level adjustment.
CAS12	Situational, but required for Medicare if there is a fourth service level adjustment.
CAS13	Situational, but not used for Medicare.
CAS14	Situational, but required for Medicare if there is a fifth service level adjustment.
CAS15	Situational, but required for Medicare if there is a fifth service level adjustment.
CAS16	Situational, but not used for Medicare.
CAS17	Situational, but required for Medicare if there is a sixth service level adjustment.
CAS18	Situational, but required for Medicare if there is a sixth service level adjustment.

CAS19	Situational, but not used for Medicare.
REF (100.A)	Situational, but required for Medicare.
REF01	Required. Only LU and 6R apply to Medicare. Two loops must be used if both LU and 6R apply.
REF02	Required. Note: The provider line item control number (6R) is not used by and will not be retained by the Medicare core system. As with a 20-digit patient account number, use the COB data repository to populate REF02 for 6R. Do not report 6R in REF01 of a reissued ERA if there is no line item control number in the repository.
REF03-04	Not used.
REF (100.B)	Situational, but required for Medicare if the rendering provider for the service is other than the payee and other than the rendering provider reported at the claim level.
REF01	Required. Prior to the NPI effective date, always enter "1C" (the flat file does not differentiate between a UPIN and any other Medicare provider number) in this loop. After the NPI is effective, enter "HPI." The other codes do not apply to Medicare.
REF02	Required.
REF03-04	Not used.
AMT (110)	Situational, but required for Medicare carriers if any of the qualifiers apply.
AMT01	Required. Only KH and B6 apply to Medicare. Two loops must be used for Medicare if both apply.
AMT02	Required.
AMT03	Not used.
QTY	Situational, but does not currently apply to Medicare carriers.
LQ	Situational, but required for Medicare whenever any service level remark codes apply.
LQ01	Required. Always enter "HE" for Medicare.
LQ02	Required.

Table 3 - Summary

PLB	Situational, but required for Medicare whenever there have been any provider-level adjustments.
PLB01	Required.
PLB02	Required. Carriers must furnish this from their provider file, or use a default value of 12/31 of the current year.
PLB03-1	Required. Only codes CS, AP, FB, LE, L6, 50, SL, WO, B2, J1, and IR apply to Medicare carriers.
PLB03-2	Situational, but required for Medicare. *Positions 1-2=RI, RB, OB, or if none of these apply, 00. Positions 3-19=the Financial Control Number or ICN, if applicable to the type of adjustment. Positions 20-30=the HIC number may be entered at the carrier's option.* NOTE: The note in the implementation guide is misphrased. Medicare carriers and DMERCs report this information in these positions when the PLB segment is included in the 835.
PLB04	Required.
PLB05-1	Situational data element, but required if there is a second provider level adjustment.
PLB05-2	Situational, but required if there is a second provider level adjustment.
PLB06	Situational, but required if there is a second provider level adjustment.
PLB07-1	Situational, but required if there is a third provider level adjustment.
PLB07-2	Situational, but required if there is a third provider level adjustment.
PLB08	Situational, but required if there is a third provider level adjustment.
PLB09-1	Situational, but required if there is a fourth provider level adjustment.
PLB09-2	Situational, but required if there is a fourth provider level adjustment.
PLB10	Situational, but required if there is a fourth provider level adjustment.
PLB11-1	Situational, but required if there is a fifth provider level adjustment.
PLB11-2	Situational, but required if there is a fifth provider level adjustment.
PLB12	Situational, but required if there is a fifth provider level adjustment.
PLB13-1	Situational, but required if there is a sixth provider level adjustment. Two loops must be used for Medicare if both apply.

PLB13-2	Situational, but required if there is a sixth provider level adjustment.
PLB14	Situational, but required if there is a sixth provider level adjustment.
SE	Required.
SE01	Required. The transaction segment count is computed by the carrier system.
SE02	Required.

50 - Standard Paper Remittance Advice Notices

A3-3754, Exhibit 1 and 2, MCM 3024.5, PM B-01-76, A-01-057, A-01-93

(Rev.)

The Standard Paper Remittance (SPR) is the hard copy version of an ERA. All carriers, intermediaries, and DMERCs must be capable of producing SPRs for providers who are unable or choose not to receive an ERA.

This instruction contains completion requirements, layout formats/templates, and information on the SPR as well as a crosswalk of the SPR data fields to the 835 version 4010 data fields.

50.1 - The Do Not Forward (DNF) Initiative

B-02-023, A-02-012, R1763B3

(Rev.)

As part of the Medicare DNF Initiative, Carriers, DMERCs and users of the Arkansas Part A Standard System (APASS) must use "return service requested" envelopes for mailing all hardcopy remittance advices. When the post office returns a remittance advice due to an incorrect address, follow the same procedures you follow for returned checks; that is:

- Flag the provider "DNF";
- Carrier staff must notify the provider enrollment area, and DMERCs must notify the National Supplier Clearing House (NSC);
- Cease generating any further payments or remittance advice to that provider or supplier until they furnish a new address that is verified; and
- When the provider returns a new address, remove the DNF flag after the address has been verified, and pay the provider any funds you are still holding due to a DNF flag. You must also reissue any remittance advice you have been holding as well.

NOTE: Previously, CMS only required corrections to the "pay to" address. However, with the implementation of this new initiative, CMS requires corrections to all addresses before the contractor can remove the DNF flag and begin paying the provider or supplier again. Therefore, do not release any payments to DNF providers until the provider enrollment area or the NSC has verified and updated all addresses for that provider's location.

Contractors must initially publish the requirement that providers must notify the intermediary and carrier or NSC of any changes of address, both on their Web sites and in their next regularly scheduled bulletins. Contractors must continue to remind suppliers and providers of this requirement in their bulletins at least yearly thereafter.

See Chapter 1, §80.5, for additional information pertaining to the DNF initiative.

50.2 - SPR Formats

A3-3754

(Rev.)

The following sections contain the separate carrier/DMERC and intermediary SPR formats. These are the general formats. The actual SPRs may contain additional (or fewer) lines, i.e., the contractor may need to add a line for additional reason code(s) after first reason code line.

50.2.1 - Part A/Intermediary SPR Format

A3-3754 Exhibit 1, PM A-00-36

INTERMEDIARY NAME / ADDRESS / CITY / STATE / ZIP / PHONE NUMBER

PROVIDER NUMBER/ PART A PAID DATE: MM/DD/CCYY REMIT#: 1234567890
PAGE 1

NAME

PATIENT NAME			PATIENT CNTRL#		RC	REM	DRG#		
	DRG OUT AMT	COINSURANCE	PAT REFUND	CONTRACT ADJ					
HIC#				ICN			RC	REM	OUTCD CAPCD
	COVD CHGS	ESRD NET ADJ	PER DIEM RTE						
FROM DT THRU DT			NACHG HICHG TO		RC	REM	PROF COMP		MSP PAYMT
	NCOVD CHGS	INTEREST	PROC CD AMT						
CLM STATUS			COST COVDY	NCOVDY	RC	REM	DRG	AMT	
	DEDUCTIBLES	DENIED CHGS	NET REIMB						
123456789012345678 1 1		12345678901234567890		123	1234	123			1234567.89
	1234567.89	1234567.89	1234567.89						
1234567890123456789			12345678901234567890		123	1234	1	1	
	1234567.89	1234567.89	1234567.89						
12345678 12345678			12	1 123	123	1234	1234567.89		1234567.89
	1234567.89	1234567.89	1234567.89						
12				1234	1234	1234	123	1234	1234567.89
	1234567.89	1234567.89	1234567.89						
SUBTOTAL FISCAL MMCCYY									
	12345678.90	12345678.90	12345678.90	12345678.90					
YEAR									
		12345678.90	12345678.90	12345678.90	12345678.90				
									12345678.90
	12345678.90	12345678.90	12345678.90	12345678.90					
		12345	12345	12345			12345678.90		12345678.90
		12345678.90	12345678.90						
SUBTOTAL PART A									
		123456789.01	123456789.01	123456789.01	123456789.01				

