CMS Manual System

Pub 100-04 Medicare Claims Processing

Transmittal 996

Department of Health & Human Services (DHHS)

Centers for Medicare & Medicaid Services (CMS)

Date: JUNE 30, 2006

Change Request 5081

Note: Transmittal 948, dated May 12, 2006, is rescinded and replaced with transmittal 996, dated June 30, 2006. Business Requirements (BRs) 5081.5 and 5081.10 have been removed. The Notes from the previous BRs 5081.6, 5081.7, and 5081.12 have been removed. The remaining BRs have been renumbered. The responsibility for the previous BR 5081.7 has been deleted for FI, RHHI, and FISS. All other information remains the same.

SUBJECT: **Stage 2 NPI Changes for Transaction 835, and Standard Paper Remittance Advice, and Changes in Medicare Claims Processing Manual, Chapter 22 - Remittance Advice**

I. SUMMARY OF CHANGES: This Change Request instructs Shared System Maintainers (SSMs) and contractors about reporting National Provider Identifier (NPI) on a Remittance Advice (RA) under different scenarios during Stage 2 of NPI Implementation, and changes in Medicare Claims Processing Manual, Chapter 22 - Remittance Advice.

NEW/REVISED MATERIAL

EFFECTIVE DATE: October 1, 2006

IMPLEMENTATION DATE: October 2, 2006

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
R	22/Table of Contents
R	22/10/Background
R	22/20/General Remittance Completion Requirements
R	22/30/Remittance Balancing
R	22/40/40.1/ANSI ASC X12N 835
R	22/40/40.2/Generating an ERA if Required Data is Missing or Invalid
R	22/40/40.4/Medicare Standard Electronic PC Print Software for Institutional Providers
N	22/40/40.5/Medicare Remit Easy Print Software for Professional Providers and Suppliers
R	22/40/40.6/835 Implementation Guide
R	22/50/Standard Paper Remittance Advice
R	22/50.2/SPR Formats
R	22/50/50.2.1/Part A/FIs/RHHIs SPR Format
R	22/50/50.2.2/Part B/Carrier and DMERC SPR Format
R	22/50/50.4/Carrier and DMERC SPR Crosswalk to the 835
R	22/60/60.1/Claim Adjustment Reason Codes
R	22/60/60.2/Remittance Advice Remark Codes
R	22/60/60.3/Group Codes
R	22/70/FI/RHHI Requirement Changes to Accommodate OPPS and HH PPS
R	22/70/70.3/Items Not Included in HH PPS Episode Payment
R	22/70/70.5/835 Version 3051.4A.01 Line Level Reporting Requirements for the Claim Payment in an Episode More than Four Visits)
R	22/70/70.6/835 Version 3051.4A.01 Line Level Reporting Requirements for the Claim Payment in an Episode Four or Fewer Visits)

III. FUNDING:

No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2006 operating budgets.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

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

Attachment – Business Requirements

Pub. 100-04	Transmittal: 996	Date: June 30, 2006	Change Request: 5081

Note: Transmittal 948, dated May 12, 2006, is rescinded and replaced with transmittal 996, dated June 30, 2006. Business Requirements (BRs) 5081.5 and 5081.10 have been removed. The Notes from the previous BRs 5081.6, 5081.7, and 5081.12 have been removed. The remaining BRs have been renumbered. The responsibility for the previous BR 5081.7 has been deleted for FI, RHHI, and FISS. All other information remains the same.

SUBJECT: Stage 2 NPI Changes for Transaction 835, and Standard Paper Remittance Advice, and Changes in Medicare Claims Processing Manual, Chapter 22 - Remittance Advice.

I. GENERAL INFORMATION

A. Background: This Change Request (CR) instructs Shared System Maintainers (SSMs) and contractors about reporting National Provider Identifier (NPI) on a Remittance Advice (RA) under different scenarios during Stage 2 of NPI Implementation.

