Program Memorandum Intermediaries/Carriers

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal AB-02-067 **Date: MAY 2, 2002**

CHANGE REQUEST 1959

SUBJECT: Remittance Advice Coding and Health Insurance Portability and Accountability Act (HIPAA) Transaction 835v4010 Completion Update

This Program Memorandum (PM) updates remark and reason codes for Medicare Part A, B and Durable Medical Equipment (DME) claims; updates the Medicare carrier and intermediary flat files; clarifies for carriers and Durable Medical Equipment Regional Carriers (DMERCs) generation of X12 835 version 4010 transactions if any required data element is missing or incomplete when received on a paper or pre-4010 electronic claim; and summarizes CMS requirements for standard systems, carriers, and DMERCs for implementation of the X12 835 version 4010 format.

Section I

X12N 835 Health Care Remittance Advice Remark Codes

CMS is the national maintainer of remittance advice remark codes used by both Medicare and non-Medicare entities. The list of remark codes is updated continuously as needed, and both Medicare and non-Medicare entities can request new codes or modifications in the existing codes to address their business needs. Some of these changes may not affect Medicare. Traditionally, remark code changes that impact Medicare are requested by Medicare staff in conjunction with a policy change. Contractors are notified of those new or modified codes in the corresponding implementation instructions in the form of a PM or manual instruction implementing the policy change.

The list of remark codes is available at http://www.wpc-edi.com/hipaa/. The list is updated each March, July, and November. Download the list from this website during those three months to obtain the most current set of approved remark codes. Medicare carriers, intermediaries, and DMERCs must use the latest approved remark codes posted on the above mentioned web site and as included in any subsequent CMS instructions in both their 835 version 4010 and subsequent versions, and the corresponding standard paper remittance advice transactions. Contractor and standard system changes must be made as necessary as part of a routine release to reflect changes such as retirement of previously used codes that may impact Medicare. See the reason code section in this PM for further information on deadlines for implementation of remark and reason code changes.

The following list summarizes changes made through February 28, 2002.

Code	Current Narrative	Type of Change
MA01	(Initial Part B determination, Medicare carrier or intermediary) --If you do not agree with what we approved for these services, you may appeal our decision. To make sure that we are fair to you, we require another individual that did not process your initial claim to conduct the review. However, in order to be eligible for a review, you must write to us within 6 months of the date of this notice, unless you have a good reason for being late. (**NOTE**: An Intermediary must add: An institutional provider, e.g., hospital, SNF, HHA or hospice may appeal only if the claim involves a medical	M**odification**

Code	Current Narrative	Type of Change
	necessity denial, a SNF recertified bed denial, or a home health denial because the patient was not homebound or was not in need of intermittent skilled nursing services, or a hospice care denial because the patient was not terminally ill, and either the patient or the provider is liable under Section 1879 of the Social Security Act, and the patient chooses not to appeal.) (**NOTE**: Carriers who issue telephone review decisions should add: If you meet the criteria for a telephone review, you should phone this office if you wish to request a telephone review.)	
MA02	(Initial Medicare Part A Determination)--If you do not agree with this determination, you have the right to appeal. You must file a written request for a reconsideration within 60 days of receipt of this notification. Decisions made by a Peer Review Organization (PRO) must be appealed to that PRO. (An institutional provider,e.g., hospital, SNF, HHA or a hospice may appeal only if the claim involves a medical necessity denial, a SNF noncertified bed denial, or a home health denial because the patient was not homebound or was not in need of intermittent skilled nursing services, or a hospice care denial because the patient was not terminally ill, and either the patient or the provider is liable under Section 1879 of the Social Security Act, and the patient chooses not to appeal.)	**Modification**
MA03	(Medicare Hearing)--If you do not agree with the approved Amounts and $100 or more is in dispute (less deductible and coinsurance), you may ask for a hearing. You must request a hearing within 6 months of the date of this notice. To meet the $100, you may combine amounts on other claims that have been denied. This includes reopened reviews if you received a revised decision. You must appeal each claim on time. At the hearing, you may present any new evidence which could affect our decision. (**NOTE**: An Intermediary must add: An institutional provider, e.g., hospital, SNF, HHA or a hospice may appeal only if the claim involves a medical necessity denial, a SNF noncertified bed denial, or a home health denial because the patient was not homebound or was not in need of intermittent skilled nursing services, or a hospice care denial because the patient was not terminally ill, and either the patient or the provider is liable under Section 1879 of the Social Security Act, and the patient chooses not to appeal.)	**Modification**
MA126	Pancreas transplant not covered unless kidney transplant performed	**New Code**
N23	Patient liability may be affected due to coordination of benefits with other carriers and/or maximum benefit provisions.	**Modification**
N70	Home health consolidated billing and payment applies.	**Modification**
N71	Your unassigned claim for a drug or biological or clinical diagnostic laboratory services or ambulance service was processed	**Modification**