123456789.01 123456789.01 123456789.01 123456789.01

123456789.01

123456789.01 123456789.01 123456789.01 123456789.01

123456 123456 123456 123456789.01 123456789.01
123456789.01 123456789.01

2000 VERSION

INTERMEDIARY NAME / ADDRESS / CITY / STATE / ZIP / PHONE NUMBER

PROVIDER NUMBER / **PART B** **PAID DATE: MM/DD/CCYY** **REMIT#: 1234567890**
PAGE 2

NAME

PATIENT NAME PATIENT CNTRL# RC REM DRG#
DRG OUT AMT COINSURANCE PAT REFUND CONTRACT ADJ

HIC# ICN RC REM OUTCD CAPCD
COVD CHGS ESRD NET ADJ PER DIEM RTE

FROM DT THRU DT NACHG HICHG TO RC REM PROF COMP MSP PAYMT
NCOVD CHGS INTEREST PROC CD AMT

CLM STATUS COST COVDY NCOVDY RC REM DRG AMT
DEDUCTIBLES DENIED CHGS NET REIMB

123456789012345678 1 1 12345678901234567890 123 1234 123 1234567.89
1234567.89 1234567.89 1234567.89

12345678901234567890 12345678901234567890 123 1234 1 1
1234567.89 1234567.89 1234567.89

12345678 12345678 12 1 123 123 1234 1234567.89
1234567.89 1234567.89 1234567.89 1234567.89

12 1234 1234 1234 123 1234 1234567.89
1234567.89 1234567.89 1234567.89

SUBTOTAL FISCAL MMCCYY
12345678.90 12345678.90 12345678.90 12345678.90

YEAR
12345678.90 12345678.90 12345678.90 12345678.90

12345678.90 12345678.90 12345678.90 12345678.90

12345 12345 12345 12345678.90 12345678.90
12345678.90 12345678.90

SUBTOTAL PART B
123456789.01 123456789.01 123456789.01 123456789.01

123456789.01 123456789.01 123456789.01 123456789.01

123456789.01 123456789.01 123456789.01 123456789.01 123456789.01

123456 123456 123456 123456789.01 123456789.01 123456789.01 123456789.01

2000 VERSION

INTERMEDIARY NAME / ADDRESS / CITY / STATE / ZIP / PHONE NUMBER

PROVIDER NUMBER / NAME PAID DATE: MM/DD/CCYY REMIT#: 1234567890 PAGE 3

SUMMARY

CLAIM DATA:

DAYS:
- COST: 1234567
- COVDY: 1234567
- NCOVDY: 1234567

CHARGES:
- COVD: 12,345,678.90
- NCOVD: 12,345,678.90
- DENIED: 12,345,678.90

PROF COMP: 12,345,678.90
MSP PAYMT: 12,345,678.90
DEDUCTIBLES: 12,345,678.90
COINSURANCE: 12,345,678.90
PAT REFUND: 12,345,678.90

INTEREST: 12,345,678.90
CONTRACT ADJ: 12,345,678.90
PROC CD AMT: 12,345,678.90

PASS THRU AMOUNTS:
- CAPITAL: 123,456,789.01
- RETURN ON EQUITY: 123,456,789.01
- DIRECT MEDICAL EDUCATION: 123,456,789.01
- KIDNEY ACQUISITION: 123,456,789.01
- BAD DEBT: 123,456,789.01
- NONPHYSICIAN ANESTHETISTS: 123,456,789.01
- TOTAL PASS THRU: 123,456,789.01
- HEMOPHILIA ADD ON: 123,456,789.01
- PIP PAYMENT: 123,456,789.01
- SETTLEMENT PAYMENTS: 123,456,789.01
- ACCELERATED PAYMENTS: 123,456,789.01
- REFUNDS: 123,456,789.01
- PENALTY RELEASE: 123,456,789.01
- TRANS OUTP PYMT: 123,456,789.01

WITHHOLD FROM PAYMENTS:
- CLAIM ACCOUNTS RECEIVABLE: 123,456,789.01
- ACCELERATED PAYMENTS: 123,456,789.01
- PENALTY: 123,456,789.01

PROVIDER PAYMENT RECAP:

PAYMENTS:
- DRG OUT AMT: 123,456,789.01
- INTEREST: 123,456,789.01

PROC CD AMT: 123,456,789.01
- NET REIMB: 123,456,789.01
- TOTAL PASS THRU: 123,456,789.01
- PIP PAYMENTS: 123,456,789.01
- SETTLEMENT PYMTS: 123,456,789.01
- ACCELERATED PYMTS: 123,456,789.01
- REFUNDS: 123,456,789.01
- PENALTY RELEASE: 123,456,789.01
- TRANS OUTP PYMT: 123,456,789.01
- HEMOPHILIA ADD ON: 123,456,789.01

WITHHOLD: 123,456,789.01

NET PROVIDER PAYMENT: 123,456,789.01
(PAYMENTS MINUS WITHHOLD)

