CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 2205	**Date: April 29, 2011**
	Change Request 7308

SUBJECT: IOM 100-04 Chapter 22 Update for Remittance Advice for version 5010 - ASC X12N 005010A1 and Related Standard Paper Remittance (SPR)

I. SUMMARY OF CHANGES: This Change Request updates the Remittance Advice chapter in the Medicare Claims Processing Manual (Pub. 100-04, Chapter 22) to accommodate the new Health Insurance Portability and Accountability Act (HIPAA) standard - ASC X12N 835 version 005010A1.

EFFECTIVE DATE: May 31, 2011
IMPLEMENTATION DATE: May 31, 2011

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N	22/80-5010 - Background
N	22/90 - General Remittance Completion
N	22/100 - Remittance Balancing
N	22/110 - Electronic Remittance Advice – ERA or 835
N	22/110/110.1 - ANSI ASC X12N 835
N	22/110/110.2 - Generating an ERA if Required Data is Missing or Invalid
N	22/110/110.3 - Electronic Remittance Advice Data Sent to Banks
N	22/110/110.4 - Medicare Standard Electronic PC-Print Software for Institutional Providers
N	22/110/110.5 - Medicare Remit Easy Print Software for Professional Providers and Suppliers
N	22/110.6 - 835 Implementation Guide (IG) or Technical Report 3 (TR3)
N	22/120 - Standard Paper Remittance Advice
N	22/120/120.1 - The Do Not Forward (DNF) Initiative
N	22/120/120.2 - SPR Formats
N	22/120/120.2.1 - Part A (A/B MACs/FIs/RHHIs) SPR Format
N	22/120/120.2.2 - Part B (A/B MACs/Carriers/ /DME MACs) SPR Format
N	22/130 - Remittance Advice Codes
N	22/130.1 - Group Codes
N	22/130.2: - Claim Adjustment Reason Codes
N	22/130.3- Remittance Advice Remark Codes
N	22/130.4 - Requests for Additional Codes

III. FUNDING:

For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

**Unless otherwise specified, the effective date is the date of service.*

Attachment – Business Requirements

Pub. 100-04	Transmittal: 2205	Date: April 29, 2011	Change Request: 7308

SUBJECT: IOM 100-04 Chapter 22 Update for Remittance Advice for version 5010 - ASC X12N 005010A1 and Related Standard Paper Remittance (SPR)

EFFECTIVE DATE: May 31, 2011
IMPLEMENTATION DATE May 31, 2011

I. GENERAL INFORMATION

A. Background: The Centers for Medicare and Medicaid Services (CMS) is in the process of implementing the next version of the Health Insurance Portability and Accountability Act (HIPAA) transactions. The Secretary of the Department of Health and Human Services (DHHS) has adopted Accredited Standards Committee (ASC) X12 Version 5010, and the National Council for Prescription Drug Programs (NCPDP) Version D.0 as the next HIPAA transaction standards for covered entities to exchange HIPAA transactions. The final rule was published on January 16, 2009. Some of the important dates in the implementation process are:

Effective Date of the regulation:	March 17, 2009
Level I compliance by:	December 31, 2010
Level II Compliance by:	December 31, 2011
All covered entities have to be fully compliant on:	January 1, 2012

Level I compliance means "that a covered entity can demonstrate that it could create and receive compliant transactions, resulting from the compliance of all design/build activities and internal testing."

Level II compliance means "that a covered entity has completed end-to-end testing with each of its trading partners, and is able to operate in production mode with the new versions of the standards."

DHHS has promulgated in the Final Rules provisions which permit dual use of existing standards (ASC X12 4010A1 and NCPDP 5.1) and the new standards (5010 and D.0) from the March 17, 2009, effective date until the January 1, 2012 compliance date to facilitate testing subject to trading partner agreement.

This Change Request (CR) instructs the contractors that Chapter 22 – Remittance Advice – of the Claims Processing Manual has been updated to reflect changes to Medicare Fee-For-Service's Remittance Advice – both Electronic Remittance Advice (ERA) and Standard Paper Remittance Advice (SPR) to accommodate the new Health Insurance Portability and Accountability Act (HIPAA) standard – ASC X12N 835 version 005010A1. The updated version of Chapter 22 has been added with different numbers at the end of current Chapter 22..

B. Policy: CMS will implement the new HIPAA standard as adopted by the Secretary**.** Final Rules were published in the Federal Register on January 16, 2009, by the Department of Health and Human Services:: 45 CFR Part 162 and on October 13, 2010 HHS published a notification adopting the Errata documents for applicable 5010 transactions including 835.

C. Business Assumptions:

a) CMS expects that external testing of ACS X12N 835 will start on January 2011, but no Trading Partner will be migrated to 005010A1 production before April 2011 when CMS implements the Errata version of 835.

b) CMS expects that during the transition period January 2011-March, 2011 contractors shall be ready to send 835 in version 004010A1as well as test 835 in version 005010. From April 2011 to December

2011, contractors shall be ready to send 835 in version 4010A1as well as test and send 835 in version 005010A1 in production.

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7308.1	Contractors shall make sure that all requirements contained within Pub. 100-04 Chapter 22-Remittance Advice – have been appropriately implemented. Note: The requirements have been communicated and implemented through prior instructions from CMS in the form of CRs	X	X	X	X	X					CEDI

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	None										

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below:

X-Ref Requirement Number	Recommendations or other supporting information:
	NA

Section B: For all other recommendations and supporting information, use this space:
N/A

V. CONTACTS

Pre-Implementation Contact(s): Sumita Sen, (410) 786-5755, Sumita.Sen@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Technical Representative (COTR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),* and/or *Carriers*:

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: *For Medicare Administrative Contractors (MACs)*:

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

Medicare Claims Processing Manual
Chapter 22 - Remittance Advice

Table of Contents

(Rev.2205, Issued: 04-29-11)

80 - 5010A1 Background

(Rev 2205, Issued: 04-29-11, Effective: 05-31-11, Implementation: 05-31-11.)

A/B Medicare Administrative Contractors (A/B MACs), carriers, Durable Medical Equipment Medicare Administrative Contractors (DME MACs), Fiscal Intermediaries (FIs), and Regional Home Health Intermediaries (RHHIs) 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 during claim adjudication. For each claim or line item payment, and/or adjustment, there is an associated remittance advice item. Adjustment is defined as:

- *denied*
- *zero payment*
- *partial payment*
- *reduced payment*
- *penalty applied*
- *additional payment*
- *supplemental payment*

Payments and/or adjustments 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.

A/B MACs, carriers, and DME MACs also send informational RAs to nonparticipating physicians, suppliers, and non-physician practitioners billing non-assigned claims (billing and receiving payments from beneficiaries instead of accepting direct Medicare payments), unless the beneficiary or the provider requests that the remittance advice be suppressed. An informational RA is identical to other RAs, but must carry a standard message to notify providers 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 (see IOM 100-04, Chapter 30) applies.

Medicare contractors are allowed to charge up to a maximum of $25.00 for generating and mailing, if applicable, duplicate remittance advice (both electronic and paper) to recoup cost when generated at the request of a provider or any entity working on behalf of the provider. Under the Health Insurance Portability and Accountability Act (HIPAA) Administrative Provisions, the Secretary of Health and Human Services has adopted ANSI ASC X12 835 (Health Care Claim/Payment Advice)version 005010A1 to be the standard effective from January 1, 2012 replacing the current standard – ANSI ASC X12N 835 version 004010A1. Medicare is in the process of implementing the new version.
Some of the important dates in the implementation process are:

Effective Date of the regulation:	*March 17, 2009*
Level I compliance by:	*December 31, 2010*
Level II Compliance by:	*December 31, 2011*
All covered entities have to be fully compliant on:	*January 1, 2012*

Level I compliance means "that a covered entity can demonstrably create and receive compliant transactions, resulting from the compliance of all design/build activities and internal testing."

Level II compliance means that a "covered entity has completed end-to-end testing with each of its trading partners, and is able to operate in production mode with the new versions of the standards".

