Medicare Claims Processing Manual
Chapter 22 - Remittance Advice

Table of Contents
(Rev. 1385, 11-30-07)

10 - Background

(Rev. 1343; Issued: 09-21-07; Effective: 07-02-07; Implementation: 07-02-07)

A/B Medicare Administrative Contractors (A/B MACs), carriers, Durable Medical Equipment Regional Carriers (DMERCs), 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 (including denial), there is an associated remittance advice item. 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, DMERCs, and DME MACs also send informational RAs to nonparticipating physicians, suppliers, and non-physician practitioners billing non-assigned claims (billing and receiving payments from patients instead of accepting direct Medicare payments), unless the beneficiary or the provider requests that the remittance notice 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 Chapter 30) applies.

Medicare contractors are allowed to charge 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. The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA, Title II) required the Department of Health and Human Services (HHS) to establish national standards for electronic health care transactions and national identifiers for providers, health plans, and employers. HIPAA also addresses the security and privacy of health data. Adopting these standards would improve the efficiency and effectiveness of the nation's health care system by encouraging the widespread use of electronic data interchange in health care.

Under the HIPAA Administrative Provisions, the Secretary of Health and Human Services has established the standard for claim payment transaction. The adopted is the ANSI ASC X12N 835 version 004010A1, and an Implementation Guide (IG) for this HIPAA compliant version of transaction 835 (Health Care Claim/Payment Advice) is available to use. An IG 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 including Medicare A/B MACs, carriers, DMERCs, DME MACs, FIs, and RHHIs. Medicare requires the use of this format exclusively for Electronic Remittance Advices (ERAs). Medicare has also established a policy that the paper formats shall mirror the ERAs as much as possible, and A/B MACs, carriers, DMERCs, DME MACs, FIs and RHHIs shall use the formats established by Medicare. 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 004010A1IG for a summary of these changes. The IG is available from Washington Publishing Company (WPC). Their Web site: http://www-wpc-edi.com/HIPAA In addition, CMS has developed a companion document for contractors and the Shared System Maintainers to explain the business requirements for Medicare following the ANSI X12N IG for Transaction 835, and is available at the Web site: http://www.cms.hhs.gov/ElectronicBillingEDITrans/11_Remittance.asp#TopOfPage Go to "Downloads and click on the file you want.

By October 2002, carriers, DMERCs FIs and, had to be able to issue HIPAA compliant 835 version 004010A1 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 CMS temporary instructions. HIPAA requires CMS policy to change such that only the current version of electronic format will be maintained, not the current and the previous version.

Effective October 2006, unless a provider has requested that Medicare revert to issuance of Standard Paper Remittance (SPR), all Electronic Remittance Advice (ERA) receivers would receive their ERAs in the HIPAA compliant format – ANSI ASC X12N 835 version 004010A1. Medicare contractors shall stop generating and sending ERAs in any other format or version effective October 1, 2006.

Medicare will accept claims only if they contain the National Provider Identifiers (NPIs) on and after a date to be determined but before May 23, 2008. NPIs received on the claims would be cross walked to Medicare assigned legacy numbers for adjudication. Depending on how providers requested NPIs and how NPIs were disseminated, the relationship could be:
one NPI to one legacy number
or
multiple NPIs to one legacy number
or
one NPI to multiple legacy numbers

The adjudication would be 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 on and after NPI becomes effective will have the National Provider Identifier (NPI) as the provider ID instead of any Medicare assigned provider number at the provider, claim and service level if NPI is received on the claim. ERAs will be sent with the legacy numbers at the payee level and additional legacy numbers at the claim/service level, if needed, if NPI is not received on the claim.

20 - General Remittance Completion Requirements

(Rev. 1063, Issued: 09-22-06, Effective: 10-01-06, Implementation: 10-23-06)

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 (A/B MAC /FI/RHHI) 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 Pmt 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.

30 - Remittance Balancing

(Rev. 1343; Issued: 09-21-07; Effective: 07-02-07; Implementation: 07-02-07)

For Medicare 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 submitted charges plus or minus payment adjustments for a single 835 remittance in accordance with the rules of the standard 835 format.