NET REIMB: 12,345,678.90 SETTLEMENT: 123,456,789.01 CHECK / EFT NUMBER: 1234567890

TOTAL WITHHOLD 123,456,789.01

2000 VERSION

50.2.2 - Part B/Carrier and DMERC SPR Format

```
CARRIER NAME
ADDRESS 1                                                    MEDICARE

ADDRESS 2                                                    REMITTANCE

CITY, STATE   ZIP                                            NOTICE

(9099) 111-2222


              PROVIDER NAME
              PROVIDER #:                                1234567890
              ADDRESS 1
                            PAGE #:                                    1 OF 999
              ADDRESS 2
                            CHECK/EFT #: 12345678901234567890
              CITY, STATE ZIP
                            REMITTANCE # 12345678901234567890 (NOT A REQUIRED FIELD)


……….
*LINE 1
                            *
*LINE 2
                            *
*LINE 3
                            *
*LINE 4
                            *
*LINE 5
                            *
*LINE 6
                            *
*LINE 7
                            *
*LINE 8
                            *
*LINE 9
                            *
*LINE 10
                            *
*LINE 11
                            *
*LINE 12
                            *
*LINE 13
                            *
*LINE 14
                            *
*LINE 15
                            *
……….

PERF  PROV  SERV DATE    POS NOS   PROC   MODS              BILLED      ALLOWED      DEDUCT     COINS
GRP/ RC-AMT         PROV  PD
_____
NAME  LLLLLLLLLLL, FFFFFFFF  HIC 123456789012  ACNT 12345678901234567890  ICN 123456789012345  ASG X      MOA  11111
22222
```

```
                                                                                                              33333  44444
          55555

1234567890 MMDD MMDDYY   12 123   PPPPP  aabbccdd   1234567.12  1234567.12  1234567.12  1234567.12   GPRRR 1234567.12
1234567.12
                                 (PPPPP)     REM:     RRRRR       RRRRR       RRRRR       RRRRR         RRRRR
1234567890 MMDD MMDDYY   12 123   PPPPP  aabbccdd   1234567.12  1234567.12  1234567.12  1234567.12   GPRRR 1234567.12
1234567.12
                                 (PPPPP)     REM:     RRRRR       RRRRR       RRRRR       RRRRR         RRRRR
1234567890 MMDD MMDDYY   12 123   PPPPP  aabbccdd   1234567.12  1234567.12  1234567.12  1234567.12   GPRRR 1234567.12
1234567.12
                                 (PPPPP)     REM:     RRRRR       RRRRR       RRRRR       RRRRR         RRRRR

PT RESP 1234567.12                                                 CLAIM TOTAL     1234567.12  1234567.12  1234567.12
1234567.12         1234567.12  1234567.12

ADJ TO TOTALS:  PREV PD 1234567.12          INTEREST   1234567.12                  LATE FILING CHARGE  1234567.12
NET  1234567.12

CLAIM INFORATION FORWARDED TO:   XXXXXXXXXXXXXXXXXXXXXXX
```

```
CARRIER NAME                                                                                  YYYY/MM/DD
                                        (999) 111-2222                                                      MEDICARE
PROVIDER #: 1234567890
                                                                  PROVIDER NAME
REMITTANCE
CHECK/EFT #:12345678901234567890
                         PAGE #:  999 OF 999                                                    NOTICE
REMITTANCE # 12345678901234567890 (NOT A  REQUIRED FIELD)

PERF  PROV  SERV DATE    POS NOS   PROC   MODS                BILLED      ALLOWED      DEDUCT     COINS
RC-AMT                                PROV  PD
__________________________________________________________________________________________________________________________
______
NAME  LLLLLLLLLLL, FFFFFFFF  HIC 123456789012  ACNT 12345678901234567890  ICN 123456789012345  ASG X      MOA  11111
22222
                                                                                                              33333  44444
          55555

1234567890 MMDD MMDDYY   12 123   PPPPP  aabbccdd   1234567.12  1234567.12   1234567.12  1234567.12  GPRRR 1234567.12
1234567.12
                                 (PPPPP)     REM:     RRRRR       RRRRR        RRRRR       RRRRR      RRRRR
1234567890 MMDD MMDDYY   12 123   PPPPP  aabbccdd   1234567.12  1234567.12   1234567.12  1234567.12  GPRRR 1234567.12
1234567.12
                                 (PPPPP)     REM:     RRRRR       RRRRR        RRRRR       RRRRR      RRRRR
1234567890 MMDD MMDDYY   12 123   PPPPP  aabbccdd   1234567.12  1234567.12   1234567.12  1234567.12  GPRRR 1234567.12
1234567.12
                                 (PPPPP)     REM:     RRRRR       RRRRR        RRRRR       RRRRR      RRRRR

PT RESP 1234567.12                                                 CLAIM TOTAL     1234567.12  1234567.12   1234567.12
1234567.12       1234567.12  1234567.12

ADJ TO TOTALS:  PREV PD 1234567.12          INTEREST   1234567.12                  LATE FILING CHARGE  1234567.12
                    NET  1234567.12

CLAIM INFORATION FORWARDED TO:   XXXXXXXXXXXXXXXXXXXXXXX
__________________________________________________________________________________________________________________________
______

TOTALS:             # OF       BILLED        ALLOWED       DEDUCT        COINS          TOTAL            PROV  PD
                    PROV                                        CHECK
                         CLAIMS      AMT           AMT                          AMT           AMT            RC-AMT
AMT        ADJ AMT         AMT
           99999    1234567.12    1234567.12    1234567.12   1234567.12      1234567.12   1234567.12   1234567.12
      1234567.12

PROVIDER ADJ  DETAILS:  PLB REASON  CODE                                 FCN
HIC                                        AMOUNT
                              1111                              12345678901234567
123456789012                             1234567.12
                                                                  2222
      12345678901234567                             123456789012                                  1234567.12
                                                                                                        3333
                        12345678901234567                123456789012                             1234567.12
                                                                                                        4444
                        12345678901234567                123456789012                             1234567.12
                                                                                                        5555
                        12345678901234567                123456789012                             1234567.12

GLOSSARY: GROUP,  REASON,  MOA,  REMARK AND REASON CODES

XX                                                       TTT………………………………………………………..
XXX                                                      TTT………………………………………………………..
MXX                                                      TTT………………………………………………………..
XX                                                       TTT………………………………………………………..
```

CARRIER NAME YYYY/MM/DD
(999) 111-2222 **MEDICARE**
PROVIDER #: 1234567890
PROVIDER NAME
REMITTANCE
CHECK/EFT #:12345678901234567890
PAGE #: 999 OF 999 **NOTICE**
REMITTANCE # 12345678901234567890 (NOT A REQUIRED FIELD)

SUMMARY OF NON-ASSIGNED CLAIMS

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

NAME LLLLLLLLLLL, FFFFFFFF HIC 123456789012 ACNT 12345678901234567890 ICN 123456789012345 ASG X MOA 11111 22222 33333 44444 55555

1234567890 MMDD MMDDYY 12 123 PPPPP aabbccdd 1234567.12 1234567.12 1234567.12 1234567.12 GPRRR 1234567.12 1234567.12
(PPPPP) REM: RRRRR RRRRR RRRRR RRRRR RRRRR
1234567890 MMDD MMDDYY 12 123 PPPPP aabbccdd 1234567.12 1234567.12 1234567.12 1234567.12 GPRRR 1234567.12 1234567.12
(PPPPP) REM: RRRRR RRRRR RRRRR RRRRR RRRRR
1234567890 MMDD MMDDYY 12 123 PPPPP aabbccdd 1234567.12 1234567.12 1234567.12 1234567.12 GPRRR 1234567.12 1234567.12
(PPPPP) REM: RRRRR RRRRR RRRRR RRRRR RRRRR

PT RESP 1234567.12 CLAIM TOTAL 1234567.12 1234567.12 1234567.12 1234567.12 1234567.12 1234567.12

CLAIM INFORATION FORWARDED TO: XXXXXXXXXXXXXXXXXXXXXX

50.3 - Intermediary SPR Crosswalk to the 835

A3-3754

(Rev.)

This crosswalk provides a systematic presentation of SPR data fields and the corresponding fields in an 835 version 4010. It also includes some computed fields for provider use that are not present in an ERA. The comment column in the crosswalk provides clarification and instruction in some special cases.