Code	Current Narrative	Type of Change
	as an assigned claim. You are required by law to accept assignment for these types of claims.	
N73	A SNF is responsible for payment of outside providers who furnish these services/supplies to residents. Only the professional component of physician services can be paid separately.	**Modification**
N95	This provider type may not bill this service.	**New Code**
N96	Patient must be refractory to conventional therapy (documented behavioral, pharmacologic and/or surgical corrective therapy) and be an appropriate surgical candidate such that implantation with anesthesia can occur.	**New Code**
N97	Patients with stress incontinence, urinary obstruction, and specific neurologic diseases (e.g., diabetes with peripheral nerve involvement) which are associated with secondary manifestations of the above three indications are excluded.	**New Code**
N98	Patient must have had a successful test stimulation in order to support subsequent implantation. Before a patient is eligible for permanent implantation, he/she must demonstrate a 50 percent or greater improvement through test stimulation. Improvement is measured through voiding diaries.	**New Code**
N99	Patient must be able to demonstrate adequate ability to record voiding diary data such that clinical results of the implant procedure can be properly evaluated.	**New Code**
N100	PPS code corrected during adjudication.	**New Code**
N101	Additional information is needed in order to process this claim. Please resubmit the claim with the identification number of the Provider where this service took place. The Medicare number of the site of service provider should be preceded with the letters "HSP" and entered into item #32 on the claim form. You may bill only one site of service provider number per claim.	**New Code**
N102	This claim has been denied without reviewing the medical record because the requested records were not received or were not received timely.	**New Code**
N103	Social Security records indicate that this beneficiary was a prisoner when this claim was submitted. Medicare does not cover items and services furnished to beneficiaries while they are incarcerated, unless under State or local law, the beneficiary is personally liable for the cost of his or her health care while incarcerated.	**New Code**
N104	This claim/service is not payable under our claims jurisdiction area. You can identify the correct Medicare contractor to	**New Code**

Code	Current Narrative	Type of Change
	process this claim/service through the CMS website at www.cms.gov .	
N105	This is a misdirected claim/service for an RRB beneficiary. Submit paper claims to the RRB carrier: Palmetto GBA, P.O. Box 10066, Augusta, GA 30999. Call 866-749-4301 for RRB EDI information for electronic claims processing.	**New Code**
N106	Payment for services furnished to Skilled Nursing Facility (SNF) inpatients (except for excluded services) can only be made to the SNF. You must request payment from the SNF rather than the patient for this service.	**New Code**
N107	Services furnished to Skilled Nursing Facility (SNF) inpatients must be billed on the inpatient claim. They can not be billed separately as outpatient services.	**New Code**
N108	This item/service was denied because the upgrade information was invalid.	**New Code**
N109	This claim was chosen for complex review and was denied after reviewing the medical records.	**New Code**
N110	This facility is not certified for film mammography.	**New Code**
N111	No appeal right except duplicate claim/service issue. This service was included in a claim that has been previously billed and adjudicated.	**New Code**
N112	This claim is excluded from your electronic remittance advice.	**New Code**

X12 N 835 Health Care Claim Adjustment Reason Codes

The committee that maintains the health care claim adjustment reason codes, a non-CMS body, meets at the beginning of each X12 trimester meeting (February, June and October) and makes decisions about additions, modifications and retirement of existing reason codes. The updated list is posted three times a year after each X12 trimester meeting at http://www.wpc-edi.com/hipaa/. Although in most cases, reason code additions, modifications and retirements are requested by entities other than Medicare and would not be routinely included in a Medicare instruction as part of a policy change, modification or retirement of an existing code could impact Medicare. A PM will be issued on a periodic basis to provide a summary of changes in the reason and remark codes introduced since the last update PM. These PMs will establish the deadline for carrier, intermediary and related standard system implementation of the reason and remark code changes applicable to Medicare that may not already have been implemented as part of a previous Medicare policy change instruction.

A reason code may be retired if determined to be duplicative or no longer applicable. These changes are always effective with a specified 835 future version, and never retroactively. Remark and reason code changes, other than retirements, are not version specific. The reason code committee has indicated that future updates will identify which code should be used in lieu of the retired code. Contractors using any of the retired codes must modify their maps or programming as necessary by the date the specified electronic version or a higher numbered version is implemented.

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

Standard systems must provide a crosswalk between the reason and remark codes to the standard system internal codes so that a carrier or intermediary can easily locate and update each internal code that may be impacted by a remittance advice reason/remark code change to eliminate the need for lengthy and error prone manual carrier and intermediary searches for identify each affected internal code. Standard systems must also make sure that 5 position remark codes can be accommodated at the claim and at the service level.

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 PM requiring implementation of a policy change that led to the issuance of the new or modified code, or the date specified in the periodic PM announcing issuance of the code changes (additions/modifications/retirements). Contractors must notify providers of the new and/or modified codes and their meanings in a provider bulletin or other instructional release prior to issuance of remittance advice transactions that include these changes.
A code may not be reported in a new remittance advice after the effective date of its retirement. If processing an adjustment involving a code that was retired after generation of the original remittance advice, the reversed claim may report the currently valid code supplanting the code that appeared in the initial notice. If easier from a mapping or programming perspective, an intermediary or carrier has the option to eliminate use of a retired code in each supported remittance advice versions, including those that pre-date the effective date of the retirement.

The committee did not approve any reason code changes in October 2001.
The committee approved the following reason code changes in February 2002:

> Reason codes 16, 17 and 125 will have an additional sentence added to their current descriptions that reads: Additional information is supplied using the “Remittance Advice Remark Codes” whenever appropriate.

X12 835 PLB Composite Adjustment Code Changes—Intermediaries that use Fiscal Intermediary Standard System (FISS) only

CMS-specific adjustment codes are reported in the PLB segment by intermediaries, but not carriers. Pre-version 4010, there was no means to differentiate among outlier and indirect medical education payments. Each of these provider transaction level adjustments was reported under CMS code CA (manual claim adjustment). Effective with version 4010, the following codes will be reported in the Flat File for reporting with X12 code CS in the composite data element of the 835 PLB segment:

- XF for outlier
- IM for Indirect Medical Education

Effective with version 4010, code ZZ for Hemophilia will be reported in the Flat File. Intermediaries must notify potentially affected providers and clearinghouses of this change. APASS intermediaries will continue reporting the way they currently report.