Medicare's implementation of NPI has been planned to be phased in over a two year period in separate stages.

Note: This Change Request (CR) supersedes and replaces the following instructions in CR 4023:

Business Requirement 4023.18
Business Requirement 4023.19
Business Requirement 4023.20
Business Requirement 4023.21
Business Requirement 4023.22
Business Requirement 4023.34
Business Requirement 4023.37

The section on "835 Payment and Remittance Advice Transactions" and "Standard Paper Remits (SPRs)"

This CR does not replace any other part of CR 4023.

May 23, 2005 – January 2, 2006: Medicare rejected claims with NPIs during this period.
January 3, 2006 – October 1, 2006: Medicare rejects claims with only NPIs and no legacy number.
October 2, 2006 – May 22, 2007: Medicare will accept claims with a legacy number and/or an NPI, and will be capable to send NPIs in outbound transaction e.g., ERA
May 23, 2007 – Forward: Medicare will only accept claims with NPIs. Small health plans have an additional year to be NPI compliant.

CMS has defined legacy provider identifiers to include OSCAR, National Supplier Clearinghouse (NSC), Provider Identification Numbers (PIN), National Council of Prescription Drug Plans (NCPDP) pharmacy identifiers, and Unique Physician Identification Numbers (UPINs). CMS's definition of legacy numbers does not include taxpayer identifier numbers (TIN) such as Employer Identification Numbers (EINs) or Social Security Numbers (SSNs). Medicare has published CR

4320 instructing contractors and the Shared System Maintainers (SSMs) how to properly use and edit NPIs received in electronic data interchange transactions, via Direct Data Entry screens, or on paper claim forms.

This CR instructs the Shared System Maintainers and Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), carriers, and Durable Medical Equipment Regional Carriers (DMERCs) how to report Medicare legacy numbers and NPIs on a Health Insurance Portability and Accountability Act (HIPAA) compliant Electronic Remittance Advice (ERA) – transaction 835, and Standard Paper Remittance (SPR) advice, any output using PC Print or Medicare Remit Easy Print (MREP) between October 2, 2006 and May 22, 2007.

During Stage 2, if an NPI is received on the claim, it will be cross walked to the Medicare legacy number(s) for processing. The crosswalk may result in:

Scenario I: Single NPI	cross walked to	Single legacy number
Scenario II: Multiple NPIs	cross walked to	Single Medicare legacy number
Scenario III: Single NPI	cross walked to	Multiple Medicare legacy numbers

CMS will adjudicate claims based upon Medicare legacy number(s) or TIN even when NPIs are received and validated. The Remittance Advice (RA) may be generated for claims with the same legacy number but different NPIs. These claims with different NPIs will be rolled up and reported in a single RA accompanied by one check or EFT. During Stage 2, Medicare will report both the legacy number(s) and NPI(s) to providers enabling them to track payments and adjustments by both identifiers. The Companion Documents for both Part A and B, and the Flat File for Part A will be updated to reflect these changes and the updated documents will be posted at http://www.cms.hhs.gov/ElectronicBillingEDITrans/11_Remittance.asp#TopOfPage.

(Note: SPR for institutional providers would include NPI information at the claim level. NPI information for professional providers and suppliers would be sent at the service level.)

Scenario I – Single NPI cross walked to single legacy number:

1. ERA: Under this scenario, use the TIN (EIN/SSN) at the Payee level as the Payee ID, and the legacy number in the REF segment as Payee Additional ID. Then add the NPI at the claim and/or at the service level, if needed.
2. SPR: Insert the legacy number at the header level and the NPI at the claim and/or the service level, if needed.
3. PC Print Software: Show the legacy number at the header level and the NPI at the claim and/or at the service level, if needed.
4. MREP software: Show the legacy number at the header level and the NPI at the claim and/or at the service level if needed.