Full Description (In Order Of Appearance)	SPR ID	SPR Field Size Characteristics	835 Location
SPR Page Headers			
FI name/ address/city/state/zip/ phone number	as written	Alpha Numeric (AN) 132 characters	Name=1-080.A-N102 Other data elements are Fiscal Intermediary (FI) generated.
Provider number	as written	AN 13	1-080.B-N104
Provider name	as written	AN 25	1-080.B-N102
Literal Value: Part A	as written	AN 06	Literal value not included on 835, Medicare Part would be indicated by the type of bill
Paid date	as written	N MM/DD/CCYY	1-020-BPR16
Remittance advice	REMIT	Numeric (N) 9(l 0)	FI generated
Literal Value: Page	as written	AN 06	FI generated
SPR Pages 1 and 2			
Patient Last Name	PATIENT NAME	AN 18	2-030.A-NM103

Full Description (In Order Of Appearance)	SPR ID	SPR Field Size Characteristics	835 Location
Patient First Name		AN 01	2-030.A-NM104
Patient Mid. Initial		AN 01	2-030.A-NM105
Health insurance claim number	HIC#	AN 19	2-030.A-NM109
Statement covers period - start	FROM DT	N MMDDCCYY	2-050.A-DTM02
Statement covers period - end	THRU DT	N MMDDCCYY	
Claim status code	CLM STATUS	AN02	2-010-CLP02
Patient control #	PATIENT CNTRL #	AN 20	2-010-CLP01
Internal control #	ICN	AN 23	2-010-CLP07
Patient name change	NACHG	AN 02	2-030.A-NM101 if '74'
HIC change	HICHG	AN 01	2-030.A-NM108 if 'C'
Type of bill	TO	AN 03	2-010-CLP08
Cost report days	COST	N S9(3)	2-033-MIA15
Covered days/visits	COVDY	N S9(3)	2-064-QTY02 when 'CA' in prior data element
Noncovered days	NCOVDY	N S9(3)	2-064-QTY02 when 'NA' in prior data element

Full Description (In Order Of Appearance)	SPR ID	SPR Field Size Characteristics	835 Location
			data element
Reason code (4 occurrences)	RC	AN 05	2-020-CAS02, 05,08 and 11
Remark code (4 occurrences)	REM	AN 05	Inpatient: 2-033-MIA -05, 20, 21, 22, Outpatient: 2-035- MOA03, 04, 05, 06
DRG #	as written	N 9(3)	2-010-CLP1 1
Outlier code	OUTCD	AN 02	2-062-AMT01 if 'ZZ'
Capital code	CAPCD	AN 01	2-033-MIA08
Professional component	PROF COMP	N S9(7).99	Total of amounts in 2-020 or 2-090, CAS03, 06, 09, 12, 15 or 18 when '89' in prior data element
DRG operating and capital amount	DRG AMT	N S9(7).99	2-033-MIA04
DRG outlier amount	DRG OUT AMT	N S9(7).99	2-062-AMT02 when 'ZZ' in prior data element
MSP primary amount	MSP PAYMT	N S9(7).99	2-062-AMT02 when 'NJ' in prior data element

Full Description (In Order Of Appearance)	SPR ID	SPR Field Size Characteristics	835 Location
Cash deductible/ blood deductibles	DEDUCTIBLES	N S9(7).99	Total of 2-020 or 2-090, CAS03, 06, 09, 12, 15 or 18 when '66' in prior data element
Coinsurance amount	COINSURANCE	N S9(7).99	Total of 2-020 or 2-090 CAS03, 06, 09, 12, 15 or 18 when '2' in prior data element
Covered charges	COVD CHGS	N S9(7).99	2-060-AMT02 when 'AU' in prior data element
Noncovered charges	NCOVD CHGS	N S9(7).99	2-010-CLP03 minus 2-060-AMT02 when 'AU' in prior data element
Denied charges	DENIED CHGS	N S9(7).99	Total of 2-020 or 2-090-CAS03, 06, 09, 12, 15 or 18
Patient refund	PAT REFUND	N S9(7).99	2-020 or 2-amount 090-CAS 03, 06, 09, 12, 15 or 18 when '100' in prior data element
Claim ESRD	ESRD NET ADJ	N S9(7).99	2-020 or 2-reduction 090-CAS 03, 06, 09, 12, 15 or 18 when '118' in prior data element
Interest	INTEREST	N S9(6).99	2-060-AMT02 when in prior data element
Contractual	CONTRACT ADJ	N S9(7).99	Total of 2-020 adjustment or 2-090 CAS03, 06, 09, 12, 15 and 17 when 'CO' in CASOI

Full Description (In Order Of Appearance)	SPR ID	SPR Field Size Characteristics	835 Location
Per Diem rate	PER DIEM RTE	N S9(7).99	2-062-AMT02 when 'DY' in prior data element
Procedure code amount	PROC CD AMT	N S9(7).99	2-035-MOA02
Net reimbursement	NET REIMB	N S9(7).99	2-010-CLP04

SPR Page 3

SPR Claim Data

Cost report days	DAYS COST	N S9(3)	Total of claim level SPR Cost
Covered days/visits	DAYS COVDY	N S9(4)	Total of claim level SPR COVDY
Noncovered days	DAYS NCOVDY	N S9(4)	Total of claim level SPR NCOVDY
Covered charges	CHARGES COVD	N S9(7).99	Total of claim level SPR COVD CHGS
Noncovered charges	CHARGES NCOVD	N S9(7).99	Total of claim level SPR NCOVD CHGS
Denied charges	CHARGES DENIED	N S9(7).99	Total of claim level SPR DENIED CHGS
Professional component	PROF COMP	N S9(7).99	Total of claim level SPR PROF COMP

Full Description (In Order Of Appearance)	SPR ID	SPR Field Size Characteristics	835 Location
MSP primary	MSP PAYMT	N S9(7).99	Total of claim amount level SPR MSP PAYMT
Cash deductible/ blood deductibles	DEDUCTIBLES	N S9(7).99	Total of claim level SPR DEDUCTIBLES
Coinsurance amount	COINSURANCE	N S9(7).99	Total of claim level SPR COINSURANCE
Patient refund	PAT REFUND	N S9(7).99	Total of claim amount level SPR PAT REFUND
Interest	INTEREST	N S9(7).99	Total of claim level SPR INTEREST
Contractual adjustment	CONTRACT ADJ	N S9(7).99	Total of claim level SPR CONTRACT ADJ.
Procedure code payable amount	PROC CD AMT	N S9(7).99	Total of claim level SPR PROC CD AMT
Claim payment amount	NET REIMB	N S9(7).99	Total of claim level SPR NET REIMB
SPR Summary Data			
Pass Thru Amounts			
Capital pass thru	CAPITAL	N S9(7).99	3-010-PLB04, 06, 08 or 10 when 'CP' in prior data element

Full Description (In Order Of Appearance)	SPR ID	SPR Field Size Characteristics	835 Location
Return on equity	as written	N S9(7).99	3-010-PLB04, 06, 08 or 10 when 'RE' in prior data element
Direct medical education	as written	N S9(7).99	3-010-PLB04, 06, 08 or 10 when 'DM' in prior data element
Kidney acquisition	as written	N S9(7).99	3-010-PLB04, 06, 08 or 10 when 'KA' in prior data element
Bad debt			3-010-PLB04, 06, 08 or 10 when 'BD' in prior data element
Nonphysician anesthetists	as written	N S9(7).99	3-010-PLB04, 06, 08 or 10 when 'CR' in prior data element
Hemophilia add on	as written	N S9(7).99	3-010-PLB04, 06, 08 or 10 when 'ZZ' in prior data element
Total pass through	as written	N S9(7).99	Total of the above pass through amounts.
Non-Pass Through Amounts			
PIP payment	as written	N S9(7).99	3-010-PLB04, 06, 08 or 10 when 'PP' in prior data element
Settlement amounts	SETTLEMENT PAYMENTS		3-010-PLB04, 06, 08 or 10 when 'FP' in prior data element
Accelerated payments	as written	N S9(7).99	3-010-PLB04, 06, 08 or 10 when 'AP' in prior data element

Full Description (In Order Of Appearance)	SPR ID	SPR Field Size Characteristics	835 Location
Refunds	as written	N S9(7).99	3-010-PLB04, 06, 08 or 10 when 'RF' in prior data element
Penalty release	as written	N S9(7).99	3-010-PLB04, 06, 08 or 10 when 'RS' in prior data element
Transitional outpatient payment	TRANS OP PYMT	N S9(7).99	3-010-PLB04, 06, 08 or 10 when 'IR' in prior data element
Withhold from Payment			
Claims accounts	as written	N S9(7).99	3-010-PLB04, 06, 08 or 10 when 'AA' in prior data element
Accelerated payments	as written	N S9(7).99	3-010-PLB04, 06, 08 or 10 when 'AW' in prior data element
Penalty	as written	N S9(7).99	3-010-PLB04, 06, 08 or 10 when 'PW' in prior data element
Settlement	as written	N S9(7).99	3-010-PLB04, 06, 08 or 10 when 'OR' in prior data element
Total withholding	TOTAL WTHLD	N S9(7).99	Total of the above withholding amounts
Provider Payment Recap			
Payments and withhold previously listed			
Net provider payment	as written	N S9(7).99	1-020-BPR02
Check/EFT number	as written	N S9(7).99	1-040-TRN02

See 835 implementation guides for data element definitions, completion and use.