Changes in X12N 835 Flat File and Companion Document - Intermediaries

The updated X12N 835 version 4010 supportive remittance advice Flat File is posted at http://www.hcfa.gov/medicare/edi/hipaadoc.htm under the file name A835v4010-3.xls and dated March 8, 2002. Subsequent adjustments may be issued if necessary to resolve problems or errors

identified during programming or testing. The most current version of the X12N 835 version 4010 Flat File (for intermediaries) includes the following changes:

Record One: Added data elements BPR11 and TRN04 in field 34 "Originating Company Supplemental Code," with PIC of X9. Rationale for one field instead of two: BPR11 is a Min/Max of X9 and the TRN04 is Min/Max of X1-30. TRN04 must equal BPR11; thus one field with PIC of X9 would be sufficient for both data elements.

Due to the addition of field 34, the filler became field 35 and was reduced to X119.

Record Twenty: Field 32 "Total Patient Reimb Amt," the "From" value was incorrect. Corrected to be 325.

These changes have been made because in 835 version 4010, payers are required to put the Federal Tax ID prefaced with a"1" in BPR10 and TRN03, rather than the Medicare intermediary number. The Medicare intermediary number now must be reported in BPR11 and TRN04.

The companion document, which was published as Attachment 1 with transmittal A-01-57, is modified in conjunction with the changes in Record One. The companion document is reprinted in full as Attachment 1 with the revisions bolded and italicized to highlight the changes.

Record Thirty: Field 23, PIP indicator, and field 24, MSP indicator, field 25, per die rate, field 26, capital code, field 27, non-covered charges, field 28, denied charges have been added to facilitate generation of paper remittance notices. The remaining filler has been reduced and moved to field 29. These changes do not impact the companion document.

Record Fifty: LQ segment PIC changed from X4 to X5 to accommodate 5 position remark codes, and a place for an additional remark code is provided. This would also bring the filler at the end of the record to X61

Standard systems should not expand remark code fields to accommodate 5 position remark codes in their flat files for pre version 4010 835 or any other electronic format. If a 5 position remark code applies, the standard system must report the last 4 positions in the flat file, e.g., "MA125" would be reported as "A125" in the flat file for any pre version 4010 835. The translator must be set to insert the truncated character ("M" in the above example) at the beginning of a remark code with 5 positions when preparing the 835.

The companion document, which was published as Attachment 1 with transmittal A-01-57, is modified in conjunction with the changes in Flat File. The companion document is reprinted in full as Attachment 1 with the revisions bolded and italicized to highlight the changes.

Changes in X12N 835 Flat File and Companion Document - Carriers

There have been a few changes in the 835 Flat File issued with Transmittal AB-01-132, dated September 21, 2001. These changes have been made to make the 835 Flat File more consistent with the 837 Flat File for carriers. The updated X12N 835 version 4010 supportive remittance advice Flat File is posted at http://www.hcfa.gov/medicare/edi/hipaadoc.htm under the file name B835v4010-3.xls and dated March 8, 2002. Subsequent adjustments may be issued if necessary to resolve problems or errors identified during programming or testing. The most current version of the X12N 835 version 4010 Flat File (for carriers) includes the following changes:

Element Identifier	Description of change
NM1	
NM109	Previous description changed from Patient control # to HIC # NSF reference changed from 400-03 to 400-07
MOA	
MOA01	PIC changed from S9(7)V99 to 9(3)V99

CAS

CAS04	PIC changed from S9(3)V99 to 9(7)
CAS07	PIC changed from S9(3)V99 to 9(7)
CAS10	PIC changed from S9(3)V99 to 9(7)
CAS13	PIC changed from S9(3)V99 to 9(7)
CAS16	PIC changed from S9(3)V99 to 9(7)
CAS19	PIC changed from S9(3)V99 to 9(7)

There is no change in the companion document in conjunction with these changes in the 835 carrier Flat File.

Section II

This section does not apply to intermediaries that use Fiscal Intermediary Standard System (FISS). There will be a separate PM to be released at a later date addressing these issues for FISS intermediaries.

Further Guidance Regarding Generating a Remittance Advice --Intermediaries, Carriers and DMERCs

Every X12 835 version 4010 transaction issued by an intermediary or carrier/DMERC must comply with the implementation guide (IG) requirements, i.e., these must balance at the service, claim and transaction levels, each required segment must be reported, each required or applicable situational data element in a required or situational segment must be reported, and the data in a data element must meet the minimum length and data attribute (AN, ID, R, etc.) specifications in the implementation guide.

Back end validation must be performed to ensure that these conditions are met. Carriers, DMERCs, and intermediaries are not required to validate codes maintained by their standard systems, such as HCPCS, that are issued in their standard system's flat file for use in the body of an 835, but they are required to validate data in the 835 envelope as well as the codes that they maintain, such as claim adjustment reason codes, that are reported in the 835. Do not 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 4010 or any other electronic claim, and does not meet the required data attribute(s) for the 835 version 4010, in which case, "gap filling" would be needed if it is to be inserted in a compliant 835 (see the following section; this is not reportedly an intermediary issue).

As discussed in CR 1523, it is permissible on an exception basis for carriers to issue a version 4010 835 with a balancing problem as long as action is initiated to correct the problem that created the out-of-balance situation. These out-of-balance 835s must be rare exceptions however, and not the rule. If an out-of-balance 835 is issued, affected providers and clearinghouses must be notified of the problem and that it would be corrected shortly. The standard systems 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.