CMS shall be fully compliant on January 1, 2012, and achieve complete Level I compliancy by December 31, 2010, and Level II compliancy by December 31, 2011. The transition period when both versions would be allowed in production mode for Medicare will be from April 1, 2011 – December 31, 2011. The 835v4010A1 and the current Standard Paper Remittance (SPR) shall not be sent on or after January 1, 2012 irrespective of the date of receipt or date of service reported on the electronic or paper claim.

CMS is implementing the new HIPAA standard following the X12 Technical Report 3 (TR 3) for transaction 835 version 5010A1, and requires the use of this format exclusively for Electronic Remittance Advices (ERAs) on or after January 1, 2012. CMS has also established a policy that the paper formats shall mirror the ERAs as much as possible, and A/B MACs, carriers, DME MACs, FIs and RHHIs shall use the paper formats established by CMS.

The new HIPAA compliant version of the 835 includes some changes from the earlier standard version. For a side-by-side comparison of the 4010A1 and the 5010A1 flat files, go to:

http://www.cms.gov/ElectronicBillingEDITrans/18_5010D0.asp

One major change for Medicare would be a new REF segment at the 2110 Loop (Health Care Policy Identification) to report the actual Local Coverage Determination (LCD) and/or National Coverage Determination (NCD) code for LCD/NCD related denials. A new PER segment at the 1000A Loop (Payer Website) would provide the contractor specific web address to help providers identify the exact reason for denial. The X12 TR3 for version 005010 is available for a fee from Washington Publishing Company (WPC). Their Web site:

http://www-wpc-edi.com/HIPAA

ERRATA: After a lot of discussion about modifications needed to implement the new HIPAA standard (version 5010) correctly, X12N released the Errata for publication in early August of 2010, and they have been adopted by the Department of Health and Human Services (DHHS) in October, 2010. In simple terms, the Erratas are modifications to some of the TR3s – Transaction 835 is one of them. CMS will implement the changes that will impact Medicare and also update the relevant flat files to reflect the modifications whether the specific modification impacts Medicare or not. It is important to note that under these guidelines, both the sender and the receiver need to adopt if they are to perform a successful exchange of information. CMS expects that external testing will start on January 2011, but no receiver will be migrated to 5010A1A1 or 5010A1A2 production before April 2011. During the transition period January 2011-March, 2011 contractors shall be ready to receive/send all transactions in production mode in version 4010A1 as well as in test mode in version 5010. From April 2011 to December 2011, contractors shall be ready to receive/send all transactions in production mode in versions 4010A1 as well as 5010A1/5010A2 as appropriate and in test mode in versions 5010A1/5010A2 as appropriate. 835 ERRATA has only one impact for Medicare – version changed from 005010 to 005010A1.

By January 1, 2011 A/B MACs, carriers, DME MACs, FIs, and RHHIs must be able to issue 835 in version 5010 in test mode to any trading partner that is certified and requests testing. By April 4, 2011 A/B MACs, *carriers, DME MACs, FIs, and RHHIs must be able to issue 835s in test as well as production mode in version 5010A1. All Shared Systems will use the updated X12 based Flat File for transaction 835 in version 5010A1 by April 1, 2011.(Refer to CR 7202 issued on November 16, 2010). HIPAA requires CMS policy to change such that only the current version of electronic format will be maintain ned, not the current and the previous version, except during the transition period when both the current and the previous version must be maintained.*

Provider Identification:
Medicare requires claims to contain National Provider Identifiers (NPIs) to be accepted for adjudication. NPIs received on the claims are cross walked to Medicare assigned legacy numbers for adjudication. Adjudication is based on each unique combination of NPI/legacy number if there is no one-to-one relationship between the two. Any ERA or SPR sent after version 5010 has been implemented will have one of the 3 provider identifications: (1)Federal Taxpayer's Identification Number; (2) Centers for Medicare and Medicaid Services PlanID; (3) Centers for Medicare and Medicaid Services National Provider Identifier (NPI) as the provider ID instead of any Medicare assigned provider number at the provider level. NPI will be sent as the provider identification at the claim level. As the Rendering Provider Identifier at the service line level, any one of the following identifiers: (1) Centers for Medicare and Medicaid Services National Provider Identifier; (2) Social Security Number; (3) Federal Tax Payer's Identification Number; (4) Medicare Provider Number; (5) Provider UPIN Number – will be sent.

90 - General Remittance Completion Requirements

(Rev 2205, Issued: 04-29-11, Effective: 05-31-11, Implementation: 05-31-11)

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. Inpatient RAs do not report service line adjustment data; only summary claim level adjustment information is reported.

- *The computed field "Net" reported in the Standard Paper Remittance (SPR) notice must include "ProvPd" (Calculated Payment to Provider, CLP04 in the 835) and interest, late filing charges and previously paid amounts.*
- *The Medicare contractors report only one crossover payer name on both the ERA and SPR, even if coordination of benefits (COB) information is sent to more than one payer. The current HIPAA compliant version of 835 does not have the capacity to report more than one crossover carrier, and the SPR mirrors the 835.*
- *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.*

100 - Remittance Balancing

(Rev 2205, Issued: 04-29-11, Effective: 05-31-11, Implementation: 05-31-11)

For Medicare the principles of remittance balancing are the same for both paper and electronic remittance formats. Balancing requires that the total paid amount is equal to the total submitted charges plus or minus payment adjustments for a single 835 remittance in accordance with the rules of the standard 835 format. Refer to Front Matter Section 1.10.2.1 for Balancing in the 835 version 005010 Technical Report 3 (TR3). Every HIPAA compliant X12N 835 transaction issued by a Medicare contractor must comply with the ANSI ASC X12 835 version 005010 TR3 requirements, i.e., these remittances must balance at the service, claim and provider levels. The flat files generated by the shared systems must be balanced at the line, claim, and provider level – refer to 5010 Change Requests (CRs). As a failsafe measure claim adjustment reason codes A7 (Part A)/121 (Part B) and PLB reason code 90 may be used at the line, claim and provider level respectively to make sure that the 835 is balanced. Shared System generated reports must track the usage of these codes, and A/B MACs, FIs, RHHIs, carriers and DME MACs must work closely with the shared system maintainers and CMS to resolve the issues resulting in out of balance situations.

110 - Electronic Remittance Advice – ERA or 835

(Rev. 2205, Issued: 04-29-11, Effective: 05-31-11, Implementation: 05-31-11)

Electronic Remittance Advice (ERA) transactions must be produced in the current HIPAA compliant Accredited Standards Committee (ASC) X12N 835 version 005010A1 Directions for version updates are posted when necessary in CMS Change Request (CR) instructions issued by CMS. A series of CRs have been issued with instructions about changes from version 004010A1 to version 5010A1 and additional instructions may be sent in the future. Refer to http://www.wpc-edi.com/HIPAA for implementation guides, record formats, and data dictionaries for the 835. You can go to: ***http://www.cms.gov/Transmittals/*** *to download relevant CRs.*

Shared systems maintainers must provide appropriate provider file structures and switching mechanisms so that contractors can select and generate the 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.

110.1 - ANSI ASC X12N 835

(Rev. 2205, Issued: 04-29-11, Effective: 05-31-11, Implementation: 05-31-11)

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 or clearinghouse. See Chapter 24 for technical information about transmission of the 835. The updated flat files are posted at:

http://www.cms.hhs.gov/ElectronicBillingEDITrans/11_Remittance.asp#TopOfPage

Go to "Downloads", and click on the file you want.

Contractor requirements are:

- *Send the remittance data directly to providers or their designated billing services or clearinghouse;*
- *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 • 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;*
- *A/B MACs, FIs and RHHIs allow Part A providers to receive a Standard Paper Remittance Advice (SPR) in addition to the 835 during the first 30 days of receiving ERAs and during other testing. After that time, A/B Macs, FIs/and RHHIs 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 for a particular provider, and a waiver is needed;*
- *A/B MACs, carriers,, and DME MACs must suppress the distribution of SPRs to those Part B providers//suppliers (or a billing agent, clearing house or other entity receiving ERAs on behalf of those providers/suppliers) 45 days of receiving both SPR and ERA formats. In rare situations (e.g., natural or man-made disasters) exceptions to this policy may be allowed at the discretion of CMS. A/B MACs/carriers/and DME MACs should contact CMS if a waiver is needed."*
- *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.*
- *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 ANSI X12N 835 transaction issued by A/B MACs, carriers, DME MACs, FIs, and RHHIs must comply with the implementation guide (IG) requirements i.e., each required segment, and each situational segment when the situation applies, must be reported. 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. A/B MACs, carriers, DME MACs, FIs, and RHHIs are not required to validate codes maintained by their shared systems, such as Healthcare Common Procedure Coding System (HCPCS), that are issued in their shared 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 and remittance advice remark 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, 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.