Every HIPAA compliant X12N 835 transaction issued by a Medicare contractor must comply with the ANSI ASC X12N 835 version 004010A1 IG requirements, i.e., these remittances must balance at the service, claim and provider 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. A/B MAC /carrier/ /DMERC/DME MAC shared systems will treat production of an out-of-balance 835 as a priority problem, and will work closely with the A/B MACs/carriers/DMERCs/DME MACs and CMS to fix the problem as soon as possible.

A/B MAC /FI/RHHI shared system must make forced balancing adjustments at the line, claim and/or transaction level as applicable to make each 835 transaction balance. A/B MAC /FI/RHHI shared system 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 A/B MAC /FI/RHHI shared system 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 be used only on a temporary exception basis, pending diagnosis of the source of the balancing problem and the A/B MAC /FI/RHHI shared system programming to correct that problem. A/B MAC /FI/RHHI 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 system would treat production of an out-of-balance 835 as a priority problem, and would work closely with the A/B MAC /FI/RHHI and CMS to fix the problem as soon as possible.

40 - Electronic Remittance Advice

(Rev. 1, 10-01-03)
A3-3750

Electronic Remittance Advice (ERA) transactions must be produced in the current HIPAA compliant Accredited Standards Committee (ASC) X12N 835 format. Directions for version updates are posted when necessary in CMS temporary instructions 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 X12N 835

(Rev. 1063, Issued: 09-22-06, Effective: 10-01-06, Implementation: 10-23-06)

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 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;

- Send the 835 to providers over a wire connection. They do not use tapes or diskettes;

- FIs/RHHIs 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, FIs/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 FI/RHHI/A/B MAC provider;

- A/B MACs, carriers, DMERCs, and DME MACs must suppress the distribution of SPRs to those providers/suppliers (or a billing agent, clearing house or other entity representing those providers/suppliers) also receiving ERAs for 45 days or more. 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/ DMERCs/DME MACs should send exception requests to RemittanceAdvice@cms.hhs.gov for review.

- 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 ANSI X12N 835 transaction issued by A/B MACs, carriers, DMERCs, DME MACs, FIs, and RHHIs must comply with the implementation guide (IG) requirements (see §40.4), 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, DMERCs, 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.

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

(Rev. 1063, Issued: 09-22-06, Effective: 10-01-06, Implementation: 10-23-06)

A. A/B MACs/carriers/DMERCs/DME MACs

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, an A/B MAC/carrier/DMERC/DME 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 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 ANSI X12N 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

(Rev. 1, 10-01-03)
A3-3751, A-01-057, A-02-070, AB-02-067, B-01-35

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

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

(Rev. 1343; Issued: 09-21-07; Effective: 07-02-07; Implementation: 07-02-07)

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 be able to operate on 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. 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.

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.

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

(Rev. 1063, Issued: 09-22-06, Effective: 10-01-06, Implementation: 10-23-06)

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. The MREP Remittance Advice is based upon the current SPR format. This software became available on

October 11, 2005 to the providers through their respective carrier/DMERC. 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 enhancement. 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/DMERCs/DME 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.

40.6 – 835 Implementation Guide

(Rev. 1063, Issued: 09-22-06, Effective: 10-01-06, Implementation: 10-23-06)

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 004010A1 Implementation Guide (IG) has been established as the standard for compliance for remittance advice transactions. The IG 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 plans 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.

The Medicare X12N 835 Version 004010A1 Companion 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 004010A1 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 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.hhs.gov/ElectronicBillingEDITrans/11_Remittance.asp#TopOfPage
Go to "Downloads", and select the file to download.

50 - Standard Paper Remittance Advice
(Rev. 1063, Issued: 09-22-06, Effective: 10-01-06, Implementation: 10-23-06)

The Standard Paper Remittance (SPR) is the hard copy version of an ERA. All A/B MACs, carriers, DMERCs, 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, DMERCs, DME MACs, FIs, and RHHIs suppress distribution of SPRs if a provider is also receiving ERAs for more than 30 days (institutional providers) and 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 004010A1 data fields.

50.1 - The Do Not Forward (DNF) Initiative
(Rev. 1063, Issued: 09-22-06, Effective: 10-01-06, Implementation: 10-23-06)

As part of the Medicare DNF Initiative, A/B MACs, carriers, DMERCs 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 DMERCs/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.

50.2 - SPR Formats

(Rev. 1063, Issued: 09-22-06, Effective: 10-01-06, Implementation: 10-23-06)

The following sections contain the separate Part B (A/B MAC/carrier/DMERC/DME MAC) and Part A (A/B MAC/FIs/RHHIs) 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.