In a partial change from CR 1522, intermediary standard systems must make forced balancing adjustments at the line, claim and/or transaction level as applicable and necessary to make each 835 version 4010 transaction to balance. Intermediary standard systems must report the amount by which a line or claim is out of balance with adjustment reason code A7 (Presumptive Payment

Adjustment) at the line or claim level. The intermediary standard systems must report the amount by which a transaction is out-of-balance with reason code CA (manual claim adjustment) as a PLB adjustment. PLB Medicare composite reason code CS/CA will be reported in this situation.

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

Further Guidance Regarding Generating a Remittance Advice if Required Data are Missing or Invalid - Carriers/DMERCs

The X12 835 version 4010 IG contains specific data requirements, which must be met to build an electronic remittance advice (ERA) in compliance with the Health Insurance Portability and Accountability Act (HIPAA). A claim could be received on paper, or in a pre 4010 or any other electronic format, that lacks data or has data that does not meet the data attribute 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 a standard paper remittance (SPR) advice or a "gap filled" ERA to avoid non-compliance with HIPAA. For example, if a procedure code is sent with only four characters and the code set specified in the IG includes only five character codes in the data element, and 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. A non-compliant ERA could be rejected by the receiver.

The standard system maintainers, working in conjunction with the users, 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 standard systems must enter meaningless characters to meet the data element minimum length requirements in any outgoing X12 transaction if insufficient data are available for entry in a required data element. Standard 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 be useable with every type of data where this situation could occur, e.g., with alphanumeric (AN), decimal (R), identifier (ID), date (DT), and other data types as appropriate. The values may not include any special characters, low values, high values, or all spaces since this could cause problems with the receivers’ translators. 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. ERAs issued for Medicare must adhere to the data attributes in the IG, including but not limited to minimum length requirements.

The *effective date* for this Program Memorandum (PM) is October 1, 2002, except as noted for Section II.

The *implementation date* for this PM is October 1, 2002, except as noted for Section II.

This PM may be discarded after October 1, 2003.

If you have any questions, contact Sumita Sen at 410-786-5755 or ssen@cms.hhs.gov**.**

Attachment

Attachment

MEDICARE X12N 835 VERSION 4010
HIPAA COMPANION DOCUMENT (INTERMEDIARIES)

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 4010 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 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 4010 implementation guide.

Table 1 - Header Data

Segment/ Data Elements	835 and Medicare Requirements/Notes
Envelope	
ISA	Required
ISA01	Required. Enter 00 pending establishment of HIPAA security requirements for transmissions. Translator Generated (TG)
ISA02	Required. Enter 10 blank spaces pending establishment of HIPAA security requirements. TG
ISA03	Required. Enter 00 pending establishment of HIPAA security requirements. TG
ISA04	Required. Enter 10 blank spaces pending establishment of HIPAA security requirements. TG
ISA05	Required. Enter ZZ as Medicare trading partners will always mutually decide on the interchange sender ID to be used. TG
ISA06	Required. Mapped to flat file (ff) record 1, field 1.
ISA07	Required. The type of number used for receiver identification is individually negotiated between trading partners. Enter 29 if using the NPI number, when effective, as the qualifier. Enter ZZ, mutually defined, if using an alternate locally defined qualifier. Alternately, one of the other qualifiers permitted in the IG can be used if trading partners choose one of those means of identification. TG
ISA08	Required. The number must be locally determined. TG
ISA09	Required. Enter the transmission date. TG
ISA10	Required. Enter the transmission time. TG
ISA11	Required. TG
ISA12	Required. TG
ISA13	Required. TG
ISA14	Required. Enter 0. TG
ISA15	Required. Mapped to ff record 1, field 12.
ISA16	Required. Locally determined, but “>” is recommended as the delimiter symbol. TG

Segment/ Data Elements	835 and Medicare Requirements/Notes
IEA	Required.
IEA01	Required. TG
IEA02	Required. TG
GS	Required
GS01	Required. TG
GS02	Required. Mapped to ff record 1, field 1.
GS03	Required. The receiver's code is established in the trading partner agreement. It may be the provider # (mapped to ff record 1, field 3), the provider chain ID # (mapped to ff record 1, field 2), the VAN ID # (in local records, TG), or the EDI submitter # (in local records, TG).
GS04	Required. TG
GS05	Required. TG
GS06	Required. TG
GS07	Required. TG
GS08	Required. TG
ST	Required.
ST01	Required. Always enter "835." TG
ST02	Required. TG
BPR	Required.
BPR01	Required. Codes U and X do not apply to Medicare. Mapped to ff record 1, field 13.
BPR02	Required. Mapped to ff record 1, field 14.
BPR03	Required. Code D does not apply to Medicare. Mapped to ff record 1, field 15.
BPR04	Required. Codes BOP and FWT do not apply to Medicare. Mapped to ff record 1, field 16.
BPR05	Situational, but required for Medicare if ACH is entered in BPR04. Mapped to ff record 1, field 17.
BPR06	Situational, but required for Medicare if ACH in BPR04. Code 04 does not apply to Medicare. Mapped to ff record 1, field 18.
BPR07	Situational, but required for Medicare if ACH in BPR04. Mapped to ff record 1, field 19.
BPR08	Situational, but required for Medicare if ACH in BPR04. Mapped to ff record 1, field 20.
BPR09	Situational, but required for Medicare if ACH in BPR04. Mapped to ff record 1, field 21.
BPR10	Situational, but required for Medicare if ACH in BPR04. Mapped to ff record 1, field 22.
BPR11	***Situational, but required for Medicare when BPR 10 is used. Mapped to ff record 1, field 34. BPR11 and TRN4 must be identical.***
BPR12	Situational, but required for Medicare if ACH in BPR04. Code 04 does not apply to Medicare. Mapped to ff record 1, field 23.
BPR13	Situational, but required for Medicare if ACH in BPR04. Mapped to ff record 1, field 24.
BPR14	Situational, but required for Medicare if ACH in BPR04. Mapped to ff record 1, field 25.
BPR15	Situational, but required if ACH in BPR04. Mapped to ff record 1, field 26.
BPR16	Required. Mapped to ff record 1, field 27.
BPR17-21	Not used.

