ANSI X12 X12N 835 VERSION 4010 & 4010A1
MEDICARE HIPAA COMPANION DOCUMENT
Carriers and DMERCS

INTRODUCTION

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 has been established as the standard for compliance for remittance advice transactions. The implementation guide for that format is available electronically at 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. This document has been prepared as a Medicare-specific companion document to that implementation guide and the flat file 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. This companion document supplements, but does not contradict any requirements in the 835 version 004010A1 implementation guide.

Table 1 - Header Data

Segment/ Data Elements	835 and Medicare Requirements/Notes
ST	Required.
ST01	Required. Always enter "835."
ST02	Required.
BPR	Required.
BPR01	Required. Codes U and X do not apply to Medicare.
BPR02	Required.
BPR03	Required. Code D does not apply to Medicare.
BPR04	Required. Codes BOP and FWT do not apply to Medicare.
BPR05	Situational, but required for Medicare if ACH is entered in BPR04.
BPR06	Situational, but required for Medicare if ACH in BPR04. Code 04 does not apply to Medicare.
BPR07	Situational, but required for Medicare if ACH in BPR04.
BPR08	Situational, but required for Medicare if ACH in BPR04.
BPR09	Situational, but required for Medicare if ACH in BPR04.
BPR10	Situational, but required for Medicare if ACH in BPR04.
BPR11	Situational, but does not apply to Medicare and should not be reported.
BPR12	Situational, but required for Medicare if ACH in BPR04. Code 04 does not apply to Medicare.
BPR13	Situational, but required for Medicare if ACH in BPR04.
BPR14	Situational, but required for Medicare if ACH in BPR04.
BPR15	Situational, but required if ACH in BPR04.
BPR16	Required.

BPR17-21	Not used.
TRN01	Required.
TRN02	Required.
TRN03	Required.
TRN04	Situational, but does not apply to Medicare.
CUR	Situational, but does not apply to Medicare.
REF (060.A)	Situational, but required for Medicare if the 835 is being sent to any entity other than the provider.
REF01	Required.
REF02	Required.
REF03-04	Not used.
REF (060.B)	Situational, but required for Medicare to identify a local version number for the implementation. Sometimes a local version number is needed to identify a post-implementation modification in programming, such as to correct a programming error. The local version number could be needed to answer a provider inquiry related to the programming modification.
REF01	Required.
REF02	Required. The version number is assigned locally.
REF03-04	Not used.
DTM (070)	Situational, but required for Medicare if the date of the 835 is different than the cutoff date for the adjudication action that generated the 835.
DTM01	Required.
DTM02	Required.
DTM03-06	Not used.
N1 (080.A)	Required for payer identification.
N101	Required.
N102	Situational, but required for Medicare.
N103	Situational. Always enter "XV" in this loop when the PlanID is effective, but not used prior to that date.
N104	Situational, but required once the PlanID is effective.
N105-106	Not used.
N3 (100)	Required for payer identification.
N301	Required.
N302	Situational, but required by Medicare if there is more than 1 address line for the payer, such as for a suite number.
N4 (110)	Required for payer identification.
N401	Required.
N402	Required.
N403	Required.
N404-406	Not used.
REF (120.A)	Situational. Required for Medicare prior to the effective date of the Plan ID. After that date, a Medicare payer may use at its option in addition to the Plan ID in the 060 REF.
REF01	Required. Only 2U applies to Medicare.
REF02	Required.
REF03-04	Not used.
PER (130)	Situational. Recommended for use for Medicare, but reporting of contact information in an 835 is at the option of individual Medicare contractors.

PER01	Required.
PER02	Situational. Optional for Medicare but recommended if this segment is used.
PER03	Situational, but required for Medicare if this segment is used.
PER04	Situational, but required for Medicare if there is an entry in PER03.
PER05	Situational. May be used at the option of a Medicare contractor to report a second contact.
PER06	Situational, but required if there is an entry in PER05.
PER07	Situational, but required for Medicare if segment is used and it is necessary to report a telephone extension number.
PER08-09	Not used.
N1 (080.B)	Required to identify the payee.
N101	Required.
N102	Situational but provided by Medicare
N103	Required. Always enter "XX." when the NPI is effective.
N104	Required.
N105-106	Not used.
N3 (100)	Situational, but required for Medicare.
N301	Required.
N302	Situational, but required if there is a second payee address line.
N4 (100.B)	Situational, but required for Medicare.
N401	Required.
N402	Required
N403	Required.
N404	Situational. Only required if the address is other than the U. S.
N405	Not used.
N406	Not used.
REF (120.B)	Situational, but required for Medicare.
REF01	Required. Always enter "TJ" in this loop when the NPI is effective.
REF02	Required.
REF03-04	Not used.