50.4 - Carrier and DMERC SPR Crosswalk to the 835

(Rev.)

B-01-076

Part B 835 version 4010 field descriptions may be viewed at http://cms.hhs.gov/providers/edi/hipaadoc.asp under the file name B835v4010&4010A1-1.zip.

Remittance Field	835 Version 4010/4010. A.1 Field	LOOP ID	NSF Version 2.01 Field #	COMMENT
CARRIER NAME	N102	1000A	100-07	
CARRIER ADDRESS 1	N301	1000A		
CARRIER ADDRESS 2	N302	1000A		
CARRIER CITY	N401	1000A		
CARRIER STATE	N402	1000A		
CARRIER ZIP	N403	1000A		
PROVIDER NAME	N102	1000B	200-06	
PROVIDER ADDRESS 1	N301	1000B		
PROVIDER ADDRESS 2	N302	1000B		
PROVIDER CITY	N401	1000B		
PROVIDER STATE	N402	1000B		
PROVIDER ZIP	N403	1000B		
PROVIDER #	REF02 when IC IN REF01	1000B	200-07	
DATE (CHECK/EFT ISSUE DATE)	BPR16		200-09	
CHECK/EFT TRACE #	TRN02		200-08	
REMITTANCE #				This is not a required field
BENEFICIARY LAST NAME (PATIENT LAST NAME)	NM103	2100	400-13	
BENEFICIARY FIRST NAME (PATIENT FIRST NAME)	NM104	2100	400-14	

Remittance Field	835 Version 4010/4010. A.1 Field	LOOP ID	NSF Version 2.01 Field #	COMMENT
HIC (INSURED IDENTIFICATION #)	NM109	2100	400-07	
ACNT (PATIENT CONTROL #)	CLP01	2100	400-03	Use a single 0 if not received on 837 (CLM01)
ICN (PAYOR CLAIM CONTROL #)	CLP07	2100	400-22	
ASG(ASSIGNMENT)	LX01	2000	500-24	
MOA CODES (CLAIM REMARK CODES)	MOA	2100	400-23 THRU 400-27	
PERF PROVIDER (PERFORMNG PROVIDER IDENTIFICATION)	REF02 when IC IN REF01	2110	450-37	If more than 1 performing provider, insert # of 1st
SERVICE DATE (FROM)	DTM02 when 150 in DTM01	2110	450-07	
SERVICE DATE (THROUGH)	DTM02 when 151 in DTM01	2110	450-08	
POS (PLACE OF SERVICE)	REF02 when LU IN REF01	2110	450-11	
NUM (UNITS OF SERVICE)	SVC05	2110	450-17	
PROC (PROCEDURE CODE - PAID)	SVC01-2	2110	450-13	
MODS (MODIFIERS)	SVC01-3 THRU SVC01-6	2110	450-14 THRU 450-16	aabbccdd in the sample
SUBMITTED PROCEDURE CODE	SVC06-2	2110	451-09	(ppppp) in the sample format
BILLED (SUBMITTED LINE CHARGE)	SVC02	2110	450-18	
ALLOWED (ALLOWED/CONTRACT AMT)	AMT02 when B6 in AMT01	2110	450-21	

Remittance Field	835 Version 4010/4010. A.1 Field	LOOP ID	NSF Version 2.01 Field #	COMMENT
DEDUCT (DEDUCTIBLE AMT)	CAS03, 06, 09,12,15, 18 when 1 in CAS 02, 05, 08, 11, 14 or 17	2110	450-22	
COINS (COINSURANCE AMT)	CAS03, 06, 09,12,15, 18 when 2 in CAS 02, 05, 08, 11, 14 or 17	2110	450-23	
PROV PD (CALCULATED PMT TO PROVIDER)	SVC03	2110	450-28	
RC (GROUP AND REASON CODES)	CAS01+ CAS02/05/0 8/11/14/17	2110	450-38 THRU 450-44	
RC-AMT (REASON CODE AMTS)	CAS03, 06, 09,12,15, 18 when no 1 or 2 in CAS 02, 05, 08, 11, 14 or 17	2110	451-10 THRU 451-14	
REM (LINE REMARK CODES)	LQ02	2110	451-16 THRU 451-20	
PT RESP (PATIENT RESPONSIBILITY)	CLP05	2100	500-23	
BILLED (SUBMITTED CLAIM LEVEL CHARGES)	CLP03	2100	500-05	
ALLOWED (ALLOWED/CONTRACT AMT-CLAIM LEVEL)		2100	500-08	
DEDUCT (DEDUCTIBLE AMT-CLAIM LEVEL))		2100	500-09	
COINS (COINSURANCE AMT-CLAIM LEVEL)		2100	500-10	
TOTAL RC AMOUNT				Computed. Excludes Interest, Late Filing Charges,

Remittance Field	835 Version 4010/4010. A.1 Field	LOOP ID	NSF Version 2.01 Field #	COMMENT
				Deductible, Coinsurance and Prev. Pd.
PROV PD (CALCULATED PMT TO PROVIDER - CLAIM LEVEL)	CLP04	2100	500-15	
NET (ACTUAL PMT TO PROVIDER FOR CLAIM)		2100	500-19	This is a computed field including Interest, Late Filing Charge and Prev. Pd.
PREVIOUSLY PAID			500-17 THRU 500-18	
INT (INTEREST PAID)	AMT02 when I in AMT01	2100	500-11	
LATE FILING CHARGE	AMT02 WHEN KH IN AMT01	2110	451-07	
INSURER TO WHOM CLAIM IS FORWARDED	NM103 when TT in NM101& 2 in NM102	2100	500-25	CRSSOVER CARRIER NAME
# OF CLAIMS			800-06	
TOAL BILLED AMT(BT SUBMITTED CHARGES)			800-08	
TOTAL ALLOWED AMT			800-11	
TOTAL DEDUCT AMT			800-12	
TOTAL COINS AMT			800-13	
TOTAL RC AMOUNT				Sum of all RC adjustments. Excludes interest, late filing charge, deductible, coinsurance, and prev. pd.
PROV PD AMT			800-18	

Remittance Field	835 Version 4010/4010. A.1 Field	LOOP ID	NSF Version 2.01 Field #	COMMENT
PROVIDER ADJ AMT			COMPUTED	
CHECK AMT	BPR02		800-22	
PROVIDER LEVEL ADJUSTMENT REASON CODE	50 OR AP OR B2 OR CS OR FB OR IR OR J1 OR L6 OR LE OR SL OR WO IN PLB03-1, PLB05-1, PLB07-1, PLB09-1, PLB11-1, PLB13-1		700-06	This and the next three lines explain the provider level adjustments.
FCN OR ADJ REASON (FINANCIAL CONROL #/PROV ADJ REASON)	PLB03-2, PLB05-2, PLB07-2, PLB09-2, PLB11-2, PLB13-2. POSITION 3-19		700-08	
HIC	PLB03-2, PLB05-2, PLB07-2, PLB09-2, PLB11-2, PLB13-2 POSITION 20-30		700-04	
PROVIDER LEVEL ADJUSTMENT AMOUNT	PLB04, PLB06, PLB 08, PLB10, PLB12, PLB14 WHEN 50 OR AP OR B2 OR CS OR FB OR IR OR J1 OR L6 OR LE OR SL OR WO IN PLB03-1, PLB05-1, PLB07-1, PLB09-1, PLB11-1, PLB13-1		700-07	Includes Interest, Late Filing Charge, Previously Paid and other adjustments as applicable

60 - Remittance Advice Codes

(Rev.)