Segment/ Data Elements	835 and Medicare Requirements/Notes
TRN	Required.
TRN01	Required. Mapped to ff record 1, field 28.
TRN02	Required. If no payment is issued, insert the remittance advice number. Mapped to ff record 1, field 29 and 30.
TRN03	Required. TRN03 must =BPR10. Mapped to ff record 1, field 22.
TRN04	***Situational but required for Medicare. Mapped to ff record 1, field 34. BPR11 and TRN4 must be identical.***
CUR	Situational, but does not apply to Medicare.
REF (060.A)	Situational, but required for Medicare if the 835 is being sent to any entity other than the payee.
REF01	Required. Always enter ”EV.” TG
REF02	Required. Must correspond to entry in ISA08. Mapped to ff record 1, field 2.
REF03-04	Not used.
REF (060.B)	Situational, but does not apply to Medicare intermediaries.
DTM (070)	Situational, but required for Medicare if the date of the 835 is different than the cutoff date for the adjudication action that generated the 835.
DTM01	Required. Mapped to ff record 1, field 31.
DTM02	Required. Mapped to ff record 1, field 32.
DTM03-06	Not used.
N1 (080.A)	Required for payer identification.
N101	Required. Mapped to ff record 10, field 12.
N102	Situational, but required for Medicare. Mapped to ff record 10, field 13.
N103	Situational. Always enter “XV” in this loop when the PlanID is effective, but not used prior to that date. Mapped to ff record 10, field 14.
N104	Situational, but required once the PlanID is effective. Mapped to ff record 10, field 15.
N105-106	Not used.
N3 (100)	Required for payer identification.
N301	Required. Mapped to ff record 10, field 16.
N302	Situational in the 835, but required by Medicare if there is more than 1 address line for the payer, such as for a suite number. Mapped to ff record 10, field 17.
N4 (110)	Required for payer identification.
N401	Required. Mapped to ff record 10, field 18.
N402	Required. Mapped to ff record 10, field 19.
N403	Required. Mapped to ff record 10, field 20.
N404-406	Not used.
REF (120.A)	Situational. Required for Medicare prior to the effective date of the PlanID. After that date, a Medicare payer may use at its option in addition to the Plan ID in the 060 REF.
REF01	Required. Enter 2U; EO, HI, and NF do not apply to Medicare. Mapped to ff record 10, field 21.
REF02	Required. Mapped to ff record 10, field 22.
REF03-04	Not used.
PER (130)	Situational, but will not be used by Medicare.

Segment/ Data Elements	835 and Medicare Requirements/Notes
N1 (080.B)	Required to identify the payee.
N101	Required. Mapped to ff record 15, field 12.
N102	Situational, but reporting of the payee's name is required for Medicare prior to the effective date of the NPI. Mapped to ff record 15, field 13.
N103	Required. Always enter "FI" until the NPI is effective. After that date, always enter "XX." Mapped to ff record 15, field 14.
N104	Required. Payee's TIN for qualifier FI mapped to ff record 15, field 23. NPI, when effective, mapped to ff record 15, field 15.
N105-106	Not used.
N3 (100.B)	Situational, but required for Medicare if data reported in the N1 segment for this loop.
N301	Required. Mapped to ff record 15, field 16.
N302	Situational, but required if this segment is used and there is a second payee address line. Mapped to ff record 15, field 17.
N4 (110.B)	Situational, but required for Medicare if data reported in the N1 segment of this loop.
N401	Required. Mapped to ff record 15, field 18.
N402	Required. Mapped to ff record 15, field 19.
N403	Required. Mapped to ff record 15, field 20.
N404	Situational. Only required if the address is other than the U. S. Mapped to ff record 15, field 21.
N405-406	Not used.
REF (120.B)	Situational, but will be required for Medicare to report the Taxpayer Identification Number (TIN) when the National Payer Identifier (NPI) is effective. The TIN will be reported in N104 until that date.
REF01	Required. Always enter "TJ" in this loop when the NPI is effective. Prior to that date, use PQ (Payee Identification) for Medicare. 0B, 1A, 1B,1C,1D, 1E, 1F, 1G, 1H, D3, G2, and N5 do not apply to Medicare intermediaries. TJ mapped to ff record 15, field 22. PQ mapped to ff record 15, field 24.
REF02	Required. TJ (TIN) mapped to ff record 15, field 23. PQ mapped to ff record 15, field 25.
REF03-04	Not used.

Table 2, Detail Data

LX	Situational, but required for Medicare.
LX01	Required. Mapped to ff record 20, field 12.
TS3	Situational, but required for intermediaries when applicable.
TS301	Required. Mapped to ff record 1, field 3.
TS302	Required. Mapped to ff record 1, field 5
TS303	Required. Mapped to ff record 1, field 4.
TS304	Required. Mapped to ff record 20, field 13.
TS305	Required. Mapped to ff record 20, field 14.
TS306	Situational, but required for Medicare if there have been any covered charges for this provider for this fiscal period. The covered charge allowable by Medicare is the submitted charge minus the non-covered charges. Mapped to ff record 20, field 15.