Additionally A/B MACs and Common Electronic Data Interchange (CEDI) for DME MACs must follow the CMS instructions for Receipt, Control and Balancing.

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

(Rev 2205, Issued: 04-29-11, Effective: 05-31-11, Implementation: 05-31-11)

The ANSI X12N 835 IG contains specific data requirements, which must be met to build a HIPAA compliant ERA. A claim could be received on paper 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 MAC 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 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. Shared System Maintainers must follow CMS gap-filling instruction. The contractors must notify the trading partners, if and when their files are affected, as to when and why gap-filling characters will appear in an 835.

110.3 - Electronic Remittance Advice Data Sent to Banks

(Rev2205, Issued: 04-29-11, Effective: 05-31-11, Implementation: 05-31-11)

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, 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 non health data clearinghouse bank cannot receive 835 data, except as provided in table one.

110.4 - Medicare Standard Electronic PC-Print Software for Institutional Providers

(Rev. 2205, Issued: 04-29-11, Effective: 05-31-11, Implementation: 05-31-11)

PC Print software enables institutional providers to print remittance data transmitted by Medicare. A/B MACs /FIs/RHHIs are required to make PC Print software available to providers for downloading at no charge. FIs/RHHIs/A/B MACs may charge up to $25.00 per mailing to recoup cost if the software is sent to provider on a CD/DVD or any other means at provider's request when the software is available for downloading. This software must include self-explanatory loading and use information for providers. It should not be necessary to furnish provider training for use of PC Print software. A/B MACs /FIs/RHHIs must supply providers with PC-Print software within three weeks of request. The FI/RHHI/A/B MAC Shared System (FISS) maintainer will supply PC Print software and a user's guide for all A/B MACs /FIs/RHHIs. The FISS maintainer must assure that the PC Print software is modified as needed to correspond to updates in the ERA and SPR formats per CMS instruction.

Providers are responsible for any telecommunication costs associated with receipt of the 835, but the software itself can be downloaded 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;*
- *View and print remittance information on all claims included in the 835;*
- *View and print remittance information for a single claim;*
- *View and print a summary of claims billed for each Type of Bill (TOB) processed on this ERA;*
- *View and print a summary of provider payments.*

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. If software malfunctions are detected, they are to be corrected through the FISS maintainer. Individual A/B MACs /FIs/RHHIs or data centers may not modify the PC Print software. PC Print Software has been updated to accommodate 835 version 005010A1.

110.5 - Medicare Remit Easy Print Software for Professional Providers and Suppliers

(Rev. 2205, Issued: 04-29-11, Effective: 05-31-11, Implementation: 05-31-11)

CMS has developed software that gives professional providers/suppliers a tool to view and print an ERA in a human readable format. This software is called Medicare Remit Easy Print (MREP). It has been developed in response to comments that CMS has received from the provider/supplier community demonstrating a need for paper documents to reconcile accounts, and facilitate claim submission to secondary/tertiary payers. This software became available on October 11, 2005 to the providers through their respective carrier/A/B MACs/CEDI. The software is scheduled to be updated three times a year to *accommodate the Claim Adjustment Reason Code and Remittance Advice Remark Code tri-annual updates, and any applicable enhancements. In addition to these three regular updates, there will be an annual enhancement update, if needed.*

The MREP software enables providers to:

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

This software can be downloaded free of cost, but A/B MACs/carriers/CEDI may charge up to $25.00 per mailing to recoup cost if the software is sent to provider on a CD/DVD or any other means at provider's request when the software is available for downloading. MREP software has been updated to accommodate 835 version 005010A1.

110.6 – 835 Implementation Guide (IG) or Technical Report 3 (TR3)
(Rev2205, Issued: 04-29-11, Effective: 05-31-11, Implementation: 05-31-11)

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 version 005010A1 Technical Report 3 (TR3) has been established as the standard for compliance for remittance advice transaction. The TR3 or the Implementation Guide (IG) for the current HIPAA compliant version of the 835 is available electronically at:

http://www.wpc-edi.com/HIPAA

Although that TR3 or implementation guide contains requirements for use of specific segments and data elements within the segments, the guide was written for use by all health plans and not specifically for Medicare. However, a Companion Document has been prepared by CMS to clarify when conditional data elements and segments must be used for Medicare reporting 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 X12N 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 occur only when the loop is used. Similarly, nested loops occur only when the higher-level loop is used.*

Companion Documents for both Part A and Part B are available at:

http://www.cms.gov/ElectronicBillingEDITrans/30_CompanionGuides.asp#TopOfPage

120 - Standard Paper Remittance Advice

(Rev. 2205, Issued: 04-29-11, Effective: 05-31-11, Implementation: 05-31-11)

The Standard Paper Remittance (SPR) is the hard copy version of an ERA. All A/B MACs, carriers, DME MACs, FIs, and RHHIs must be capable of producing SPRs for providers who are unable or choose not to receive an ERA. A/B MACs, carriers, , DME MACs, FIs, and RHHIs suppress distribution of SPRs if a provider is also receiving ERAs for more than 30 days (institutional providers) or 45 days (professional providers/suppliers) respectively.

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 005010A1A1 data fields.

120.1 - The Do Not Forward (DNF) Initiative

(Rev2205, Issued: 04-29-11, Effective: 05-31-11, Implementation: 05-31-11)

As part of the Medicare DNF Initiative, A/B MACs, carriers, and DME MACs 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 followed for returned checks; that is:

- *Flag the provider "DNF"; • A/B MAC/carrier staff must notify the provider enrollment area, and DME*
MACs 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, contractors remove the DNF flag after the address has been*
verified, and pay the provider any funds still being held due to a DNF flag. Contractors must also reissue
any remittance that has been held as well.

NOTE: *Previously, CMS required corrections only 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 A/B MAC/carrier/FI/RHHII 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 for additional information pertaining to the DNF initiative.

120.2 - SPR Formats

(Rev. 2205, Issued: 04-29-11, Effective: 05-31-11, Implementation: 05-31-11)

The following sections contain the separate Part A (A/B MACs/FIs/RHHIs) and Part B (A/B MACs/carriers/ /DME MACs 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) or remark codes after first reason code or remark code line.