60.1 - Standard Adjustment Reason Codes

(Rev.)

AB-02-142, AB-02-067, A-02-070, AB-01-132, AB-03-012

Standard adjustment reason codes are used on the Medicare electronic and paper remittance advice. The indicated wording may not be modified without approval of the Health Care Code Maintenance Committee. These codes were developed for use by all U.S. health payers. As a result, they are generic, and there are a number of codes that do not apply to Medicare.

Changes to this code list occur more frequently than the version changes for the 835 standard. However, the most current list can be used in any Medicare-recognized version of the 835 standard and the SPRs.

Any reference to procedures or services in the CAS reason codes apply equally to products, drugs, supplies or equipment. References to prescriptions also include certificates of medical necessity (CMNs).

These reason codes report the reasons for any claim financial adjustments, such as denials, reductions or increases in payment. CAS reason codes may be used at the service or claim level, as appropriate. Multiple CAS reason codes may be entered for each service or claim as warranted.

Early in the history of CAS reason codes, some codes, such as codes 69-83 were implemented for informational rather than adjustment purposes. However, these codes and their amounts interfered with balancing of the remittance data. Approval of new codes is now limited to those that involve an adjustment from the amount billed. There are basic criteria that the Health Care Code Maintenance Committee considers when evaluating requests for new codes:

- Can the information be conveyed by the use or modification of an existing CAS reason code?
- Is the information available elsewhere in the 835?
- Will the addition of the new CAS reason code make any significant difference in the action taken by the provider who receives the message?

The list of Adjustment Reason Codes can be found at http://www.wpc-edi.com/ClaimAdjustment_40.asp. This list is updated every four months based on the outcome of each Health Care Code Maintenance Committee meeting held before X12 trimester meeting in February, June, and October. The updated list is published in the months of March, July and November. Medicare contractors must download the list after each update to make sure they are using the latest approved adjustment reason codes in 835 and standard paper remittance advice transactions.

Individual carriers and intermediaries are responsible for entering claim adjustment reason code updates to their standard system and entry of parameters for standard system use to determine how and when particular codes are to be reported in remittance advice transactions. In most cases, remittance and remark codes reported in remittance advice transactions are mapped to alternate codes used by a standard system. These standard system codes may exceed the number of the reason and remark codes approved for reporting in a remittance advice transaction. A particular 835 reason or remark code might be mapped to one or more standard system codes, or vice versa, making it difficult for a carrier or intermediary to determine each of the internal codes that may be impacted by remark or reason code modification, retirement or addition.

Standard systems must provide a crosswalk between the reason and remark codes to the standard system internal codes so that a carrier or intermediary can easily locate and

update each internal code that may be impacted by a remittance advice reason/remark code change to eliminate the need for lengthy and error prone manual carrier and intermediary searches to identify each affected internal code. Standard systems must also make sure that 5-position remark codes can be accommodated at both the claim and service level for version 4010 onwards.

The effective date of programming for use of new or modified reason/remark codes applicable to Medicare is the earlier of the date specified in the contractor manual transmittal or program memorandum (PM) requiring implementation of a policy change that led to the issuance of the new or modified code, or the date specified in the periodic PM announcing issuance of the code changes (additions/modifications/retirements). Contractors must notify providers of the new and/or modified codes and their meanings in a provider bulletin or other instructional release prior to issuance of remittance advice transactions that include these changes.

A code may not be reported in a new remittance advice after the effective date of its retirement. If processing an adjustment involving a code that was retired after generation of the original remittance advice, the reversed claim may report the currently valid code supplanting the code that appeared in the initial notice. If easier from a mapping or programming perspective, an intermediary or carrier has the option to eliminate use of a retired code in each supported remittance advice versions, including those that pre-date the effective date of the retirement.

60.2 - Remittance Advice Remark Codes

(Rev.)

AB-02-142, AB-01-132, AB-02-067, AB-03-012

Remark codes are used in a remittance advice to further explain an adjustment or relay informational messages that cannot be expressed with a claim adjustment reason code. Remark codes are maintained by CMS, but may be used by any health care payer when they apply. Medicare contractors must report any remark codes that apply, subject to capacity limits in the standard.

Most remark codes were initially separated into service level (line level) and claim level categories. Some of the same messages were included in both categories. To simplify remark code use, these categories have been eliminated. Any remark code may now be reported at the service or the claim level, as applicable, in any electronic or paper remittance advice version. To eliminate duplication, the following remark code messages have been made inactive and should no longer be used effective with implementation of version 4010 of the X12 835: 'M34' (duplicates 'MA120'), 'M72' (duplicates 'MA52'), 'MA05' (information included in 'MA30', or 'MA40', or 'MA43'), 'N41' (duplicates reason code '39'), and 'N44' (duplicates reason code '137').

Rather than renumber existing 'M' (prior service level) and 'MA' (prior claim level) codes, and possibly confuse providers, old code numbers have been retained. All new post-consolidation remark codes, however, will begin with an 'N'. The 'N' is used to quickly

differentiate remark codes from claim adjustment reason codes. Remark codes that apply at the service level must be reported in the X12 835 LQ segment. Remark codes that apply to an entire claim must be reported in either an X12 835 MIA (inpatient) or MOA (noninpatient) segment, as applicable.

The list of Remittance Advice Remark Codes can be found at http://www.wpc-edi.com/Remittance_40.asp and http://www.cms.hhs.gov/providers/edi/hipaadoc.asp. The remark code list is updated every four months, and the updated list is posted each March, July, and November. Medicare contractors must download the updated list every four months to make sure they are using the latest approved remark codes as included in any CMS instructions in their 835 and the corresponding standard paper remittance advice transactions. Contractor and shared system changes must be made, as necessary, as part of a routine release to reflect changes such as retirement of previously used codes or newly created codes that may impact Medicare.

60.3 - Group Codes

(Rev.)

MCM 7030.2

A group code is a code identifying the general category of payment adjustment. A group code must always be used in conjunction with a claim adjustment reason code to show liability for amounts not covered by Medicare or to identify a correction or reversal of a prior decision. Contractors have discretion as to which group and reason codes, value, and remark codes and messages are appropriate for use, according to the decision you make on a service or a claim, within the Medicare coverage, payment, development and appeal parameters. Contractors do not have discretion to omit appropriate codes and messages. Contractors must use claim adjustment reason codes, group codes, value codes and remark codes and messages when they apply. Contractors must print an appeal code and message on the remittance notice for every claim. Contractors must use a limitation of liability code and message and a coordination of benefits code and message where applicable.