Segment/ Data Elements	835 and Medicare Requirements/Notes
TS307	Situational, but required for Medicare if there have been any non-covered charges for this provider for this fiscal period. Mapped to ff record 20, field 16.
TS308	Situational, but required for Medicare if there have been any denied charges for this provider for this fiscal period. Mapped to ff record 20, field 17.
TS309	Situational, but required for Medicare if there have been any payments to this provider for this fiscal period. Includes total interest. The amount can be less than zero. Mapped to ff record 20, field 18.
TS310	Situational, but required for Medicare if there have been any interest payments to this provider for this fiscal period. Mapped to ff record 20, field 19.
TS311	Situational but required for Medicare if there have been any A2 contractual adjustments for this provider for this fiscal period. Mapped to ff record 20, field 20.
TS312	Situational, but required for Medicare if there have been any Gramm-Rudman reductions for this provider for this fiscal period. Mapped to ff record 20, field 21.
TS313	Situational, but required for Medicare if there have been any payments made by payer(s) primary to Medicare for claims processed by Medicare for this type of bill for this fiscal period. This includes any coinsurance and deductible amounts another payer paid for a beneficiary. Mapped to ff record 20, field 22.
TS314	Situational but required for Medicare if any blood deductible amounts have applied to this provider for this type of bill for this fiscal period. Mapped to ff record 20, field 23.
TS315	Situational, but required for Medicare if there have been payments made using the clinical lab or orthotics and prosthetics fee schedules. Equals the total covered charges minus sum of charges for line items paid on either the clinical lab or orthotics and prosthetics fee schedules. Mapped to ff record 20, field 24.
TS316	Situational, but required for Medicare if any coinsurance was due to this provider for this type of bill summary for this fiscal period. Mapped to ff record 20, field 25.
TS317	Situational, but required for Medicare if provider billed for HCPCS line items payable on either clinical lab or orthotics and prosthetics fee schedules for this type of bill for this fiscal period. Mapped to ff record 20, field 26.
TS318	Situational, but required for Medicare if benefits allowed for HCPCS line items covered by the clinical lab or orthotics and prosthetics fee schedules for this provider for this fiscal period. Mapped to ff record 20, field 27.
TS319	Situational, but required for Medicare if any cash deductible applied for this provider for this type of bill for this fiscal period. Mapped to ff record 20, field 28.\
TS320	Situational, but required for Medicare if any professional component amounts were paid to this provider for this type of bill for this fiscal period. Mapped to ff record 20, field 29.

Segment/ Data Elements	835 and Medicare Requirements/Notes
TS321	Situational, but required for Medicare if other payers satisfied the patient liability amounts (reason codes in the PR group) for this provider for this type of bill for this fiscal period. Mapped to ff record 20, field 30.
TS322	Situational, but required if any refund made to patients by Medicare on behalf of this provider for this type of bill for this fiscal period. Mapped to ff record 20, field 31.
TS323	Situational, but required for Medicare if this provider was on PIP for any portion of this fiscal period. Mapped to ff record 20, field 32.
TS324	Situational, but required for Medicare if this provider was on PIP for any portion of this fiscal period. Mapped to ff record 20, field 33.
TS2	Situational, but required for Medicare if there have been inpatient PPS payments to this provider for this type of bill for this fiscal period.
TS201	Required. Mapped to ff record 21, field 12.
TS202	Situational, but required for Medicare if any federal-specific operating DRG amounts have been paid. Mapped to ff record 21, field 13.
TS203	Situational, but required for Medicare if any hospital-specific operating DRG amounts have been paid. Mapped to ff record 21, field 14.
TS204	Situational, but required for Medicare if any disproportionate share payments have been paid. Mapped to ff record 21, field 15.
TS205	Situational, but required for Medicare if capital payments, other than capital outliers, have been paid. Mapped to ff record 21, field 16.
TS206	Situational, but required for Medicare if any indirect medical education payments made. Mapped to ff record 21, field 17.
TS207	Situational, but required for Medicare if any day outlier payments made. Mapped to ff record 21, field 18.
TS208	Situational, but required for Medicare if any day outlier payments made. Mapped to ff record 21, field 19.
TS209	Situational, but required for Medicare if any cost outlier payments made. Mapped to ff record 21, field 20.
TS210	Situational, but required for Medicare if DRG payments made. This is the geometric average length of stay for DRGs for this interchange transmission. Mapped to ff record 21 field 21.
TS211	Situational, but required for Medicare when there have been discharges. Mapped to ff record 21, field 22.
TS212	Situational, but required for Medicare if there have been cost report days. Mapped to ff record 21, field 23.
TS213	Situational, but required for Medicare if there have been covered days. Mapped to ff record 21, field 24.