120.2.1 - Part A (A/B MACs /FIs/RHHIs/) SPR Format

(Rev. 2205, Issued: 04-29-11, Effective: 05-31-11, Implementation: 05-31-11

EXAMPLE:

```
INTERMEDIARY NAMEXXXXXXXXXXXXXXXXXXXX ADDERSS 1XXXXXXXXXXXXXXXXXXXXXXXXXX CITYXXXXXXXXXXXX ST ZIPXXXXXX
VER# XXXXXXX
 BUSINESS CONTACT NAMEXXXXXXXXXXXXXXX PHONE XXX-XXX-XXXX EXT XXX, FAX XXX-XXX-XXXX EXT XXX, EMAIL
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
 PROVIDER/NPI   PROVIDER NAME XXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXX  XXXXXXXXXXXXXX  XX  XXXXX
 PART A          PAID DATE: MM/DD/CCYY       REMIT#: 99999      PAGE:   99999
 PATIENT NAME           PATIENT CNTRL NUMBER    RC    REM  DRG#          DRG OUT AMT   COINSURANCE   PAT
REFUND     CONTRACT ADJ
 HIC NUMBER             ICN NUMBER              RC    REM  OUTCD         NEW TECH      COVD CHGS     ESRD
NET ADJ   PATIENT RESP
 FROM DT    THRU DT            HICHG  TOB       RC    REM  PROF COMP     MSP PAYMT     NCOVD CHGS
INTEREST       PROC CD AMT
 CLM STATUS             COST  COVDY   NCOVDY    RC    REM  DRG AMT       DEDUCTIBLES   DENIED CHGS   PRE PAY
ADJ    NET REIMB
 XXXXXXXXXXXXXXXXXX X X XXXXXXXXXXXXXXXXXXXX    XXX XXXXX XXXX            9999999.99    9999999.99
9999999.99     9999999.99
 XXXXXXXXXXXXXXXXXXX    XXXXXXXXXXXXXXXXXXXXXXX XXX XXXXX    XX           9999999.99    9999999.99
9999999.99     9999999.99
 MM/DD/CCYY MM/DD/CCYY           X     XXX      XXX XXXXX  9999999.99     9999999.99    9999999.99
9999999.99     9999999.99
      XX               999  9999     9999       XXX XXXXX  9999999.99     9999999.99    9999999.99
9999999.99     9999999.99
 SUBTOTAL FISCAL YEAR - CCYY                                             99999999.99   99999999.99
99999999.99    99999999.99
                                                                         99999999.99   99999999.99

99999999.99
                                                           99999999.99   99999999.99   99999999.99

99999999.99    99999999.99
                       999  9999     9999                  99999999.99   99999999.99   99999999.99
99999999.99
 SUBTOTAL PART A                                                         99999999.99   99999999.99
99999999.99    99999999.99
                                                                         99999999.99   99999999.99

99999999.99
                                                           99999999.99   99999999.99   99999999.99

99999999.99    99999999.99
                       999  9999     9999                  99999999.99   99999999.99   99999999.99
99999999.99


WHEN THE REMITTANCE IS FOR A HOME HEALTH PROVIDER THERE WILL BE A SUBTOTAL BY HOME HEALTH TYPE OF BILLS 32X
AND 33X



INTERMEDIARY NAMEXXXXXXXXXXXXXXXXXXXX  ADDERSS 1XXXXXXXXXXXXXXXXXXXXXXXXXX CITYXXXXXXXXXXXX ST  ZIPXXXXXX
VER# XXXXXXX
 BUSINESS CONTACT NAMEXXXXXXXXXXXXXXX PHONE XXX-XXX-XXXX EXT XXX, FAX XXX-XXX-XXXX EXT XXX, EMAIL
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
 PROVIDER/NPI   PROVIDER NAME XXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXX  XXXXXXXXXXXXXX  XX  XXXXX
 PART B          PAID DATE: MM/DD/CCYY       REMIT#: 99999      PAGE:   99999
 PATIENT NAME           PATIENT CNTRL NUMBER    RC    REM  DRG#          DRG OUT AMT   COINSURANCE   PAT
REFUND     CONTRACT ADJ
 HIC NUMBER             ICN NUMBER              RC    REM  OUTCD         NEW TECH      COVD CHGS     ESRD
NET ADJ   PATIENT RESP
 FROM DT    THRU DT            HICHG  TOB       RC    REM  PROF COMP     MSP PAYMT     NCOVD CHGS
INTEREST       PROC CD AMT
```

```
 CLM STATUS             COST  COVDY   NCOVDY    RC   REM  DRG AMT       DEDUCTIBLES   DENIED CHGS   PRE PAY
ADJ    NET REIMB
 XXXXXXXXXXXXXXXXXX X X XXXXXXXXXXXXXXXXXXXX    XXX XXXXX XXXX           9999999.99    9999999.99
9999999.99     9999999.99
 XXXXXXXXXXXXXXXXXXX    XXXXXXXXXXXXXXXXXXXXXXX XXX XXXXX    XX          9999999.99    9999999.99
9999999.99     9999999.99
 MM/DD/CCYY MM/DD/CCYY           X     XXX      XXX XXXXX  9999999.99    9999999.99    9999999.99
9999999.99     9999999.99
      XX               999  9999     9999       XXX XXXXX  9999999.99    9999999.99    9999999.99
9999999.99     9999999.99
 SUBTOTAL FISCAL YEAR - CCYY                                            99999999.99   99999999.99
99999999.99    99999999.99
                                                                        99999999.99   99999999.99
99999999.99
                                                          99999999.99   99999999.99   99999999.99
99999999.99    99999999.99
                       999  9999     9999                 99999999.99   99999999.99   99999999.99
99999999.99
 SUBTOTAL PART B                                                        99999999.99   99999999.99
99999999.99    99999999.99
                                                                        99999999.99   99999999.99
99999999.99
                                                          99999999.99   99999999.99   99999999.99
99999999.99    99999999.99
                       999  9999     9999                 99999999.99   99999999.99   99999999.99
99999999.99


WHEN THE REMITTANCE IS FOR A HOME HEALTH PROVIDER THERE WILL BE A SUBTOTAL BY HOME HEALTH TYPE OF BILLS 34X



INTERMEDIARY NAMEXXXXXXXXXXXXXXXXXXX  ADDERSS 1XXXXXXXXXXXXXXXXXXXXXXXXXX CITYXXXXXXXXXXXX ST  ZIPXXXXXX
VER# XXXXXXX
 BUSINESS CONTACT NAMEXXXXXXXXXXXXXX PHONE XXX-XXX-XXXX EXT XXX, FAX XXX-XXX-XXXX EXT XXX, EMAIL
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
 PROVIDER/NPI   PROVIDER NAME XXXXXXXXXXXXXXXXXXXXXX  XXXXXXXXXXXXXX  XXXXXXXXXXXXXX  XX  XXXXX
                                        S U M M A R Y     PAID DATE: MM/DD/CCYY       REMIT#: 99999
PAGE:   99999
 CLAIM DATA:                           PASS THRU AMOUNTS:
                                           CAPITAL                   :  99,999,999.99    PROVIDER PAYMENT
RECAP    :
 DAYS           :                          RETURN ON EQUITY          :  99,999,999.99
  COST          : 999999999                DIRECT MEDICAL EDUCATION  :  99,999,999.99      PAYMENTS
:
  COVDY         :    999999                KIDNEY ACQUISITION        :  99,999,999.99         DRG OUT AMT
:  99,999,999.99
  NCOVDY        :    999999                BAD DEBT                  :  99,999,999.99         INTEREST
:  99,999,999.99
                                           NON PHYSICIAN ANESTHETISTS:  99,999,999.99         PROC CD AMT
:  99,999,999.99
 CHARGES        :                              TOTAL PASS THRU       :  99,999,999.99         NET REIMB
:  99,999,999.99
  COVD          : 99,999,999.99                                                               TOTAL PASS
THRU      :  99,999,999.99
  NCOVD         : 99,999,999.99        PIP PAYMENT                   :  99,999,999.99         PIP PAYMENTS
:  99,999,999.99
  DENIED        : 99,999,999.99        SETTLEMENT PAYMENTS           :  99,999,999.99         SETTLEMENT
PYMTS     :  99,999,999.99
                                       ACCELERATED PAYMENTS          :  99,999,999.99         ACCELERATED
PAYMENTS:  99,999,999.99
                                       REFUNDS                       :  99,999,999.99         REFUNDS
:  99,999,999.99
 PROF COMP      : 99,999,999.99        PENALTY RELEASE               :  99,999,999.99         PENALTY
RELEASE      :  99,999,999.99
 MSP PYMT       : 99,999,999.99        TRANS OUTP PYMT               :  99,999,999.99         TRANS OUTP
PYMT      :  99,999,999.99
 DEDUCTIBLES    : 99,999,999.99        HEMOPHILIA ADD-ON             :  99,999,999.99         HEMOPHILIA
ADD-ON    :  99,999,999.99
 COINSURANCE    : 99,999,999.99        NEW TECH ADD-ON               :  99,999,999.99         NEW TECH ADD-
ON      :  99,999,999.99
```

```
                                        VOID/REISSUE                : 99,999,999.99        VOID/REISSUE
:  99,999,999.99
                                        935 PAYMENTS                : 99,999,999.99        935 PAYMENTS
:  99,999,999.99
                                                                                           BALANCE
FORWARD       :  99,999,999.99
 PAT REFUND      : 99,999,999.99        WITHHOLD FROM PAYMENTS      :                      WITHOLD
:  99,999,999.99
 INTEREST        : 99,999,999.99            CLAIMS ACCOUNTS RECEIVABLE: 99,999,999.99
 CONTRACT ADJ    : 99,999,999.99            ACCELERATED PAYMENTS    : 99,999,999.99        NET PROVIDER
PAYMENT :  99,999,999.99
 PROC CD AMT     : 99,999,999.99            PENALTY                 : 99,999,999.99       (PAYMENTS
MINUS WITHOLD)
 NET REIMB       : 99,999,999.99            SETTLEMENT              : 99,999,999.99       CHECK/EFT
NUMBER       :      9999999999
                                            THIRD PARTY PAYMENT     : 99,999,999.99
                                            AFFILIATED WITHHOLDING  : 99,999,999.99
                                            935 WITHHOLDING         : 99,999,999.99
                                            FEDERAL PAYMENT LEVY    : 99,999,999.99
                                            NON-TAX FPLP            : 99,999,999.99
                                            TOTAL WITHHOLD          : 99,999,999.99
```