Scenario II: Multiple NPIs cross walked to Single Medicare legacy number:

1. ERA: Under this scenario, use the TIN (EIN/SSN) at the Payee level as the Payee ID, and the legacy number in the REF segment as Payee Additional ID. Then add the specific NPIs at the claim and/or at the service level, if needed. The specific NPI associated with the claim(s)/service lines included in the ERA will need to be identified using additional information provided on the claim.

2. SPR: Insert the legacy number at the header level. Add the specific NPIs at the claim and/or at the service level, if needed.
3. PC Print Software: Show the legacy number at the header level and the specific NPI at the claim and/or at the service level, if needed.
4. MREP software: Show the legacy number at the header level and the specific NPI at the claim and/or at the service level, if needed.

Scenario III: Single NPI cross walked to Multiple Medicare legacy numbers:

1. ERA: Under this scenario, use the TIN (EIN/SSN) at the Payee level as the Payee ID, and the appropriate legacy number in the REF segment as Payee Additional ID. Then add the NPI at the claim and/or service level, if needed.
   (Under this scenario, if there are 50 claims with the same NPI and that NPI crosswalks to 5 legacy numbers, we will issue 5 separate RAs and 5 separate checks/EFTs per each legacy number)
2. SPR: Insert the appropriate legacy number at the header level, and the NPI at the claim and/or at the service level, if needed.
3. PC Print Software: Show the appropriate legacy number at the header level and the NPI at the claim and/or at the service level, if needed.
4. MREP software: Show the appropriate legacy number at the header level and the NPI at the claim and/or at the service level, if needed.

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
5081.1	Shared System Maintainers, FIs, RHHIs, carriers, and DMERCs shall make necessary programming changes to report both the Medicare legacy and NPI numbers in a remittance advice if NPIs are received on the claim at the provider, claim and service level in the billing/pay to, or rendering provider loops.	X	X	X	X	X	X	X		
5081.2	Shared System Maintainers, FIs, RHHIs, carriers and DMERCs shall report the TIN (EIN/SSN) in Loop 1000B, data field N104 with qualifier FI in data field N103 in the 835 during Stage 2. **Note:** NPI shall be reported in this data field in stage 3.	X	X	X	X	X	X	X		

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
5081.3	Shared System Maintainers, FIs, RHHIs, carriers and DMERCs shall report the Medicare legacy number in Loop 1000B, data field REF 02 with qualifier 1C or PQ in data field REF 01 in the 835 during Stage 2.	X	X	X	X	X	X	X		
5081.4	If NPI has been received on the claim, and has been validated, the NPI shall be returned on the 835 at the claim level in Loop 2100, data field NM 109 with qualifier XX in data field NM 108 during Stage 2.	X	X	X	X	X	X	X		
5081.5	If NPI has been received on the claim, and validated, and the specific NPI is associated with a specific service line, the NPI shall be returned on the 835 at the service line level in Loop 2110, data field REF 02 with qualifier HPI in data field REF 01 under Scenario II.			X	X		X	X		
5081.6	If applicable, specific legacy number associated with a specific service line shall be returned on the 835 at the service line level in Loop 2110, data field REF 02 with qualifier 1C in data field REF 01.			X	X		X	X		
5081.7	Shared System Maintainers, FIs, RHHIs, carriers and DMERCs shall insert the Medicare legacy number at the header level in SPRs under all three scenarios during Stage 2.	X	X	X	X	X	X	X		
5081.8	If NPI has been received on the claim, and validated, FISS, FIs, and RHHIs shall return the NPI at the claim level on the SPRs. **Note:** The specific NPI associated with the specific claim included in this SPR will be identified using additional information provided on the claim under Scenario II.	X	X			X				

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
5081.9	If NPI has been received on the claim, and has been validated, and the specific NPI is associated with a specific service line, the NPI shall be returned on the SPR at the service line level under Scenario II.			X	X		X	X		
5081.10	If a specific legacy number is associated with a specific service line, that legacy number shall be returned on the SPR at the service line level.			X	X		X	X		
5081.11	VMS shall update Medicare Remit Easy Print software to accommodate changes as instructed in 5081.2, 5081.3, 5081.4, 5081.5 and 5081.6.							X		
5081.12	FISS shall update PC Print software to accommodate changes as instructed in 5081.2, 5081.3, and 5081.4.					X				

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
5081.13	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLNMatters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider									

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	education article shall be included in your next regularly scheduled bulletin and incorporated into any educational events on this topic. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.									