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

(Rev. 1343; Issued: 09-21-07; Effective: 07-02-07; Implementation: 07-02-07)

EXAMPLE

MEDICARE PART A P.O. BOX ABC123 LITTLE ROCK AR 72207 TEL# 0000000000 VER# 004010-A1

NPI PROVIDER NAME PART A PAID DATE: XX/XX/XXXX REMIT#: XXXXX PAGE: 1

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

HIC NUMBER ICN NUMBER RC REM OUTCD CAPCD NEW TECH COVD CHGS ESRD NET ADJ PER DIEM RTE

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

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

XXXXXXXXXX X X XXXXXXXXXXXXX XX XXXXX XXX .00 .00 .00 .00

XXXXXXXXXX XXXXXXXXXXXXXX XX X .00 .00 .00 .00

XX/XX/XXXX XX/XX/XXXX XX X XXX XX .00 .00 .00 .00 .00

X X XX XX .00 .00 .00 .00 .00

SUBTOTAL FISCAL YEAR - XXXX .00 .00 .00 .00

.00 .00 .00 .00

.00 .00 .00 .00 .00

X X .00 .00 .00 .00 .00

SUBTOTAL PART A .00 .00 .00 .00

14

.00 .00 .00 .00

.00 .00 .00 .00 .00

XX XX .00 .00 .00 .00 .00

15

EXAMPLE

MEDICARE PART B P.O. BOX ABC123 LITTLE ROCK AR 72207 TEL# 0000000000 VER# 004010-A1

NPI PROVIDER NAME PART B PAID DATE: XX/XX/XXXX REMIT#: XXXXX PAGE: 1

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

HIC NUMBER ICN NUMBER RC REM OUTCD CAPCD NEW TECH COVD CHGS

ESRD NET ADJ PER DIEM RTE

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

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

XXXXXXXXXXX X X XXXXXXXXXXX XX XXXX 000 .00 .00 .00 .00

XXXXXXXXXX XXXXXXXXXXXXXX XX .00 .00 .00 .00

XX/XX/XXXX XX/XX/XXXX XX X XXX XX .00 .00 .00 .00 .00

1 X XX .00 .00 .00 .00 .00

SUBTOTAL FISCAL YEAR - XXXX .00 .00 .00 .00

.00 .00 .00 .00

.00 .00 .00 .00 .00

X .00 .00 .00 .00 .00

SUBTOTAL PART B .00 .00 .00 .00

.00 .00 .00 .00

.00 .00 .00 .00 .00

X .00 .00 .00 .00 .00

16

EXAMPLE

MEDICARE PART A P.O. BOX ABC123 LITTLE ROCK AR 72207 TEL# 0000000000 VER# 4010-A1

PROV # PROVIDER NAME PAID DATE: XX/XX/XX REMIT#: XXXXX PAGE: 2

S U M M A R Y

CLAIM DATA: PASS THRU AMOUNTS:

CAPITAL : .00 PROVIDER PAYMENT RECAP :

DAYS : RETURN ON EQUITY : .00

COST : 0 DIRECT MEDICAL EDUCATION : .00 PAYMENTS :