Note: when there is a dollar value in the Federal Payment Levy or Non-Tax FPLP a phone number will be in this section.

SPR and 4010A1/5010A1 Comparison:

	Remittance Field	**Loop ID**	**835 V 5010A1A1**	**Loop ID**	**835 V 4010 A1**	**Comments**
Line 1	FI/MAC Name	1000 A	N102	RT10	Field 14	
	FI/MAC Address	1000 A	N301	RT10	Field 17	
	FI/MAC City	1000 A	N401	RT10	Field 19	
	FI/MAC State	1000 A	N402	RT10	Field 20	
	FI/MAC Zip Code	1000 A	N403	RT10	Field 21	
	VER #		ISA12			
Line 2	FI/MAC Business Contact Name	1000 A	PER02	N/A	N/A	Not Used in 4010A1.
	Telephone Number and Extension	1000 A	PER04/06/08	N/A	N/A	Not Used in 4010A1.
	FAX Number and Extension	1000 A	PER04/06/08	N/A	N/A	Not Used in 4010A1.
	Email Address	1000 A	PER04/06	N/A	N/A	Not Used in 4010A1.
Line 3	Provider Number/NPI	1000 B	N104	RT15	Field 16	
	Provider Name	1000 B	N102	RT15	Field 14	
	Provider Address	1000 B	N301	RT15	Field 17	
	Provider City	1000 B	N401	RT15	Field 19	
	Provider State	1000 B	N402	RT15	Field 20	

	Provider Zip Code	1000 B	N403	RT15	Field 21	
Line 4	Section Header (Part A or Part B)					This is system set.
	Paid Date	Header	BPR16	RT01	Field 28	
	Remit #	Header	TRN02	RT01	Field 31	
	Page:					This is system set.
Line 5	Patient Name	2100	NM103/04/05	RT40	Field 15, 16, 17	
	Patient Control Number	2100	CLP01	RT30	Field 13	
	RC (Adjustment Reason Code)	2100	CAS02/05/08/11/14/17	RT31	Fields 14, 17, 20, 23	
	REM (Remark Code)	2100	MIA05/MOA03	RT42/ RT43	Field 17/15	MIA for Inpatient Claims and MOA for Outpatient Claims
	DRG #	2100	CLP11	RT30	Field 20	
	DRG OUT AMT	2100	MIA14	RT44	Field 32	
	Coinsurance	2100	CAS02/05/08/11/14/17	RT31/ RT51	Fields 14, 17, 20, 23, etc.	When CAS Adjustment equals 2
	Pat Refund					This is system set. Bene Reimbursement Amt, claim page 10.
	Contract Adj	2100/ 2110	CAS02/05/08/11/14/17	RT31/ RT51	Fields 14, 17, 20, 23, etc.	When Group Code is CO as we do today
Line 6	HIC Number	2100	NM109	RT40	Field 19	
	ICN Number	2100	CLP07	RT30	Field 7	
	RC (Adjustment Reason Code)	2100	CAS02/05/08/11/14/17	RT31	Fields 14, 17, 20, 23	

	REM (Remark Code)	2100	MIA20/MOA04	RT42/ RT43	Field 32/116	MIA for Inpatient Claims and MOA for Outpatient Claims. RT42 for Inpatient and RT43 for Outpatient
	OUTCD		Populate as we do 4010A1		TS208 & TS209 Inpatient Only	Outlier
	New Tech/ECT		Populate as we do 4010A2			Value code 77
	COVD CHGS	2100	AMT01	RT44	Field 34	When qualifier equals AU
	ESRD Net Adj	2100	MOA08	RT43	Field 20	
Line 7	From DT	2100	DTM02	RT44	Field 18	When qualifier equals 232
	Thru DT	2100	DTM02	RT45	Field 19	When qualifier equals 233
	HICHG	2100	NM108	RT40	Field 22	
	TOB	2000	CLP08/09	RT30	Fields 18 & 19	
	RC (Adjustment Reason Code)	2100	CAS02/05/08/11/14/17	RT31	Fields 14, 17, 20, 23	
	REM (Remark Code)	2100	MIA21/MOA05	RT42/ RT43	Field 33/17	MIA for Inpatient Claims and MOA for Outpatient Claims
	Prof Comp	2100	MIA19/MOA09	RT43	Field 21	
	MSP Paymt		Populate as we do 4010A1			MSP Value codes
	Ncovd Chgs	2100	QTY02	RT30	Field 27	When qualifier equals NE
	Interest	2100	AMT02	RT44	Field 30	When qualifier equals I

	Proc CD Amt	2100	MOA02			Payable amount from the line when HCPC present
Line 8	CLM Status	2100	CLP02	RT30	Field 14	
	Cost	2100	MIA15	RT42	Field 27	Value code amt.
	Covdy	2100	QTY01	RT44	Field 36	
	Ncovdy	2100	QTY02	RT44	Field 38	Value code 81
	RC (Adjustment Reason Code)	2100	CAS02/05/08/11/14/17	RT31	Fields 14, 17, 20, 23	
	REM (Remark Code)	2100	MIA22/MOA06	RT42/RT43	Field 34/18	MIA for Inpatient Claims and MOA for Outpatient Claims
	DRG Amt	2100	MIA04	RT42	Field 16	
	Deductibles	2100	CLP05	RT31/RT51	Fields 14, 17, 20, 23, etc.	When CAS Adjustment equals 1
	Denied Chgs			RT30	Field 28	Treat as current
	Pre Pay Adj	2100/2110	CAS02/05/08/11/14/17	RT31/RT51	Fields 14, 17, 20, 23, etc.	When CAS Adjustment equal A7.
	Net Reimb	2100	CLP04	RT30	Field 16	
Subtotal Fiscal Year						This is system calculated
Subtotal Part A or Part B for Home Health Type of Bills when Provider is a Home Health Provider						This is system calculated
Subtotal Part A or Part B						This is system calculated
Summary Page						
Line 1	FI/MAC Name	1000A	N102	RT10	Field 14	
	FI/MAC Address	1000A	N301	RT10	Field 17	
	FI/MAC City	1000A	N401	RT10	Field 19	

	FI/MAC State	1000 A	N402	RT10	Field 20	
	FI/MAC Zip Code	1000 A	N403	RT10	Field 21	
	VER #		ISA12			
Line 2	FI/MAC Business Contact Name	1000 A	PER02	N/A	N/A	
	Telephone Number and Extension	1000 A	PER04/06/08	N/A	N/A	
	FAX Number and Extension	1000 A	PER04/06/08	N/A	N/A	
	Email Address	1000 A	PER04/06	N/A	N/A	
Line 3	Provider Number/NPI	1000 B	N104	RT15	Field 16	
	Provider Name	1000 B	N102	RT15	Field 14	
	Provider Address	1000 B	N301	RT15	Field 17	
	Provider City	1000 B	N401	RT15	Field 19	
	Provider State	1000 B	N402	RT15	Field 20	
	Provider Zip Code	1000 B	N403	RT15	Field 21	
Line 4	Section Header (Summary)					This is system set.
	Paid Date	Header	BPR16	RT01	Field 28	
	Remit #	Header	TRN02	RT01	Field 31	
	Page:					This is system set.
Line 5	Section Header (Claim Data:)					This is system set.
	Section Header (Pass Thru Amounts:)					This is system set.
	Section Header (Provider Payment Recap:)					This is system set.
Line 6	**PLB03-1 & 2 Code Values will not be included in SPR unless otherwise directed by CMS. ERA and the SPR are being developed with the 4010A1 PLB codes until the CMS PLB Change Request (CR 7068) is implemented.**					
	Capital :		PLB04/06/08/10/12/14	RT60	Fields 13, 16, 19, 22, etc.	When PLB03-1/05-1/07-1/09-1/11-1/13-1 is CV and PLB03-2/05-2/07-2/09-2/11-2/13-2 is CP. This is for 4010A1 and 5010A1.