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: October 1, 2006 **Implementation Date:** October 2, 2006 **Pre-Implementation Contact(s):** Sumita Sen,	**No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2006 operating budgets.**

410-786-5755, sumita.sen@cms.hhs.gov **Post-Implementation Contact(s):** Sumita Sen, 410-786-5755, sumita.Sen@cms.hhs.gov	

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

Medicare Claims Processing Manual

Chapter 22 - Remittance Advice

Table of Contents

(Rev. 996, 06-30-06)

10 - Background

(Rev. 996, Issued: 06-30-06; Effective: 10-01-06; Implementation: 10-02-06948, Issued: 05-12-06, Effective: 10-01-06, Implementation: 10-02-06)

FIs*/RHHIs*, carriers, and Durable Medical Equipment Regional Carriers (DMERCs) send to providers, physicians, and suppliers, as a companion to claim payments, a notice of payment, referred to as the Remittance Advice (RA). RAs explain the payment and any adjustment(s) made. For each claim or line item payment, *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.

Carriers and DMERCs also send informational RAs to physicians that do not accept assignment (acceptance of direct Medicare payments instead of billing the patient), unless the beneficiary or physician requests that the remittance notice be suppressed. An informational RA is identical to other RAs, but must carry a standard message to notify physicians that do not accept assignment that they do not have appeal rights beyond those afforded when limitation on liability (rules regulating the amount of liability that an entity can accrue because of medical services which are not covered by Medicare – see Chapter 30) applies. Suppliers that do not accept assignment may not be sent an RA.

The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA, Title II) requires 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. The legislation also addresses the security and privacy of health data. Adopting these standards will 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 standard is the ANSI ASC X12N transaction 835 version 004010A1, and* an implementation guide for *this* HIPAA compliant version of *transaction 835* (Health Care Claim/Payment Advice) *is available at*: *http://www.wpc-edi.com/HIPAA*

An implementation guide is a reference document governing the implementation of an electronic format. It contains all information necessary to use the subject format, e.g., instructions and structures. Medicare requires the use of this format exclusively for ERAs. Medicare has also established *a policy that the* paper formats *shall closely mirror the ERAs, and* carriers, DMERCs and FIs/*RHHIs shall use the standard paper 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 004010 implementation guide for a summary of these changes.

In addition, a companion document for contractors and the Shared System Maintainers to explain the business requirements for Medicare following the ANSI X12N Implementation Guide for Transaction 835 Version 004010A1 is available at the Web site *http://www.cms.hhs.gov/ElectronicBillingEDITrans/11_Remittance.asp#TopOfPage Go to "Downloads", and select the file to download*.

By October 2002, FIs */RHHIs*, carriers, and DMERCs had to be able to issue HIPAA compliant 835 version *00*4010*A1* transactions in production mode to any provider or clearinghouse that requested production data in that version.

20 - General Remittance Completion Requirements

(Rev. 996, Issued: 06-30-06; Effective: 10-01-06; Implementation: 10-02-06948, Issued: 05-12-06, Effective: 10-01-06, Implementation: 10-02-06)

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 (FI) RAs do not report service line adjustment data, only summary claim level adjustment information.
- The computed field “Net” must include “ProvPd” (Calculated Pmt to Provider, CLP04 in the 835) and interest, late filing charges and previously paid amounts.
- The Medicare contractor reports only *one crossover* payer *name* on the remittance advice, even if coordination of benefits (COB) information is sent to more than one payer. (The current HIPAA compliant 835 does not have the capacity to report more than one crossover carrier.)
- The check amount is the sum of all claim-level payments, including claims and service-level adjustments, less any provider level adjustments.
- Positive adjustment amounts reduce the amount of the payment and negative adjustment amounts increase it.
- The contractor does not issue an RA for a voided or cancelled claim. It issues an RA for the adjusted claim with “Previously Paid” (CLP04 in the 835) showing the amount paid for the voided claim.