COVDY : 2 KIDNEY ACQUISITION : .00 DRG OUT AMT : .00

NCOVDY : 0 BAD DEBT : .00 INTEREST : .00

NON PHYSICIAN ANESTHETISTS: .00 PROC CD AMT : .00
CHARGES : TOTAL PASS THRU : .00 NET REIMB : .00

COVD : .00 TOTAL PASS THRU : .00

NCOVD : .00 PIP PAYMENT : .00 PIP PAYMENTS : .00

DENIED : .00 SETTLEMENT PAYMENTS : .00 SETTLEMENT PYMTS : .00

ACCELERATED PAYMENTS : .00 ACCELERATED PAYMENTS : .00

REFUNDS : .00 REFUNDS : .00

PROF COMP : .00 PENALTY RELEASE : .00 PENALTY RELEASE : .00

MSP PAYMT : .00 TRANS OUTP PYMT : .00 TRANS OUTP PYMT : .00

DEDUCTIBLES : .00 HEMOPHILIA ADD-ON : .00 HEMOPHILIA ADD-ON : .00

COINSURANCE : .00 NEW TECH ADD-ON : .00 NEW TECH ADD-ON : .00

1718

BALANCE FORWARD: .00

PAT REFUND: .00 WITHHOLD FROM PAYMENTS: WITHHOLD: .00

INTEREST: .00 CLAIMS ACCOUNTS RECEIVABLE: .00 ADJUSTMENT TO BALANCE: .00

CONTRACT ADJ: .00 ACCELERATED PAYMENTS: .00 NET PROVIDER PAYMENT: .00

PROC CD AMT: .00 PENALTY: .00 (PAYMENTS MINUS WITHHOLD)
NET REIMB: .00 SETTLEMENTS: .00

TOTAL WITHHOLD: .00 CHECK/EFT NUMBER

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

(Rev. 1343; Issued: 09-21-07; Effective: 07-02-07; Implementation: 07-02-07)

A/B MAC/carrier/DMERC/DME MAC NAME

ADDRESS 1

MEDICARE

ADDRESS 2

REMITTANCE ADVICE

CITY, STATE ZIP

(9099) 111-2222

PROVIDER NAME		NPI :	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

RENDERING PROVIDER NPI

(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

A/B MAC/carrier/DMERC/DME MAC NAME YYYY/MM/DD (999) 111-2222 **MEDICARE**

NPI: 1234567890 PROVIDER NAME

REMITTANCE ADVICE

CHECK/EFT #:12345678901234567890 PAGE #: 999 OF 999

REMITTANCE # 12345678901234567890 (NOT A REQUIRED FIELD)

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

*

NAME LLLLLLLLLLLL, 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

RENDERING PROVIDER NPI (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 CLAIMS	BILLED AMT	ALLOWED AMT	DEDUCT AMT	COINS AMT	TOTAL RC-AMT	PROV PD AMT	PROV ADJ AMT	CHECK AMT
99999	1234567.12	1234567.12	1234567.12	1234567.12	1234567.12	1234567.12	1234567.12	1234567.12	

PROVIDER ADJ DETAILS:

PLB REASON CODE	AMOUNT	FCN	HIC
1111	1234567.12	12345678901234567	123456789012
2222	1234567.12	12345678901234567	123456789012
3333	1234567.12	12345678901234567	123456789012
4444	1234567.12	12345678901234567	123456789012
5555	1234567.12	12345678901234567	123456789012

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

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

A/B MAC/carrier/DMERC/DME MAC NAME YYYY/MM/DD (999) 111-2222 **MEDICARE**

NPI: 1234567890 PROVIDER NAME **REMITTANCE ADVICE**

CHECK/EFT #:12345678901234567890 PAGE #: 999 OF 999

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
RENDERING PROVIDER NPI				(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: XXXXXXXXXXXXXXXXXXXXXXX

50.3 - Part A (A/B MAC /FI/RHHI/) SPR Crosswalk to the 835

(Rev. 1343; Issued: 09-21-07; Effective: 07-02-07; Implementation: 07-02-07)

This crosswalk provides a systematic presentation of SPR data fields and the corresponding fields in an 835 version 004010A1. 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.
NPI	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
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
23Full Description (In Order Of Appearance) SPR ID SPR Field Size Characteristics 835 Location			
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
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'

24Full Description (In Order Of Appearance) SPR ID SPR Field Size Characteristics 835 Location

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
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

25Full Description (In Order Of Appearance) SPR ID SPR Field Size Characteristics 835 Location

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
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	N	Total of claim level SPR NCOVD

charges		S9(7).99	

26Full Description (In Order Of Appearance)	SPR ID	SPR Field Size	Characteristics 835 Location
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
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

27Full Description (In Order Of Appearance)	SPR ID	SPR Field Size	Characteristics 835 Location
Pass Thru Amounts			
Capital pass thru	CAPITAL	N S9(7).99	3-010-PLB04, 06, 08 or 10 when ‘CP’ in prior data element
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
Refunds	as written	N S9(7).99	3-010-PLB04, 06, 08 or 10 when ‘RF’ in prior data element

28Full Description (In Order Of Appearance) SPR ID SPR Field Size Characteristics 835 Location

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 - Part B (A/B MAC /Carrier/ / DMERC/DME MAC) SPR Crosswalk to the 835

(Rev. 1343; Issued: 09-21-07; Effective: 07-02-07; Implementation: 07-02-07)

Part B 835 version 004010 field descriptions may be viewed at

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

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

Remittance Field	835V4010 Field	LOOP ID	NSF V 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 NPI	N104 when XX IN N103	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	
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	
RENDERING PROVIDER NPI	REF02 when HPI IN REF01	2110	450-37	If different from the Payee NPI at the Payee level
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	
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+ CAS02/05/08/11/14/17	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, 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	
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,		700-07	Includes Interest, Late Filing Charge, Previously Paid and other

	PLB09-1, PLB11-1, PLB13-1			adjustments as applicable

60 - Remittance Advice Codes

(Rev. 1063, Issued: 09-22-06, Effective: 10-01-06, Implementation: 10-23-06)

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

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.