Table 2 - Detail Data

LX	Situational, but required for Medicare.
LX01	Required.
TS3	Situational. Used by Medicare carriers/DMERCS only if a NPI, not received on the claim, is used at the payee level as the primary provider ID per a Medicare/provider agreement. Under this scenario, the NPI received on the claim will be reported in data field TS301.
TS301	Required. Report the NPI received as the Billing or Pay-to-Provider in the 837 or as the Provider Identifier NPI in the NCPDP claim or sent in block 33a or 56 in a CMS 1500 or UB04 form respectively when a different NPI is reported at the payee level.
TS302	Required. Use the place of service code as the Facility Code Value.
TS303	Required
TS304	Required
TS305	Required.
TS306-TS324	Situational but do not apply to Medicare carriers/DMERCs

TS2	Situational. Not used by Medicare carriers/DMERCS, only by intermediaries.
CLP	Required.
CLP01	Required.
CLP02	Required. Codes 25 and 27 do not apply to Medicare and are not in the flat file.
CLP03	Required.
CLP04	Required.
CLP05	Situational, but required for Medicare if there is any patient financial responsibility for amounts not paid by Medicare.
CLP06	Required. Carriers always enter "MB." None of the other 835 codes apply to Medicare.
CLP07	Situational, but required for Medicare.
CLP08	Situational, but required for Medicare.
CLP09	Situational, but does not apply to Medicare carriers.
CLP10	Not used.
CLP11	Situational, but does not apply to carriers.
CLP12	Situational, but does not apply to carriers.
CLP13	Situational, but does not apply to carriers.
CAS (claim)	Situational, but does not apply to carriers. Adjustments for Medicare carriers should always be reported at the line level Unlike prior 835 versions, version 4010/4010A1 does not require entry of an OA 93 message in a claim level CAS when there are no claim level adjustments.
NM1 (030.A)	Required to report patient-related information.
NM101	Required.
NM102	Required.
NM103	Required.
NM104	Required.
NM105	Situational, but required for Medicare when a middle name or initial is available for the patient.
NM106	Not used.
NM107	Situational, but will not be used for Medicare.
NM108	Situational, but required for Medicare. Enter "HN" for Medicare, until notified that the HIPAA Individual Identifier is effective, at which point enter "II" in this data element. DMERCs enter MI or HN. None of the other qualifiers apply to Medicare.
NM109	Situational, but required for Medicare if reported on the incoming claim.
NM110-111	Not used.
NM1 (030.B)	Situational, but the loop is intended for information on an insured when different than the patient. This situation does not apply in Medicare. Not used.
NM1 (030.C)	Situational, but is required for Medicare when the patient's name, as received on the claim, has been corrected.
NM101	Required. For Medicare purposes, the insured is the patient.
NM102	Required. Code 2 does not apply to Medicare.
NM103	Situational, but required for Medicare if the last name has been corrected.
NM104	Situational, but required for Medicare if the first name has been corrected.
NM105	Situational, and optional for Medicare carrier to report a corrected middle name or initial.
NM106	Not used.

NM107 Situational, but not used for Medicare.
NM108 Situational, but required for Medicare if the ID # has been corrected.
NM109 Situational, but required for Medicare if the ID # has been corrected.
NM110-111 Not used.

NM1 (030.D) Situational, but required by the IG if the rendering provider is other than the payee. Rendering provider could vary by service. If the rendering provider for a service is different than reported at the claim level, the other rendering provider(s) must be identified at the service level. It is not necessary to repeat information for a rendering provider at the service level when the same as reported at the claim level. If there is more than one rendering provider other than the payee, enter either the identity of the provider who performed more of the services at the claim level, or if that would create programming difficulties, the identity of the first of the listed rendering providers.

NM101 Required.
NM102 Required. Code 2 does not apply to Medicare.
NM103 Situational, but do not report for Medicare. (Medicare reports only the number, not the name of the rendering provider.)
NM104 Situational, but do not report for Medicare. (Medicare reports only the number, not the name of the rendering provider.)
NM105 Situational, but do not report for Medicare. (Medicare reports only the number, not the name of the rendering provider.)
NM106 Not used.
NM107 Situational, but do not report for Medicare. (Medicare reports only the number, not the name of the rendering provider.)
NM108 Required. Required. Use "XX." when the NPI is effective.

NM109 Required.
NM110-111 Not used.

NM1 (030.E) Situational, but required for Medicare if claim data is being transferred to another payer under a coordination of benefits (COB) agreement with that payer. Note: Although Medicare may send claim and payment information to multiple secondary payers, the 835 does not permit identification of more than one of those secondary payers. When COB transmissions are sent to more than one secondary payer for the same claim, enter remark code N89 (see attachment 2) in a MOA segment remark code data element.
NM101 Required.
NM102 Required.
NM103 Required.
NM104-107 Not used.
NM108 Required. Until the PlanID is effective, always enter "PI" for Medicare; when effective, enter "XV." AD, FI, NI, and PP do not apply to Medicare.
NM109 Required.
NM110-111 Not used.