Valid Group Codes for use on Medicare claims:

PR (Patient Responsibility Adjustment) - Any adjustment where the patient will be assuming or has assumed financial responsibility.

CR (Correction) - Change to a previously processed claim.

OA (Other adjustment) - Any other adjustment. Do not include any adjustment for which the patient or provider has financial liability.

CO (Contractual Obligations) – Payment adjustment where the provider did not meet a program requirement and is financial liability.

60.4 - Requests for Additional Codes

AB-02-142, AB-03-012

(Rev.)

The CMS has national responsibility for maintenance of the remittance advice remark codes. Requests for new or changed remark codes should be submitted to CMS via the Washington Publishing Company Web page (http://www.wpc-edi.com/HIPAA) remark code request function. Requests for codes must include the name, phone number, company name, and e-mail address of the requestor, the suggested wording for the new or revised message, and an explanation of how the message will be used and why it is needed. A fax number or mail address is acceptable in the absence of an e-mail address. Requests may also be mailed to:

Centers for Medicare & Medicaid Services
OIS/BSOG/DDIS
Mail Stop N2-13-16
7500 Security Blvd.
Baltimore MD 21244-1850

To provide a summary of changes introduced in the previous four months, a PM will be issued if in the last four months (a) any new remark or reason code is introduced; and/or (b) an existing code is discontinued; and/or c) the wording for an existing code is modified, and at least one of these changes impact Medicare. These PMs will establish the deadline for Medicare standard system and contractor changes to complete the reason and/or remark code updates that had not already been implemented as part of a previous Medicare policy change instruction.

70 - Intermediary ERA Requirement Changes to Accommodate OPPS and HH PPS

(Rev.)

B-02-050, A3-3754

The type of bill in CLP08 identifies whether a service is an outpatient hospital, Community Mental Health Center (CMHC), Home Health Agency (HHA), or other category of intermediary processed claim. A remittance advice does not typically identify which of the possible cost bases is being used for payment.

The CMS had to assure both these PPS payment systems could be accommodated in the 835 transaction when they were implemented in 2000.

Changes to accommodate these PPS systems include:

- **Detailed service** line level data will only be reported in 3051.4A.01 and later versions of the 835. Detailed service line data is not reported in paper remittance advice notices, or in pre-3051.4A.01 versions of the 835 supported

by the FISS. Current versions of the SPR and ERA continue to report claims-level summary data.

- **2-062-AMT02** modified to allow reporting of either inpatient or partial hospitalization per diem. Intermediaries also report the amount of any outlier determined payable for the claim, by the Outpatient Prospective Payment System (OPPS) and Home Health (HH) Prospective Payment System (PPS) Medicare Contractor PRICER software (PRICER software calculates a payment amount), in a separate AMT loop with 'ZZ' in AMT01 and the outlier amount in AMT02.

- **2-100.A-REF and REF02** modified to allow service line reporting of the Ambulatory Payment Classification (APC) and the Health Insurance Prospective Payment System (HIPPS), representing a Home Health Resource Group (HHRG) for HH PPS) group numbers. The APC will supplant the Ambulatory Surgical Center (ASC) group for outpatient hospital claims paid under PPS.

- **2-100.B-REF** modified to allow service line reporting of the home health payment percentage. This segment applies to ASC and Home Health PPS payments, but does not apply to APC payments.

- **2-110.A-AMT** modified to allow service line reporting of the allowed amount for APC and home health HIPPS payments.

For OPPS, the standard provider level adjustment reason codes in Appendix B have been expanded to include the X12 835 code of BN (bonus) for the reporting of transitional OPPS payments (TOPS payments). This is a claim level segment and must be reported. TOPS payments will be discontinued after December 2003 for all but specified children's and cancer hospitals.

For OPPS, Intermediaries treat the amount determined payable for an OPPS service, whether APC, average wholesale price (AWP), etc., as the allowed amount for a service.

For OPPS, Intermediaries report services that do not have a related APC, and which are considered to be included in the payment for one or more other APCs, with Group Code CO and reason code 97 (payment included in the allowance for another service/procedure). If a non-APC service on the same claim is denied for another reason, such as not reasonable or necessary (CO 50), they report the specific reason code that applies to that denial rather than CO 97.

For OPPS, Intermediaries use the 835 bundling methodology to report APC payment when multiple HCPCS are included in a single APC. When bundling services into an APC grouping, they report service line information back to a provider in the same way as billed, so the provider may automatically identify the services involved and post payment information to patient accounts.

For OPPS, Intermediaries report each procedure billed in a remittance advice, even if bundled for payment into a single APC. However, they report the payment for all of the

services in a single APC on the line for the first listed service in that APC. Since the payment for the entire APC will be higher than for that procedure code alone, Intermediaries must enter group code OA (other adjustment) and reason code 94 (processed in excess of charges) for the amount of the excess (difference between the billed amount for the service and the allowed rate for the APC) as a negative amount to enable the line and claim to balance. They report the remaining procedures for that APC on the following lines of the remittance advice with group code CO and reason code 97 (payment included in the allowance for another service/procedure) for each. They repeat the process if there are multiple APCs for the same claim.

For Home Health, there may be situations in which a beneficiary is under a home health plan of care, but Common Working File (CWF) does not yet have a record of either a request for anticipated payment or a home health claim for the episode of care. To help inform therapy providers that the services they performed may be subject to consolidated billing, provide the following remark code on the remittance advice for the conditions noted.

Remark Code	Message	Conditions for Use
N116	This payment is being made conditionally because the service was provided in the home, and it is possible that the patient is under a home health episode of care. When a patient is treated under a home health episode of care, consolidated billing requires that certain therapy services and supplies, such as this, be included in the home health agency's (HHA's) payment. This payment will need to be recouped from you if we establish that the patient is concurrently receiving treatment under an HHA episode of care.	Provide this message on a remittance advice when CWF indicates that the service is payable, and all three of the following conditions are true: 1. The place of service is "12 home." 2. The HCPCS code is a therapy code subject to home health consolidated billing (refer to the most recent PM announcing affected services and codes). 3. The CWF has not returned a message indicating the presence of a request for anticipated payment (RAP).

70.1- Scope of Remittance Changes for HH PPS

A3-3753

(Rev.)

Additional HH PPS changes in specific versions of the electronic remittance format are presented in the next few subsections of this manual, and are additions to joint requirements with OPPS in §70. However, CMS will not make additional paper

remittance format changes, 835 version 3051.4A.01 implementation guide changes, or PC-Print changes for HH PPS.

All the statements below on home health billing apply only to type of bills submitted as 32x, which may be processed as 33x, or what was submitted prior to HH PPS on both 32x and 33x claims. Type of bill is reported on form locator 4 on the Form CMS-1450 (UB-92) claim form.

70.2 - Payment Methodology of the HH PPS Remittance: HIPPS Codes

A3-3753

(Rev.)

HH PPS episode payment is represented by a HIPPS code on a claim or a Request for Anticipated Payment (RAP). As a general rule, the amount of the first payment for a 60-day HH PPS episode, made in response to a RAP submitted on a claim form and processed like a claim, will be reversed and withheld from the full payment made for the episode, in response to a claim, at the end of the 60 days. Episodes of 4 or fewer visits will be paid using standard per visit rates, rather than under HH PPS episode methodology.

Two HIPPS can appear on a single line item. This new feature is used for HH PPS when, during processing, Medicare finds payment should have been made on a HIPPS other than the one submitted by the provider. Standard systems carry the corrected HIPPS in the panel code field of the line item. As noted below, the remittance carries both the submitted and paid HIPPS.