60.1 - Claim Adjustment Reason Codes

(Rev. 1385, Issued: 11-30-07, Effective: 04-01-08, Implementation: 04-07-08)

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 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 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 CMS Change Requests or downloading the list 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.

60.2 - Remittance Advice Remark Codes

(Rev. 1063, Issued: 09-22-06, Effective: 10-01-06, Implementation: 10-23-06)

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 any remark code(s) 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.

Remark codes that apply 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, in the months following X12N trimester meetings. Medicare contractors must use the latest approved remark codes as included in the regular code update Change Request or in any other CMS instructions in their 835 version 004010A1 and subsequent versions, the corresponding standard paper remittance advice, and the X12N Coordination of Benefit transaction (outbound 837). 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. 1063, Issued: 09-22-06, Effective: 10-01-06, Implementation: 10-23-06)

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 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 advice 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 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.

- CR - Corrections and Reversals. This group code shall be used for correcting a prior claim. It applies when there is a change to a previously adjudicated claim. When correcting a prior claim, CLP02 (claim status code) needs to be 22. See ASC X12N Health Care Claim Payment/Advice Implementation Guide (835) section 2.2.8 for complete information about corrections and reversals.

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

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

60.4 - Requests for Additional Codes

(Rev. 1063, Issued: 09-22-06, Effective: 10-01-06, Implementation: 10-23-06)

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) 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. Additionally, these recurring CRs will also notify A/B MACs/ carriers/ DMERCs/ 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.

70 - A/B MAC /FI/RHHI ERA Requirement Changes to Accommodate OPPS and HH PPS

(Rev. 1063, Issued: 09-22-06, Effective: 10-01-06, Implementation: 10-23-06)

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 A/B MAC /FI/RHH/ 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 be reported only in 004010A1 version of the 835. Detailed service line data is not reported in paper remittance advice notices. 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. A/B MAC /FIs/RHHIs 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 ANSI X12N 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, A/B MAC /FIs/RHHIs 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, A/B MAC /FIs/RHHIs 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), then report the specific reason code that applies to that denial rather than CO 97.

For OPPS, A/B MAC /FIs/RHHIs 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, A/B MAC /FIs/RHHIs 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, A/B MAC /FIs/RHHIs 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 codes on the remittance advice for the conditions noted.

Remark Code	Message (the text may change if this code is modified in the future)	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

(Rev. 1063, Issued: 09-22-06, Effective: 10-01-06, Implementation: 10-23-06)

Additional HH PPS changes in the HIPAA compliant 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 004010A1 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

(Rev. 1, 10-01-03)

A3-3753

The 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 four 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. Shared 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
(Rev. 1063, Issued: 09-22-06, Effective: 10-01-06, Implementation: 10-23-06)

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. A/B MACs/FIs/RHHIs 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 004010A1 Line Level Reporting Requirements for the Request for Anticipated Payment (RAP) Payment for an Episode
(Rev. 1063, Issued: 09-22-06, Effective: 10-01-06, Implementation: 10-23-06)

A/B MACs:/FIs/RHHIs

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.

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 shared 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 004010A1 Line Level Reporting Requirements for the Claim Payment in an Episode (More Than Four Visits)

(Rev. 1063, Issued: 09-22-06, Effective: 10-01-06, Implementation: 10-23-06)

1. A/B MACs:/FIs/RHHIs 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. A/B MACs:/FIs/RHHIs 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. A/B MACs:/FIs/RHHIs 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, A/B MACs:/FIs/RHHIs also enter the actual individual HCPCS for the services furnished. They include a separate loop for each service. Revenue code "027X," "0623," "027X," and

"062X" services may not be billed with a HCPCS, and must be reported in a separate SVC loop in the remittance advice.