30 - Remittance Balancing

(Rev. 996, Issued: 06-30-06; Effective: 10-01-06; Implementation: 10-02-06948, Issued: 05-12-06, Effective: 10-01-06, Implementation: 10-02-06)

For Medicare the principles of remittance balancing are the same for both paper and electronic remittance formats. Balancing requires that the total paid for all claims in a remittance advice is equal to the total billed *charges* plus or minus payment adjustments including those at the provider level for a single 835 remittance in accordance with the rules of the 835 format.

Every HIPAA compliant 835 issued by a *Medicare contractor* must comply with the *ANSI ASC X12N* implementation guide (IG) requirements, i.e., these remittances must

balance at the service, claim and transaction levels. Back end validation must be performed to ensure that these conditions are met.

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

FI shared systems must make forced balancing adjustments at the line, claim and/or transaction level as applicable to make each 835 transaction balance. The FI 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 FI 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 by FIs*/RHHIs* on a temporary exception basis, pending FI diagnosis of the source of the balancing problem and FI shared system programming to correct that problem. FIs*/RHHIs* must notify effected providers and clearinghouses of the problem and the expected date of correction whenever A7 or CA is used to force 835s to balance. The shared systems will treat production of an out-of-balance 835 as a priority problem, and will work closely with the /RHHIs and CMS to fix the problem as soon as possible.

40.1 - ANSI ASC X12N 835

(Rev. 996, Issued: 06-30-06; Effective: 10-01-06; Implementation: 10-02-06948, Issued: 05-12-06, Effective: 10-01-06, Implementation: 10-02-06)

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 file is posted at:
http://www.cms.hhs.gov/ElectronicBillingEDITrans/11_Remittance.asp#TopOfPage
Go to "Downloads", and select the file to download.

Contractors are required to:

- 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 the provider's bank has that capability. The contractor does not allow any party to view beneficiary information, unless authorized by specific instructions from CMS see §40.1 for additional information;
- Issue the remittance advice specifications and technical interface specifications to all requesting providers within three weeks of their request. Interface specifications must contain sufficient detail to enable a reasonably knowledgeable provider to interpret the RA, without the need to pay the contractor or an associated business under the same corporate umbrella for supplemental services or software;
- Contractors send the 835 to providers over a wire connection. They do not use tapes or diskettes;
- 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 on a particular FI provider;

  • *Carriers and Durable Medical Equipment Regional Carriers (DMERCs) must suppress the distribution of standard paper remittance advices (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. Carriers/DMERCs 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 X12N 835 transaction issued by an FI or carrier/DMERC 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. Each required or

applicable situational data element in a required or situational segment must be reported, and the data in a data element must meet the minimum length and data attribute (AN, ID, R, etc.) specifications in the implementation guide.

Back end validation must be performed to ensure that these conditions are met. Carriers, DMERCs, and FIs*/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 or a pre HIPAA electronic claim, and does not meet the required data attribute(s) for a 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. 996, Issued: 06-30-06; Effective: 10-01-06; Implementation: 10-02-06948, Issued: 05-12-06, Effective: 10-01-06, Implementation: 10-02-06)

A. Carriers/DMERCs

The X12N 835 IG contains specific data requirements, which must be met to build a HIPAA compliant ERA. A claim could be received on paper, or in a pre HIPAA ANSI X12N *837* or another electronic format that lacks data or has data that does not meet the data attributes or length requirements for preparation of a HIPAA-compliant ERA. If not rejected as a result of standard or IG level editing, a carrier/DMERC must either send an SPR advice or a "gap filled" ERA to avoid noncompliance with HIPAA.