NM1 (030.F) Situational. Required for Medicare when a claim is denied or rejected due to the need for processing by a primary payer. That primary payer should be identified in the remittance advice.
NM101 Required.
NM102 Required.
NM103 Required.
NM104-107 Not used.

NM108	Required. Until the PlanID is effective, always enter "PI" for Medicare in this loop. When effective, always enter "XV" for Medicare. AD, FI, NI, and PP do not apply to Medicare.
NM109	Required. Enter the PlanID when effective. Prior to that date, zero-fill.
NM110-111	Not used.
MIA	Situational, but does not apply to Medicare carriers/DMERCS.
MOA	Situational, but required for Medicare carriers/DMERCS whenever any claim level remark code applies, such as an appeal rights remark code or when there is more than one COB payer.
MOA01	Situational, but does not apply to Medicare carriers.
MOA02	Situational, but does not apply to Medicare carriers.
MOA03	Situational, but required for Medicare whenever at least one claim level remark code applies, such as for an appeal remark code.
MOA04	Situational, but required for Medicare if more than one claim level remark code applies.
MOA05	Situational, but required for Medicare if a third claim level remark code applies.
MOA06	Situational, but required for Medicare if a fourth claim level remark code applies.
MOA07	Situational, but required for Medicare if a fifth claim level remark code applies.
MOA08	Situational, but does not apply to Medicare carriers.
MOA09	Situational, but does not apply to Medicare carriers.
REF (040.A)	Situational, but does not apply to Medicare carriers.
REF (040.B)	Situational, but does not apply to Medicare. Carriers identify rendering providers, if different than billing providers, at the service level.
DTM (050)	Situational, but required for Medicare.
DTM01	Required. Always enter "050" for Medicare. This data element would only be used to report the date of receipt of the claim. Medicare carriers must report the start and end dates of care at the service level, and expiration of coverage information (036) does not apply to Medicare.
DTM02	Required.
DTM03-06	Not used.
PER	Situational, Medicare contractors may report contact information at their option, either in table 1, or table 2, but it should not be necessary to report contact information in both tables.
PER01	Required.
PER02	Situational, and optional for use by a Medicare carrier. If furnished, contact data must be supplied by the carrier rather than the standard system.
PER03	Situational, but required for Medicare if the segment is used. Contact data must be furnished by the carrier.
PER04	Situational, but required for Medicare if this segment is used. Carrier must furnish the data.
PER05	Situational, and optional for use by a Medicare carrier if the carrier Would like to report additional contact information. If used, the data must be furnished by the carrier.
PER06	Situational, but required for Medicare if an entry in PER05. Data must be furnished by the carrier.
PER07	Situational, and optional for a carrier to use to report the extension number of any phone number reported in PER04 or 06. Data must be furnished by the carrier.

PER08	Situational, and optional for a carrier to use to report the extension number of any phone number reported in PER04 or 06. Data must be furnished by the carrier.
PER09	Not used.

AMT (062)	Situational, but required for Medicare if the claim reported the patient made any payment for the claim.
AMT01	Required. Only F5 and I apply to Medicare carriers. No other codes for this data element apply to Medicare.
AMT02	Required.
AMT03	Not used.

QTY	Situational, but does not apply to Medicare carriers.

SVC	Situational, but required for Medicare carriers. Note: The HCPCS, modifiers, and when applicable, NDC code reported on a claim for a service must be reported on the 835 for that service, including in situations where a service is being adjusted for submission of an invalid procedure code or modifier. This situation is considered an exception to the HIPAA requirement that standard transactions be limited to reporting of valid medical codes.
SVC01-1	Required. Only codes HC and N4 apply to Medicare carriers. A separate loop need for each service reported.
SVC01-2	Required.
SVC01-3	Situational, but required for Medicare if HC applies and at least one modifier was reported on the claim for the service.
SVC01-4	Situational, but required for Medicare if HC applies and a second modifier was reported on the claim for the service.
SVC01-5	Situational, but required for Medicare if HC applies and a third modifier was reported on the claim for the service.
SVC01-6	Situational, but required for Medicare if HC applies and a fourth modifier was reported on the claim for the service.
SVC01-7	Situational, but text language may not be reported for Medicare on a remittance advice.
SVC02	Required.
SVC03	Required.
SVC04	Situational, but does not apply to carriers.
SVC05	Situational, but required for carriers.
SVC06-1	Situational, but required if the procedure or drug code has been changed during adjudication. Only HC and N4 apply to Medicare carriers.
SVC06-2	Situational, but required if the procedure or drug code has been changed during adjudication. Insert the original submitted code.
SVC06-3--7	Situational, but required for Medicare if modifiers are changed.
SVC07	Situational, but required for Medicare if the paid units of service is different than the billed units of service.