c. A/B MACs:/FIs/RHHIs 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. A/B MACs:/FIs/RHHIs 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. FIs/RHHIs 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. A/B MACs:/FIs/RHHIs 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, A/B MACs:/FIs/RHHIs 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, A/B MACs:/FIs/RHHIs 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, A/B MACs:/FIs/RHHIs 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 004010A1 Line Level Reporting Requirements for the Claim Payment in an Episode (Four or Fewer Visits)

(Rev. 1063, Issued: 09-22-06, Effective: 10-01-06, Implementation: 10-23-06)

1. A/B MACs:/FIs/RHHIs follow §70.5 steps 1-2.

2. Now that the first payment has been reversed, A/B MACs:/FIs/RHHIs pay and report the claim on a per visit basis rather than on a prospective basis. They enter HC in SVC01-1, the paid HCPCS for the visit(s) in SVC01-2, 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 submitted HCPCS in SVC06-2 if different than the paid

HCPCS shown in SVC01-2, and the number of visits submitted in SVC07 if different than the number of visits paid shown in SVC05.

3. A/B MACs:/FIs/RHHIs 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. A/B MACs:/FIs/RHHIs enter “B6” in 2-110.C-AMT01 and the allowed amount for the visit(s) in AMT02.

6. A/B MACs:/FIs/RHHIs report the number of covered and noncovered (if applicable) visits in separate loops in segment 2-120-QTY.

7. A/B MACs:/FIs/RHHIs 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, A/B MACs:/FIs/RHHIs 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 - PPS Partial Episode Payment (PEP) Adjustment

(Rev. 1063, Issued: 09-22-06, Effective: 10-01-06, Implementation: 10-23-06)

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

> Claim Adjustment Reason Code B20 - Payment adjusted because procedure/service was partially or fully furnished by another provider; and
>
> Remittance Advice Remark Code N120 - Payment is subject to home health prospective payment system partial episode payment adjustment. Beneficiary transferred or was transferred/discharged/readmitted during payment episode.

These are not applicable to the standard paper remittance advice.

Transmittals Issued for this Chapter

Rev #	Issue Date	Subject	Impl Date	CR#
R1385CP	11/30/2007	Shared System Participation in Claim Adjustment Reason Code and Remittance Advice Remark Code Maintenance	04/07/2008	5806
R1343CP	09/21/2007	Stage 3 NPI Changes for Transaction 835 and Standard Paper Remittance Advice	07/02/2007	5452
R1241CP	05/18/2007	Stage 3 NPI Changes for Transaction 835 and Standard Paper Remittance Advice - Replaced by Transmittal 1343	07/02/2007	5452
R1063CP	09/22/2006	Ending the Contingency Plan for Remittance Advice and Charging for PC Print, Medicare Remit Easy Print, and Duplicate Remittance Advice	10/23/2006	5308
R1033CP	08/18/2006	Revise Chapters 22 and 24 to delete references to free downloads of X12 implementation guides adopted as HIPAA standards from Washington Publishing Company (WPC)	11/20/2006	5247
R996CP	06/30/2006	Stage 2 NPI Changes for Transaction 835, and Standard Paper Remittance Advice, and Changes in Medicare Claims Processing Manual, Chapter 22 - Remittance Advice - Replaces Rev. 948	10/02/2006	5081
R948CP	05/12/2006	Stage 2 NPI Changes for Transaction 835, and Standard Paper Remittance Advice, and Changes in Medicare Claims Processing Manual, Chapter 22 - Remittance Advice	10/02/2006	5081
R885CP	03/10/2006	Suppression of Standard Paper Remittance Advice to Providers and Suppliers Also Receiving Electronic Remittance Advice for 45 Days or More.	06/01/2006	4376
R555CP	05/02/2005	Fiscal Intermediary (FI) Reporting of Add-on Payments that Do Not Result in a Specific Increase or Decrease in the Amount Reported as Payable for a Claim or a Service on a	10/03/2005	3866

Rev #	Issue Date	Subject	Impl Date	CR#
		Remittance Advice.		
R252CP	07/23/2004	Expansion of paper remittance advice to accommodate forced balanced amount, corresponding change in the flat file, and a change in the companion document for fiscal intermediaries (FIs) and their shared system maintainer (SSM)	01/03/2005	3344
R001CP	10/01/2003	Initial Publication of Manual	NA	NA