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

The shared system maintainers, working in conjunction with their contractors, must decide whether to generate an SPR, which is not covered by HIPAA, or to "gap fill" in this situation, depending on system capability and cost. Except in some very rare

situations, “gap filling” would be expected to be the preferred solution. To “gap fill,” the shared systems must enter meaningless characters to meet the data element minimum length requirements in any outgoing 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.

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

(Rev. 996, Issued: 06-30-06; Effective: 10-01-06; Implementation: 10-02-06948, Issued: 05-12-06, Effective: 10-01-06, Implementation: 10-02-06)

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

FIs*/RHHIs* must supply providers with PC-Print software within three weeks of request. The FI Shared System (FISS) maintainer will supply PC-Print software and a user’s guide for all 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 is provided at no cost.

The PC-Print software enables providers to:

- Receive, over a wire connection, an 835 electronic remittance advice transmission on a personal computer (PC) and write the 835 file in American National Standard Code for Information Interchange (ASCII) to the provider’s “A:” drive;
- 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. Since the software performs limited functions, malfunctions should rarely occur. If software malfunctions are detected, they are to be corrected through the FISS maintainer. Individual 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. 996, Issued: 06-30-06; Effective: 10-01-06; Implementation: 10-02-06948, Issued: 05-12-06, Effective: 10-01-06, Implementation: 10-02-06)

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 output of MREP 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. In addition to these three regular updates, there will be an annual enhancement update every October

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 three special reports.*

40.*6* - 835 Implementation Guide

(Rev. 996, Issued: 06-30-06; Effective: 10-01-06; Implementation: 10-02-06948, Issued: 05-12-06, Effective: 10-01-06, Implementation: 10-02-06)

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 benefit

payers, and not specifically for Medicare. However, a Companion Document was prepared by CMS to clarify when conditional data elements and segments must be used for Medicare reporting, and identify those codes and data elements that never apply to Medicare and which may not be used in Medicare remittance advice transactions.

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 004010/004010A1 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.

Both FIs*/RHHIs* and Carrier/DMERC Companion Documents 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. 996, Issued: 06-30-06; Effective: 10-01-06; Implementation: 10-02-06948, Issued: 05-12-06, Effective: 10-01-06, Implementation: 10-02-06)

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

50.2 - SPR Formats

(Rev. 996, Issued: 06-30-06; Effective: 10-01-06; Implementation: 10-02-06948, Issued: 05-12-06, Effective: 10-01-06, Implementation: 10-02-06)

The following sections contain the separate carrier/DMERC and 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/ FIs*/RHHIs* SPR Format

(Rev. 996, Issued: 06-30-06; Effective: 10-01-06; Implementation: 10-02-06948, Issued: 05-12-06, Effective: 10-01-06, Implementation: 10-02-06)

EXAMPLE

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

PROV # 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

.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

PROV # (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 SETTLEMENT : .00

TOTAL WITHHOLD : .00 CHECK/EFT NUMBER :

50.2.2 – Part B/Carrier and DMERC SPR Format

(Rev. 996, Issued: 06-30-06; Effective: 10-01-06; Implementation: 10-02-06948, Issued: 05-12-06, Effective: 10-01-06, Implementation: 10-02-06)