Line 7	Header - Days :					This is system set.
	Return on Equity :		PLB04/06/08/10/12/14	RT60	Fields 13, 16, 19, 22, etc.	When PLB03-1/05-1/07-1/09-1/11-1/13-1 is RE and PLB03-2/05-2/07-2/09-2/11-2/13-2 is RE. This is for 4010A1 and 5010A1.
Line 8	Cost :					The system calculates this amount from the claims detail.
	Direct Medical Education :		PLB04/06/08/10/12/14	RT60	Fields 13, 16, 19, 22, etc.	When PLB03-1/05-1/07-1/09-1/11-1/13-1 is DM and PLB03-2/05-2/07-2/09-2/11-2/13-2 is DM. This is for 4010A1 and 5010A1.
	Header - Payments					This is system set.
Line 9	Covdy :					The system calculates this amount from the claims detail.
	Kidney Acquisition :		PLB04/06/08/10/12/14	RT60	Fields 13, 16, 19, 22, etc.	When PLB03-1/05-1/07-1/09-1/11-1/13-1 is OA and PLB03-2/05-2/07-2/09-2/11-2/13-2 is KA. This is for 4010A1 and 5010A1.
	DRG Out Amt :					The system calculates this amount from the claims detail.

Line 10	*Ncovdy :*					*The system calculates this amount from the claims detail.*
	Bad Debt :		*PLB04/06/08/10/12/14*	*RT60*	*Fields 13, 16, 19, 22, etc.*	*When PLB03-1/05-1/07-1/09-1/11-1/13-1 is BD and PLB03-2/05-2/07-2/09-2/11-2/13-2 is BD. This is for 4010A1 and 5010A1.*
	Interest :		*PLB04/06/08/10/12/14*	*RT20*	*Field 20*	*When PLB03-1/05-1/07-1/09-1/11-1/13-1 is L6 and PLB03-2/05-2/07-2/09-2/11-2/13-2 is IN. This is for 5010A1.*
Line 11						
	Non Physician Anesthetists :		*PLB04/06/08/10/12/14*	*RT60*	*Fields 13, 16, 19, 22, etc.*	*When PLB03-1/05-1/07-1/09-1/11-1/13-1 is CW and PLB03-2/05-2/07-2/09-2/11-2/13-2 is CR. This is for 4010A1 and 5010A1.*
	Proc CD Amt :					*The system calculates this amount from the claims detail.*
Line 12	*Header - Charges*					*This is system set.*
	Total Pass Thru :					*This is system calculated.*
	Net Reimb :					*This is system calculated.*

Line 13	*Covd :*					*The system calculates this amount from the claims detail.*
	Total Pass Thru :					*This is system calculated.*
Line 14	*Ncovd :*					*The system calculates this amount from the claims detail.*
	PIP Payment :		*PLB04/06/08/10/12/14*	*RT60*	*Fields 13, 16, 19, 22, etc.*	*When PLB03-1/05-1/07-1/09-1/11-1/13-1 is PI and PLB03-2/05-2/07-2/09-2/11-2/13-2 is PP. This is for 4010A1 and 5010A1.*
	PIP Payment :		*PLB04/06/08/10/12/15*	*RT60*	*Fields 13, 16, 19, 22, etc.*	*When PLB03-1/05-1/07-1/09-1/11-1/13-1 is PI and PLB03-2/05-2/07-2/09-2/11-2/13-2 is PP. This is for 4010A1 and 5010A1.*
Line 15	*Denied :*					*The system calculates this amount from the claims detail.*

	Settlement Payments :		PLB04/06/08/10/12/14	RT60	Fields 13, 16, 19, 22, etc.	When PLB03-1/05-1/07-1/09-1/11-1/13-1 is IS, PL, RA, C5 and PLB03-2/05-2/07-2/09-2/11-2/13-2 is IR, FS, TR, TS respectively. . This is for 4010A1 and 5010A1.
	Settlement Pymts :		PLB04/06/08/10/12/15	RT60	Fields 13, 16, 19, 22, etc.	When PLB03-1/05-1/07-1/09-1/11-1/13-1 is IS, PL, RA, C5 and PLB03-2/05-2/07-2/09-2/11-2/13-2 is IR, FS, TR, TS respectively. . This is for 4010A1 and 5010A1.
Line 16						
	Accelerated Payments :		PLB04/06/08/10/12/14	RT60	Fields 13, 16, 19, 22, etc.	When PLB03-1/05-1/07-1/09-1/11-1/13-1 is AP and PLB03-2/05-2/07-2/09-2/11-2/13-2 is AP. This is for 4010A1 and 5010A1.
	Accelerated Payments :		PLB04/06/08/10/12/15	RT60	Fields 13, 16, 19, 22, etc.	When PLB03-1/05-1/07-1/09-1/11-1/13-1 is AP and PLB03-2/05-2/07-2/09-2/11-2/13-2 is AP. This is for 4010A1 and 5010A1.
Line 17						

	Refunds :		PLB04/06/08/10/12/14	RT60	Fields 13, 16, 19, 22, etc.	When PLB03-1/05-1/07-1/09-1/11-1/13-1 is B2 and PLB03-2/05-2/07-2/09-2/11-2/13-2 is RF. This is for 4010A1 and 5010A1.
	Refunds :		PLB04/06/08/10/12/15	RT61	Fields 13, 16, 19, 22, etc.	When PLB03-1/05-1/07-1/09-1/11-1/13-1 is B2 and PLB03-2/05-2/07-2/09-2/11-2/13-2 is RF. This is for 4010A1 and 5010A1.
Line 18	Prof Comp :					The system calculates this amount from the claims detail.
	Penalty Release :		PLB04/06/08/10/12/14	RT60	Fields 13, 16, 19, 22, etc.	When PLB03-1/05-1/07-1/09-1/11-1/13-1 is L3 and PLB03-2/05-2/07-2/09-2/11-2/13-2 is RS. This is for 4010A1 and 5010A1.
	Penalty Release :		PLB04/06/08/10/12/14	RT60	Fields 13, 16, 19, 22, etc.	When PLB03-1/05-1/07-1/09-1/11-1/13-1 is L3 and PLB03-2/05-2/07-2/09-2/11-2/13-2 is RS. This is for 4010A1 and 5010A1.
Line 19	MSP Paymt :					Sum of all detail MSP Pay.

	Trans OutP Pymt :		PLB04/06/08/10/12/14	RT60	Fields 13, 16, 19, 22, etc.	When PLB03-1/05-1/07-1/09-1/11-1/13-1 is IR and PLB03-2/05-2/07-2/09-2/11-2/13-2 is IS. This is for 4010A1 and 5010A1.
	Trans OutP Pymt :		PLB04/06/08/10/12/14	RT60	Fields 13, 16, 19, 22, etc.	When PLB03-1/05-1/07-1/09-1/11-1/13-1 is IR and PLB03-2/05-2/07-2/09-2/11-2/13-2 is IS. This is for 4010A1 and 5010A1.
Line 20	*Deductibles :*					*The system calculates this amount from the claims detail.*
	Hemophilia Add-On :		PLB03-1/06/08/10/12/14 value HM	RT60	Fields 13, 16, 19, 22, etc.	When PLB03-1/05-1/07-1/09-1/11-1/13-1 is ZZ and PLB03-2/05-2/07-2/09-2/11-2/13-2 is ??. This is for 4010A1. Dollar amount based on HCPC submitted on claim.