70.3 - Items Not Included in HH PPS Episode Payment

A3-3753

(Rev.)

By law, durable medical equipment (DME) is not included in payment of home health PPS episodes, though episodes are global payment for most other home health services and items. DME must be reported in a separate line/loop for the claim closing an episode. DME may not be included in the Request for Anticipated Payment (RAP) for an episode. DME will continue to be paid under the DME fee schedule as at present. Intermediaries continue to pay osteoporosis drug, flu injection, vaccines or outpatient benefits delivered by home health agencies, such as splints or casts, separately from home health PPS as 34x type of bill claims.

70.4 - 835 Version 3051.4A.01 Line Level Reporting Requirements for the Request for Anticipated Payment (RAP) Payment for an Episode

A3-3753

(Rev.)

Intermediaries:

1. Enter 'HC' (HCPCS revenue code qualifier) in 2-070-SVC01-01, and the Health Insurance PPS (HIPPS) code under which payment is being issued in 2-070-SVC01-02. The HIPPS code is treated as a type of level 3 HCPCS in version 3051.4A.1.

2. Enter '0' (zero) in 2-070-SVC02 for the HIPPS billed amount and the amount they are paying in SVC03.

3. Enter '0023' (home health revenue code) in SVC04.

4. Enter the number of covered days, as calculated by the standard system for the HIPPS, in SVC05, the covered units of service - this number should be 1, representing the same date used as the from and through date on the RAP.

5. Enter the billed HIPPS in 2-070-SVC06-02 with qualifier 'HC' in 2-070-SVC06-01 if the HIPPS has been down coded or otherwise changed during adjudication.

6. Enter the start of service date (claim from date) in 2-080-DTM for the 60-day episode. If a revenue code other than '0023' is billed, they report the line item date associated with that revenue code instead of the claim from date. The only line item receiving Medicare payment on RAP should be the single '0023' revenue code line.

7. Enter group code 'OA' (other adjustment), reason code '94' (processed in excess of charges), and the difference between the billed and paid amounts for the service in 2-090-CAS. They report the difference as a negative amount.

8. Enter '1S' (ambulatory patient group qualifier) in 2-100.A-REF01 and the HIPPS code in 2-100.A-REF02.

9. Enter 'RB' (rate code number qualifier) in 2-100.B-REF01 and the percentage code (0, 50, 60) in 2-100.B-REF02.

10. Enter the appropriate line level remark codes in 2-130-LQ. There are no messages specific to home health HIPPS payments. There are no appeal rights for initial percentage episode payments.

2-110-AMT (ASC, APC or HIPPS priced amount or per diem amount, conditional) does not apply, and should not be reported for either the first or the final remittance advice for a HIPPS episode.

2-120-QTY does not apply to a first bill/payment in an episode. This data element is used for home health payment only when payment is based on the number of visits (when four or fewer visits) rather than on the HIPPS.

70.5 - 835 Version 3051.4A.01 Line Level Reporting Requirements for the Claim Payment in an Episode (More Than Four Visits)

A3-3753

(Rev.)

1. Intermediaries reverse the initial payment for the episode. They repeat the data from the first bill in steps 1-7 in §70.4, but change the group code to 'CR' and reverse the amount signs, i.e., change positive amounts to negatives and negatives to positives.

2. Intermediaries enter 'CW' (claim withholding) and repeat the reversal amount from 2-070-SVC03 in 3-010-PLB for this remittance advice. This will enable the first 60-day payment to be offset against other payments due for this remittance advice.

3. The full payment for the episode can now be reported for the end of episode bill.

    a. Intermediaries repeat steps 1-11 from §70.4 for the service as a reprocessed bill. They report this data in a separate claim loop in the same remittance advice. Up to six HIPPS may be reported on the second bill for an episode.

    b. In addition to the HIPPS code service loop, Intermediaries also enter the actual individual HCPCS for the services furnished. They include a separate loop for each service. Revenue code '27x', '623', '27x', and '62x' services may not be billed with a HCPCS, and must be reported in a separate SVC loop in the remittance advice.

    c. Intermediaries report payment for the service line with the HIPPS in the HCPCS data element at the 100 percent rate (or the zero rate if denying the service) in step 9.

    d. Intermediaries report group code 'CO', reason code '97' (Payment included in the allowance for another service/procedure), and zero payment for each of the individual HCPCS in the 2-070-SVC segments. Payment for these individual services is included in that HIPPS payment. Intermediaries do not report any allowed amount in 2-110.A-AMT for these lines. They do not report a payment percentage in the loops for HCPCS included in HIPPS payment(s).

    e. Intermediaries enter the appropriate appeal or other line level remark codes in 2-130-LQ. There are no messages specific to home health HIPPS payments.

f. If DME, oxygen or prosthetics/orthotics is paid, Intermediaries report in a separate loop(s), and enter the allowed amount for the service in 2-110.A-AMT.

4. If PRICER determines that a cost outlier is payable for the claim, Intermediaries report the amount PRICER determines payable in a claim adjustment reason code segment (2-020-CAS) with reason code '70' (cost outlier) and a negative amount to reflect additional payment supplementing the usual allowed rate.

5. If insufficient funds are due the provider to satisfy the withholding created in step 2 above, Intermediaries carry the outstanding balance forward to the next remittance advice by entering 'BF' (Balance Forward) in the next available provider adjustment reason code data element in 3-010-PLB. They report the amount carried forward as a negative amount.

70.6 - 835 Version 3051.4A.01 Line Level Reporting Requirements for the Claim Payment in an Episode (Four or Fewer Visits)

(Rev.)

A3-3753

1. Intermediaries follow §70.5 steps 1-2.

2. Now that the first payment has been reversed, Intermediaries pay and report the claim on a per visit basis rather than on a prospective basis. They enter HC in 2-070-SVC01-01, the HCPCS for the visit(s) in 2-070-SVC01-02, submitted charge in SVC02, the paid amount in SVC03, appropriate revenue code (other than 0023) in SVC04, the number of visits paid in SVC05, the billed HCPCS if different than the paid HCPCS in SVC06, and the billed number of visits if different from the paid number of visits in SVC07.

3. Intermediaries report the applicable service dates and any adjustments in the DTM and CAS segments.

4. The 2-100-REF segments do not apply to per visit payments.

5. Intermediaries enter 'B6' in 2-110.C-AMT01 and the allowed amount for the visit(s) in AMT02.

6. Intermediaries report the number of covered and noncovered (if applicable) visits in separate loops in segment 2-120-QTY.

7. Intermediaries enter the appropriate appeal or other line level remark codes in 2-130-LQ.

8. If insufficient funds are due the provider to satisfy the withholding created in §70.5 step 2, Intermediaries carry the outstanding balance forward to the next remittance advice by entering 'BF' (Balance Forward) in the next available

provider adjustment reason code data element in 3-010-PLB. They report the amount carried forward as a negative amount.

70.7- HH PPS Partial Episode Payment (PEP) Adjustment

(Rev.)

A-02-103

Medicare systems apply two codes to the ERA to indicate a PEP adjustment is being reported. The codes are defined as follows:

B20 - Payment adjusted because procedure/service was partially or fully furnished by another provider; and

N120 - Payment is subject to home health prospective payment system partial episode payment adjustment. Beneficiary transferred or was discharged/readmitted during payment episode.

These are not applicable to the standard paper remittance advice.