CARRIER NAME
ADDRESS 1
ADDRESS 2
CITY, STATE ZIP
(9099) 111-2222

MEDICARE REMITTANCE
ADVICE

PROVIDER NAME
ADDRESS 1

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

PT RESP 1234567.12 CLAIM TOTAL 1234567.12 1234567.12 1234567.12 1234567.12 1234567.12 1234567.12

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

CLAIM INFORATION FORWARDED TO: XXXXXXXXXXXXXXXXXXXXXXX

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

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

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

33333 44444 55555

1234567890 MMDD MMDDYY 12 123 PPPPP aabbccdd 1234567.12 1234567.12 1234567.12 1234567.12 GPRRR 1234567.12 1234567.12
RENDERING PROVIDER (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	FCN	HIC	AMOUNT
1111	12345678901234567	123456789012	1234567.12
2222	12345678901234567	123456789012	1234567.12
3333	12345678901234567	123456789012	1234567.12
4444	12345678901234567	123456789012	1234567.12
5555	12345678901234567	123456789012	1234567.12

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

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

CARRIER NAME YYYY/MM/DD (999) 111-2222 **MEDICARE**
PROVIDER #: 1234567890 PROVIDER NAME **REMITTANCE**
CHECK/EFT #:12345678901234567890 PAGE #: 999 OF 999 **ADVICE**
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				(PPPPP)	REM:	RRRRR	RRRRR	RRRRR	RRRRR	RRRRR	
1234567890	MMDD MMDDYY	12	123	PPPPP	aabbccdd	1234567.12	1234567.12	1234567.12	1234567.12	GPRRR 1234567.12	1234567.12
				(PPPPP)	REM:	RRRRR	RRRRR	RRRRR	RRRRR	RRRRR	
1234567890	MMDD MMDDYY	12	123	PPPPP	aabbccdd	1234567.12	1234567.12	1234567.12	1234567.12	GPRRR 1234567.12	1234567.12
				(PPPPP)	REM:	RRRRR	RRRRR	RRRRR	RRRRR	RRRRR	
PT RESP 1234567.12		CLAIM TOTAL				1234567.12	1234567.12	1234567.12	1234567.12	1234567.12	1234567.12

CLAIM INFORATION FORWARDED TO: XXXXXXXXXXXXXXXXXXXXXX

50.4 - Carrier and DMERC SPR Crosswalk to the 835

(Rev. 996, Issued: 06-30-06; Effective: 10-01-06; Implementation: 10-02-06948, Issued: 05-12-06, Effective: 10-01-06, Implementation: 10-02-06)

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 #	REF02 when IC IN REF01	1000B	200-07	
DATE (CHECK/EFT ISSUE DATE)	BPR16		200-09	
CHECK/EFT TRACE #	TRN02		200-08	
REMITTANCE #				This is not a required field
BENEFICIARY LAST NAME (PATIENT LAST NAME)	NM103	2100	400-13	
BENEFICIARY FIRST NAME (PATIENT FIRST NAME)	NM104	2100	400-14	
HIC (INSURED IDENTIFICATION #)	NM109	2100	400-07	
RENDERING PROVIDER IDENTIFIER	*NM109 when XX in NM108*	*2100*		
RENDERING PROVIDER IDENTIFIER	*REF02 when 1C IN REF01*	*2100*		
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 IDENTIFIER	*REF02 when HPI IN REF01*	*2110*	450-37	~~If more than 1 performig provider, insert # of 1st~~
RENDERING PROVIDER IDENTIFIER	*REF02 when 1C IN REF01*	*2110*		
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. 996, Issued: 06-30-06; Effective: 10-01-06; Implementation: 10-02-06 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. 996, Issued: 06-30-06; Effective: 10-01-06; Implementation: 10-02-06 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. 996, Issued: 06-30-06; Effective: 10-01-06; Implementation: 10-02-06 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, PLB09-1, PLB11-1, PLB13-1		700-07	Includes Interest, Late Filing Charge, Previously Paid and other adjustments as applicable

60.1 - *Claim* Adjustment Reason Codes

(Rev. 996, Issued: 06-30-06; Effective: 10-01-06; Implementation: 10-02-06948, Issued: 05-12-06, Effective: 10-01-06, Implementation: 10-02-06)

Claim Adjustment Reason Codes (CARC) 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 claim 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 *February, June, and October*. Medicare contractors must download the list after each update to make sure they are using the latest approved *claim* adjustment reason codes in 835 and standard paper remittance advice transactions.