Segment/ Data Elements	835 and Medicare Requirements/Notes
TS214	Situational, but required for Medicare if there have been any non-covered days. Mapped to ff record 21, field 25.
TS215	Situational, but required for Medicare if MSP pass-through amounts applied. Mapped to ff record 21, field 26.
TS216	Situational, but required for Medicare if DRG payments made. Mapped to ff record 21, field 27.
TS217	Situational, but required for Medicare if any PPS capital FSP DRG payment made. Mapped to ff record 21, field 28.
TS218	Situational, but required for Medicare if any PPS capital HSP DRG payment made. Mapped to ff record 21, field 29.
TS219	Situational, but required for Medicare if any PPS DSH DRG payment made. Mapped to ff record 21, field 30.
CLP	Required.
CLP01	Required. Mapped to ff record 30, field 12.
CLP02	Required. Mapped to ff record 30, field 13. Codes 5-17, 25 and 27 do not apply to Medicare.
CLP03	Required. Mapped to ff record 30, field 14.
CLP04	Required. Mapped to ff record 30, field 15.
CLP05	Situational, but does not apply to intermediaries.
CLP06	Required. Intermediaries must always enter "MA." None of the other 835 codes apply to Medicare intermediaries. Mapped to ff record 30, field 16.
CLP07	Situational, but required for Medicare. Mapped to ff record 1, field 7.
CLP08	Situational, but required for Medicare. Mapped to ff record 30, field 17.
CLP09	Situational, but required for Medicare intermediaries. Mapped to ff record 30, field 18.
CLP10	Not used.
CLP11	Situational, but required for intermediaries if DRG payments made. Mapped to ff record 30, field 19.
CLP12	Situational, but required for Medicare if DRG payment made. Mapped to ff record 30, field 20.
CLP13	Situational, but required for Medicare if discharge fraction was a factor in payment to an institution. Mapped to ff record 30, field 21.

Segment/ Data Elements	835 and Medicare Requirements/Notes
CAS (020)	Situational. May only be used if there are claim level adjustments. Adjustments reported at the service level may not be reported again, individually or in total, at the claim level. Unlike prior 835 versions, version 4010 does not require entry of an OA 93 message in a claim level CAS when there are no claim level adjustments. Payers, including Medicare, are prohibited from use of any reason code that is not listed for use with version 4010 in the official reason code compendium maintained at *www.wpc-edi.com* under 835 codes. This list is generally updated in late February, July and October. See the service level CAS segment for more information on Medicare use of the CAS.
CAS01	Required. Medicare contractors are limited to use of the CO, CR, OA, and PR group codes. PI may not be used for Medicare. Mapped to ff record 31, field 12. (If 2nd loop, mapped to ff record 31, field 31.)
CAS02	Required. Mapped to ff record 31, field 13. (If 2nd loop, mapped to field 32.)
CAS03	Required. Mapped to ff record 31, field 14. (If 2nd loop, mapped to field 33.)
CAS04	Situational. Mapped to ff record 31, field 15. (If 2nd loop, mapped to field 34.)
CAS05	Situational, but required for Medicare if a second claim level adjustment applies to this group code. Mapped to ff record 31, field 16. (If 2nd loop, mapped to field 35.)
CAS06	Situational, but required for Medicare if a second claim level adjustment applies to this group code. Mapped to ff record 31, field 17. (If 2nd loop, mapped to field 36.)
CAS07	Situational, but required for Medicare if a second claim level adjustment applies to this group code. Mapped to ff record 31, field 18. (If 2nd loop, mapped to field 37.)
CAS08	Situational, but required for Medicare if a third claim level adjustment applies to this group code. Mapped to ff record 31, field 19. (If 2nd loop mapped to field 38.)
CAS09	Situational, but required for Medicare if a third claim level adjustment applies to this group code. Mapped to ff record 31, field 20. (If 2nd loop, mapped to field 39.)
CAS10	Situational, but required for Medicare if a third claim level adjustment applies to this group code. Mapped to ff record 31, field 21. (If 2nd loop, mapped to field 40.)
CAS11	Situational, but required for Medicare if a fourth claim level adjustment applies to this group code. Mapped to ff record 31, field 22. (If 2nd loop, mapped to field 41.)
CAS12	Situational, but required for Medicare if a fourth claim level adjustment applies to this group code. Mapped to ff record 31, field 23. (If 2nd loop, mapped to field 42.)

CAS13	Situational, but required for Medicare if a fourth claim level adjustment applies to this group code. Mapped to ff record 31, field 24. (If 2nd loop, mapped to field 43.)

Segment/ Data Elements	835 and Medicare Requirements/Notes
CAS14	Situational, but required for Medicare if a fifth claim level adjustment applies to this group code. Mapped to ff record 31, field 25. (If 2nd loop, mapped to field 44.)
CAS15	Situational, but required for Medicare if a fifth claim level adjustment applies to this group code. Mapped to ff record 31, field 26. (If 2nd loop, mapped to field 45.)
CAS16	Situational, but required for Medicare if a fifth claim level adjustment applies to this group code. Mapped to ff record 31, field 27. (If 2nd loop, mapped to field 46.)
CAS17	Situational, but required for Medicare if a sixth claim level adjustment applies to this group code. Mapped to ff record 31, field 28. (If 2nd loop, mapped to field 47.)
CAS18	Situational, but required for Medicare if a sixth claim level adjustment applies to this group code. Mapped to ff record 31, field 29. (If 2nd loop, mapped to field 48.)
CAS19	Situational, but required for Medicare if a sixth claim level adjustment applies to this group code. Mapped to ff record 31, field 30. (If 2nd loop, mapped to field 49.)
NM1 (030.A)	Required to report patient-related information.
NM101	Required. Mapped to ff record 40, field 12.
NM102	Required. Mapped to ff record 40, field 13.
NM103	Required. Mapped to ff record 40, field 14.
NM104	Required. Mapped to ff record 40, field 15.
NM105	Situational, but required for Medicare when a middle name or initial is available for the patient. Mapped to ff record 40, field 16.
NM106	Not used.
NM107	Situational, but will not be used by Medicare.
NM108	Situational, but required for Medicare. Always enter "HN" for Medicare until notified that the HIPAA Individual Identifier is effective, at which point enter "II" in this data element. None of the other qualifiers apply to Medicare. Mapped to ff record 40, field 17.
NM109	Situational, but required for Medicare if reported on the incoming claim. Mapped to ff record 40, field 18.