DTM (080)	Situational, but required for Medicare.
DTM01	Required.
DTM02	Required.
DTM03-06	Not used.

CAS (svc)	Situational, but required for Medicare whenever the amount paid for a service does not equal the amount billed. Medicare carriers are required to separately report every adjustment made to a service.

CAS01	Required. PI does not apply to Medicare. Necessary to use separate loops if more than 1 group code applies, or if there are more than 6 procedure codes per group.
CAS02	Required.
CAS03	Required.
CAS04	Situational, but not used for Medicare.
CAS05	Situational, but required for Medicare if there is a second service level adjustment.
CAS06	Situational, but required for Medicare if there is a second service level adjustment.
CAS07	Situational, but not used for Medicare.
CAS08	Situational, but required for Medicare if there is a third service level adjustment.
CAS09	Situational, but required for Medicare if there is a third service level adjustment.
CAS10	Situational, but not used for Medicare.
CAS11	Situational, but required for Medicare if there is a fourth service level adjustment.
CAS12	Situational, but required for Medicare if there is a fourth service level adjustment.
CAS13	Situational, but not used for Medicare.
CAS14	Situational, but required for Medicare if there is a fifth service level adjustment.
CAS15	Situational, but required for Medicare if there is a fifth service level adjustment.
CAS16	Situational, but not used for Medicare.
CAS17	Situational, but required for Medicare if there is a sixth service level adjustment.
CAS18	Situational, but required for Medicare if there is a sixth service level adjustment.
CAS19	Situational, but not used for Medicare.

REF (100.A)	Situational, but required for Medicare.
REF01	Required. Only LU and 6R apply to Medicare. Two loops must be used if both LU and 6R apply.
REF02	Required. Note: The provider line item control number (6R) is not used by and will not be retained by the Medicare core system. As with a 20-digit patient account number, use the COB data repository to populate REF02 for 6R. Do not report 6R in REF01 of a reissued ERA if there is no line item control number in the repository.
REF03-04	Not used.

REF (100.B)	Situational, but required for Medicare if the rendering provider for the service is other than the payee and other than the rendering provider reported at the claim level.
REF01	Required. Use only "HPI". The other codes do not apply to Medicare.
REF02	Required.
REF03-04	Not used.

AMT (110)	Situational, but required for Medicare carriers if any of the qualifiers apply.
AMT01	Required. Only KH and B6 apply to Medicare. Two loops must be used for Medicare if both apply.
AMT02	Required.
AMT03	Not used.

QTY	Situational, but does not currently apply to Medicare carriers.

LQ	Situational, but required for Medicare whenever any service level remark codes apply.
LQ01	Required. Always enter "HE" for Medicare.
LQ02	Required.

Table 3 - Summary

PLB	Situational, but required for Medicare whenever there have been any provider-level adjustments.
PLB01	Required. Use the Payee NPI
PLB02	Required. Carriers must furnish this from their provider file, or use a default value of 12/31 of the current year.
PLB03-1	Required. Only codes CS, AP, FB, LE, L6, 50, SL, WO, B2, J1, IR, and 72 apply to Medicare carriers.
PLB03-2	Situational, but required for Medicare. Positions 1-2=RI, RB, OB, or if none of these apply, 00. Positions 3-19=the Financial Control Number or ICN, if applicable to the type of adjustment. Positions 20-30=the HIC number may be entered at the carrier's option. Medicare carriers and DMERCs report this information in these positions when the PLB segment is included in the 835.
PLB04	Required.
PLB05-1	Situational data element, but required if there is a second provider level adjustment.
PLB05-2	Situational, but required if there is a second provider level adjustment.
PLB06	Situational, but required if there is a second provider level adjustment.
PLB07-1	Situational, but required if there is a third provider level adjustment.
PLB07-2	Situational, but required if there is a third provider level adjustment.
PLB08	Situational, but required if there is a third provider level adjustment.
PLB09-1	Situational, but required if there is a fourth provider level adjustment.
PLB09-2	Situational, but required if there is a fourth provider level adjustment.
PLB10	Situational, but required if there is a fourth provider level adjustment.
PLB11-1	Situational, but required if there is a fifth provider level adjustment.
PLB11-2	Situational, but required if there is a fifth provider level adjustment.
PLB12	Situational, but required if there is a fifth provider level adjustment.
PLB13-1	Situational, but required if there is a sixth provider level adjustment. Two loops must be used for Medicare if both apply.
PLB13-2	Situational, but required if there is a sixth provider level adjustment.
PLB14	Situational, but required if there is a sixth provider level adjustment.
SE	Required.
SE01	Required. The transaction segment count is computed by the carrier system.
SE02	Required.