	Hemophilia Add-On :		*PLB03-1/04/06/08/10/12/14*	*RT60*	*Fields 13, 16, 19, 22, etc.*	*When PLB03-1/05-1/07-1/09-1/11-1/13-1 is ZZ and PLB03-2/05-2/07-2/09-2/11-2/13-2 is ??. This is for 4010A1. Dollar amount based on HCPC submitted on claim.*
Line 21	*Coinsurance :*					*The system calculates this amount from the claims detail.*
	New Tech/ECT Add-On :		*PLB04/06/08/10/12/14*	*RT60*	*Fields 13, 16, 19, 22, etc.*	*Sum of all detail.*
	New Tech/ECT Add-On :		*PLB04/06/08/10/12/15*	*RT61*	*Fields 13, 16, 19, 22, etc.*	*Sum of all detail.*
Line 22						
	Void/Reissue :		*PLB04/06/08/10/12/14*	*RT60*	*Fields 13, 16, 19, 22, etc.*	*When PLB03-1/05-1/07-1/09-1/11-1/13-1 is CS and PLB03-2/05-2/07-2/09-2/11-2/13-2 is RI. This is for 4010A1 and 5010A1.*
	Void/Reissue :		*PLB04/06/08/10/12/14*	*RT60*	*Fields 13, 16, 19, 22, etc.*	*When PLB03-1/05-1/07-1/09-1/11-1/13-1 is CS and PLB03-2/05-2/07-2/09-2/11-2/13-2 is RI. This is for 4010A1 and 5010A1.*

Line 23						
	935 Payments :		*PLB04/06/08/10/12/14*	*RT60*	*Fields 13, 16, 19, 22, etc.*	*When PLB03-1/05-1/07-1/09-1/11-1/13-1 is PL and PLB03-2/05-2/07-2/09-2/11-2/13-2 is 935. This is for 4010A1 and 5010A1.*
	935 Payments :		*PLB04/06/08/10/12/15*	*RT60*	*Fields 13, 16, 19, 22, etc.*	*When PLB03-1/05-1/07-1/09-1/11-1/13-1 is PL and PLB03-2/05-2/07-2/09-2/11-2/13-2 is 935. This is for 4010A1 and 5010A1.*
Line 24						
	Balance Forward :		*PLB04/06/08/10/12/15*	*RT60*	*Fields 13, 16, 19, 22, etc.*	*When PLB03-1/05-1/07-1/09-1/11-1/13-1 is FB and PLB03-2/05-2/07-2/09-2/11-2/13-2 is CO. This is for 4010A1 and 5010A1.*
Line 25	*Pat Refund :*					*This is system calculated from claim detail.*
	Header - Withhold From Payments					*This is system set.*
	Withhold :					*This is system calculated.*
Line 26	*Interest :*					*The system calculates this amount from the claims detail.*

	Claims Accounts Receivable :		PLB04/06/08/10/12/14	RT60	Field 31	When PLB03-1/05-1/07-1/09-1/11-1/13-1 is E3 and PLB03-2/05-2/07-2/09-2/11-2/13-2 is CW. This is for 5010A1.
Line 27	Contract Adj :					The system calculates this amount from the claims detail.
	Accelerated Payments :		PLB04/06/08/10/12/14	RT60	Fields 13, 16, 19, 22, etc.	When PLB03-1/05-1/07-1/09-1/11-1/13-1 is AP and PLB03-2/05-2/07-2/09-2/11-2/13-2 is AW. This is for 4010A1 and 5010A1.
	Net Provider Payment :	Header	BPR02	RT01	Field 15	
Line 28	Proc CD Amt :					The system calculates this amount from the claims detail.
	Penalty :		PLB04/06/08/10/12/14	RT60	Fields 13, 16, 19, 22, etc.	When PLB03-1/05-1/07-1/09-1/11-1/13-1 is L3 and PLB03-2/05-2/07-2/09-2/11-2/13-2 is PW. This is for 4010A1 and 5010A1.
	(Payments Minus Withhold)					
Line 29	Net Reimb :					The system calculates this amount.

	Settlement :		*PLB04/06/08/10/12/14*	*RT60*	*Fields 13, 16, 19, 22, etc.*	*When PLB03-1/05-1/07-1/09-1/11-1/13-1 is L3 and PLB03-2/05-2/07-2/09-2/11-2/13-2 is SW. This is for 4010A1 and 5010A1.*
	Check/EFT Number :	*Header*	*TRN02*	*RT01*	*Field 30*	
Line 30						
	Third Party Payment :		*PLB04/06/08/10/12/14*	*RT60*	*Fields 13, 16, 19, 22, etc.*	*When PLB03-1/05-1/07-1/09-1/11-1/13-1 is L3 and PLB03-2/05-2/07-2/09-2/11-2/13-2 is ??. This is for 4010A1 and 5010A1.*
Line 31						
	Affiliated Withholding :		*PLB04/06/08/10/12/14*	*RT60*	*Fields 13, 16, 19, 22, etc.*	*When PLB03-1/05-1/07-1/09-1/11-1/13-1 is OB and PLB03-2/05-2/07-2/09-2/11-2/13-2 is ??. This is for 4010A1 and 5010A1.*
Line 32	*935 Withholding :*		*PLB04/06/08/10/12/14*	*RT60*	*Fields 13, 16, 19, 22, etc.*	*When PLB03-1/05-1/07-1/09-1/11-1/13-1 is WO and PLB03-2/05-2/07-2/09-2/11-2/13-2 is 935. This is for 4010A1 and 5010A1.*

Line 33							
	Federal Payment Levy :		*PLB04/06/08/10/12/14*	*RT60*	*Fields 13, 16, 19, 22, etc.*	*When PLB03-1/05-1/07-1/09-1/11-1/13-1 is LE and PLB03-2/05-2/07-2/09-2/11-2/13-2 is Treasury Tax withhold. This is for 4010A1 and 5010A1.*
Line 34							
	Non-Tax FPLP :		*PLB04/06/08/10/12/14*	*RT60*	*Fields 13, 16, 19, 22, etc.*	*When PLB03-1/05-1/07-1/09-1/11-1/13-1 is WU and PLB03-2/05-2/07-2/09-2/11-2/13-2 is Treasury Tax withhold. This is for 4010A1 and 5010A1.*
Line 35	*Total Withhold :*					*This is system calculated.*

120.2.2 - Part B (A/B MAC /Carrier/ /DME MAC) SPR Format

(Rev. 2205, Issued: 04-29-11, Effective: 05-31-11, Implementation: 05-31-11)

Example of updated SPR - Professional

Format of Carrier and Provider Identification Section

```
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX          <-- (Carrier Contact:)
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX <-- (Carrier name)                          MEDICARE
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX <-- (Carrier address 1)                     REMITTANCE
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX <-- (Carrier address 2)                       Advice
XXXXXXXXXXXXXXXXXXXXXXXX, XX 99999-9999  <-- (Carrier city, state, and zip)
(999) 999-9999                           <-- (Carrier telephone number)
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX <-- (Carrier website URL)

(Provider
 name) -->  XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX              PROVIDER #:  XXXXXXXXXX
            XXXXXXXXXX...       <-- (Provider address 1)   PAGE #:      1 OF 999
            XXXXXXXXXX...       <-- (Provider address 2)   DATE:       MM/DD/YY
(Provider --> XXXXXXXXX..., XX  99999...                  CHECK/EFT #: XXXXXXXXX
city, state, and zip)
```