Individual carriers/*DMERCs* and FIs*/RHHIs* 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 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 carrier/*DMERC* or FI*/RHHI* 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 carrier/*DMERC* or FI*/RHHI* can easily locate and update each internal code that may be impacted by a remittance advice reason/remark code change to eliminate the need for lengthy and error prone manual carrier/*DMERC* and FI*/RHHI* 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.

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

60.2 - Remittance Advice Remark Codes

(Rev. 996, Issued: 06-30-06; Effective: 10-01-06; Implementation: 10-02-06948, Issued: 05-12-06, Effective: 10-01-06, Implementation: 10-02-06)

Remittance Advice Remark C~~o~~odes *(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 care payer when they apply. Medicare contractors must report any remark codes that apply, subject to capacity limits in the standard.

Most remark codes were initially separated into service level (line level) and claim level categories. Some of the same messages were included in both categories. To simplify remark code use, these categories have been eliminated. Any remark code may now be reported at the service or the claim level, as applicable, in any electronic or paper remittance advice version.

Remark codes that apply at the service 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.

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 *00*4010*A1* 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. 996, Issued: 06-30-06; Effective: 10-01-06; Implementation: 10-02-06948, Issued: 05-12-06, Effective: 10-01-06, Implementation: 10-02-06)

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.

70 – FI/*RHHI* ERA Requirement Changes to Accommodate OPPS and HH PPS

(Rev. 996, Issued: 06-30-06; Effective: 10-01-06; Implementation: 10-02-06948, Issued: 05-12-06, Effective: 10-01-06, Implementation: 10-02-06)

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 FI*/RHHI* 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 3051.4A.01 and later versions of the 835. Detailed service line data is not reported in paper remittance advice notices, or in pre-3051.4A.01 versions of the 835 supported by the FISS. Current versions of the SPR and ERA continue to report claims-level summary data.
- 2-062-AMT02 modified to allow reporting of either inpatient or partial hospitalization per diem. 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, 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, 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), they report the specific reason code that applies to that denial rather than CO 97.

For OPPS, 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, 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, /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 code 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).

70.3 - Items Not Included in HH PPS Episode Payment

(Rev. 996, Issued: 06-30-06; Effective: 10-01-06; Implementation: 10-02-06948, Issued: 05-12-06, Effective: 10-01-06, Implementation: 10-02-06)

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. 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.

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

(Rev. 996, Issued: 06-30-06; Effective: 10-01-06; Implementation: 10-02-06948, Issued: 05-12-06, Effective: 10-01-06, Implementation: 10-02-06)

1. 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. 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. 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, 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. 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. 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. 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, 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, 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, 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 3051.4A.01 Line Level Reporting Requirements for the Claim Payment in an Episode (Four or Fewer Visits)

(Rev. 996, Issued: 06-30-06; Effective: 10-01-06; Implementation: 10-02-06948, Issued: 05-12-06, Effective: 10-01-06, Implementation: 10-02-06)

1. FIs*/RHHIs* follow §70.5 steps 1-2.
2. Now that the first payment has been reversed, FIs*/RHHIs* pay and report the claim on a per visit basis rather than on a prospective basis. They enter HC in 2-070-SVC01-01, the HCPCS for the visit(s) in 2-070-SVC01-02, submitted charge in SVC02, the paid amount in SVC03, appropriate revenue code (other than 0023) in SVC04, the number of visits paid in SVC05, the billed HCPCS if different than the paid HCPCS in SVC06, and the billed number of visits if different from the paid number of visits in SVC07.
3. 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. FIs*/RHHIs* enter “B6” in 2-110.C-AMT01 and the allowed amount for the visit(s) in AMT02.
6. FIs*/RHHIs* report the number of covered and noncovered (if applicable) visits in separate loops in segment 2-120-QTY.
7. 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, 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.