Format of Claim Detail Section

The addition of Health Care Policy Identifiers (HCPI) required 4 detail level HCPIs to be recorded on the claim record. The HCPIs added were a length of 11.

```
PERF PROV  SERV DATE  POS NOS  PROC   MODS  BILLED    ALLOWED  DEDUCT      COINS      GRP/RC-AMT    PROV PD
________________________________________________________________________________________________________________
NAME XXXXXXXXXXXXX, XXXXXXXX  HIC XXXXXXXXXXXX  ACNT XXXXXXXXXXXXXXXXX  ICN XXXXXXXXXXXXX    ASG Y  MOA XXXXX XXXXX
                                                                                                XXXXX XXXXX XXXXX
XXXXXXXXXX MMDD MMDDYY XX 9999.9 XXXXX  AA  9999999.99 9999999.99 99999.99    99999.99  XX-XXX 99999.99 9999999.99
                             (XXXXX)                                                     XX-XXX 99999.99
                                                                                         XX-XXX 99999.99
REM: XXXXX XXXXX XXXXX XXxxx xxxxx                                                       XX-XXX 99999.99
HCPI: XXXXXXXXXXX   XXXXXXXXXXX XXXXXXXXXXX  XXXXXXXXXXX                                  XX-XXX 99999.99

XXXXXXXXXX MMDDYY    XX 9999.9 XXXXX  AA  9999999.99 9999999.99 99999.99    99999.99    XX-XXX 99999.99 9999999.99
                             (XXXXX)                                                     XX-XXX 99999.99
                                                                                         XX-XXX 99999.99
                                                                                         XX-XXX 99999.99
                                                                                         XX-XXX 99999.99
REM: xxxxx xxxxx xxxxx xxxxx xxxxx                                                       XX-XXX 99999.99
HCPI  xxxxxxxxxxx xxxxxxxxxxx xxxxxxxxxxx xxxxxxxxxxx                                    XX-XXX 99999.99
PT RESP 9999999.99         CLAIM TOTAL   9999999.99 9999999.99  99999.99    99999.99         9999999.99 9999999.99

ADJ TO TOTALS:  PREV PD    9999999.99      INTEREST 9999999.99    LATE FILING CHARGE 9999999.99   OTHER  XX-XXX 9999999.99
CLAIM INFORMATION FORWARDED TO: XXXXXXXXXXXXXXXXXXXXXXXXXXX                                          NET 9999999.99
```

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130 - Remittance Advice Codes

(Rev. 2205, Issued: 04-29-11, Effective: 05-31-11, Implementation: 05-31-11)

The remittance advice provides explanation of any adjustment(s) made to the payment. The difference between the submitted charge and the actual payment must be accounted for in order for the 835 to balance. The term "adjustment" may mean any of the following:

- *denied*

- *zero payment*

• partial payment

• reduced payment

• penalty applied

• additional payment

• supplemental payment

Group Codes, Claim Adjustment Reason Codes and Remittance Advice Remark Codes are used to explain adjustments at the claim or service line level. Provider Level Adjustment or PLB Reason Codes are used to explain any adjustment at the provider level.

130.1 Group Codes

(Rev. 2205, Issued: 04-29-11, Effective: 05-31-11, Implementation: 05-31-11)

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... Contractors do not have discretion to omit appropriate codes and messages. Contractors must use appropriate group, claim adjustment reason, and remittance advice remark codes to communicate clearly why an amount is not covered by Medicare and who is financially responsible for that amount.

Valid Group Codes for use on Medicare remittance advice:

● CO - Contractual Obligations. This group code shall be used when a contractual agreement between the payer and payee, or a regulatory requirement, resulted in an adjustment. Generally, these adjustments are considered a write off for the provider and are not billed to the patient.

● OA - Other Adjustments. This group code shall be used when no other group code applies to the adjustment.

● PR - Patient Responsibility. This group code shall be used when the adjustment represent an amount that may be billed to the patient or insured. This group would typically be used for deductible and copay adjustments. –

130.2: Claim Adjustment Reason Codes

(Rev. 2205, Issued: 04-29-11, Effective: 05-31-11, Implementation: 05-31-11)

Claim Adjustment Reason Codes (CARCs) are used on the Medicare electronic and paper remittance advice, and Coordination of Benefit (COB) claim transaction. The Claim Adjustment Status and Reason Code Maintenance Committee maintains this code set. A new code may not be added and the indicated wording may not be modified without the approval of this 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. This code set is updated three times a year. Medicare contractors shall use only most current valid codes in ERA, SPR, and COB claim transactions.

Any reference to procedures or services mentioned in the reason codes apply equally to products, drugs, supplies or equipment. References to prescriptions also include certificates of medical necessity (CMNs). These reason codes explain the reasons for any financial adjustments, such as denials, reductions or increases in payment. These codes may be used at the service or claim level, as appropriate. Current 835 structure only allows one reason code to explain any one specific adjustment amount.

There are basic criteria that the Claim Adjustment Status and Reason Code Maintenance Committee considers when evaluating requests for new codes:

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

The list of Claim Adjustment Reason Codes can be found at:
http://www.wpc-edi.com/codes

The updated list is published three times a year after the committee meets before the ANSI ASC X12 trimester meeting in the months of January/February, June, and September/October. Medicare contractors must make sure that they are using the latest approved claim adjustment reason codes in ERA, SPR and COB transaction by implementing necessary code changes as instructed in the Recurring Update Notification or any other CMS instruction or downloading the list from the WPC Website after each update. The Shared System Maintainers shall make sure that a deactivated code (either reason or remark) is not allowed to be used in any original business message, but is allowed and processed when reported in derivative business messages. Code deactivation may be implemented prior to the stop date posted at WPC web site to follow Medicare release schedule. SSMs shall implement deactivation on the earlier date if the implementation date in the recurring code update CR is different than the stop date posted at the WPC Web site.

Contractors are responsible for entering claim adjustment reason code updates to their shared system and entry of parameters for shared system use to determine how and when particular codes are to be reported in remittance advice and coordination of benefits transactions. In most cases, reason and remark codes reported in remittance advice transactions are mapped to alternate codes used by a shared system. These shared 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 shared system codes, or vice versa, making it difficult for a contractor to determine each of the internal codes that may be impacted by remark or reason code modification, retirement or addition.
Shared systems must provide a crosswalk between the reason and remark codes to the shared system internal codes so that a contractor 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 contractor searches to identify each affected internal code. Shared systems must also make sure that 5-position remark codes can be accommodated at both the claim and service level for 835 version 004010 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 CMS recurring code update change request or the Medicare Claims Processing Manual transmittal that implemented a policy change that led to the issuance of the new or modified code. 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. Some CARCs are so generic that the reason for adjustment cannot be communicated clearly without at least one remark code. These CARCs have a note added to the text for identification. A/B MACs, DME MACs, FIs, carriers, and RHHIs must use at least one appropriate remark code when using one of these CARCs.

130.3- Remittance Advice Remark Codes

(Rev. 2205, Issued: 04-29-11, Effective: 05-31-11, Implementation: 05-31-11)

Remittance Advice Remark Codes (RARC) 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 plan when they apply. Medicare contractors must report appropriate remark code(s) that apply.

Remark codes at the service line level must be reported in the X12N 835 LQ segment. Remark codes that apply to an entire claim must be reported in either an X12N 835 MIA (inpatient) or MOA (non-inpatient) segment, as applicable. Although the IG allows up to 5 remark codes to be reported in the MOA/MIA segment and up to 99 remark codes in the LQ segment, system limitation may restrict how many codes Medicare contractors can actually report.

The remark code list is updated three times a year, and the list as posted at the WPC Website and gets updated at the same time when the reason code list is updated. Both code lists are updated on or around March 1, July 1, and November 1Medicare contractors must use the latest approved remark codes as included in the Recurring Update Notification or any other CMS instruction or downloading the list from the WPC Website after each update. 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.

130.4 - Requests for Additional Codes

(Rev2205, Issued: 04-29-11, Effective: 05-31-11, Implementation: 05-31-11)

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/codes 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.

To provide a summary of changes introduced in the previous four months, a code update instruction in the form of a change request (CR) is issued. Additionally, these recurring CRs will also notify A/B MACs/ carriers/CEDI / DME MACs/ FIs/RHHIs of any enhancement(s) being added to the MREP software. These CRs will establish the deadline for Medicare shared 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.