NM110-111	Not used.
NM1 (030.B)	Situational, but the loop is intended for information on an insured when different than the patient. This situation does not apply in Medicare.
NM1 (030.C)	Situational, but required for Medicare when the HIC number has been corrected.
NM101	Required. For Medicare purposes, the insured is the patient. Mapped to ff record 40, field 19.
NM102	Required. Code 2 does not apply to Medicare. Mapped to ff record 40, field 20.
NM103	Situational, but not used by Medicare.
NM104	Situational, but not used by Medicare.
NM105	Situational, but not used by Medicare.
NM106	Not used.
NM107	Situational, but not used for Medicare.
NM108	Situational, but required for Medicare if the patient's ID # has been corrected. Mapped to ff record 40, field 21.
NM109	Situational, but required for Medicare if the patient's ID # as been corrected. Mapped to ff record 40, field 22.
NM110-111	Not used.
NM1 (030.D)	Situational, but does not apply to Medicare intermediaries.
NM1 (030.E)	Situational, but required for Medicare if claim data is being transferred to another payer under a coordination of benefits (COB) agreement with that payer. NOTE: Although Medicare may send claim and payment information to multiple secondary payers, the 835 does not permit identification of more than one of those secondary payers. When COB transmissions are sent to more than one secondary payer for the same claim, report remark code N89 (see attachment 1) in a claim level remark code data element.
NM101	Required. Mapped to ff record 41, field 12.
NM102	Required. Mapped to ff record 41, field 13.
NM103	Required. Mapped to ff record 41, field 14
NM104-107	Not used.
NM108	Required. Until the PlanID is effective, enter "PI" for Medicare if another or no ID number is available for the payer. When PlanID is effective, enter "XV." AD, FI, NI, and PP do not apply to Medicare. Mapped to ff record 41, field 15.

Segment/ Data Elements	835 and Medicare Requirements/Notes
NM109	Required. Enter the Plan ID when effective. Prior to that date, enter the other number if available with PI, or if no ID number is available, enter 00 with PI. Mapped to ff record 41, field 16.
NM110-111	Not used.
NM1 (030.F)	Situational, but required for Medicare when a claim is denied or rejected due to the need for processing by a primary payer. That primary payer must be identified in the remittance advice. This segment notifies the provider whom to bill first. Do not use when NM1 segment 030.E applies.
NM101	Required. Mapped to ff record 41, field 17. (If 2nd loop, mapped to field 22.)
NM102	Required. Mapped to ff record 41, field 18. (If 2d loop, mapped to field 23.)
NM103	Required. Mapped to ff record 41, field 19. (If 2nd loop, mapped to field 24.)
NM104-107	Not used.
NM108	Required. Until the PlanID is effective, always enter "PI" for Medicare in this loop. When effective, always enter "XV" for Medicare. AD, FI, NI, and PP do not apply to Medicare. Mapped to ff record 41, field 20. (If 2nd loop, mapped to field 25.)
NM109	Required. Enter the PlanID when effective. Prior to that date, enter 00. Mapped to ff record 41, field 21. (If 2nd loop, mapped to field 26.)
NM110-111	Not used.
MIA	Situational, but required for Medicare when there has been inpatient care.
MIA01	Required. Always enter zero. Mapped to ff record 42, field12.
MIA02	Situational, but required for Medicare if there has been an operating outlier payment. Mapped to ff record 42, field 13.
MIA03	Situational, but required for Medicare if lifetime psychiatric days used. Mapped to ff record 42, field 14.
MIA04	Situational, but required for Medicare if DRG payment made. Mapped to ff record 42, field 15.
MIA05	Situational, but required for Medicare if at least one claim level remark code applies. Mapped to ff record 42, field 16.
MIA06	Situational, but required for Medicare if a disproportionate share amount is paid. Mapped to ff record 42, field 17.
MIA07	Situational, but required for Medicare if an MSP pass-through amount paid. Mapped to ff record 42, field 18.
MIA08	Situational. But required for Medicare if PP capital amount paid. Mapped to ff record 42, field 19.

Segment/ Data Elements	835 and Medicare Requirements/Notes
MIA09	Situational, but required for Medicare if PPS capital FSP DRG amount paid. Mapped to ff record 42, field 20.
MIA10	Situational, but required for Medicare if PPS capital HSP DRG amount paid. Mapped to ff record 42, field 21.
MIA11	Situational, but required for Medicare if PPS capital DSH DRG amount paid. Mapped to ff record 42, field 22.
MIA12	Situational, but required for Medicare if old capital amount paid. Mapped to ff record 42, field 23.
MIA13	Situational, but required for Medicare if PPS capital IME amount paid. Mapped to ff record 42, field 24.
MIA14	Situational, but required for Medicare if PPS operating HSP DRG amount paid. Mapped to ff record 42, field 25.
MIA15	Situational, but required for Medicare if cost report days apply. Mapped to ff record 42, field 26.
MIA16	Situational, but required for Medicare if PPS operating FSP DRG amount paid. Mapped to ff record 42, field 27.
MIA17	Situational, but required for Medicare if PPS outlier amount paid. Mapped to ff record 42, field 28.
MIA18	Situational, but required for Medicare if indirect teaching amount paid. Mapped to ff record 42, field 29.
MIA19	Situational, but required for Medicare if professional component amount billed but not payable by this provider. Mapped to ff record 42, field 30.
MIA20	Situational but required for Medicare if a second claim level remark code applies. Mapped to ff record 42, field 31.
MIA21	Situational but required for Medicare if a third claim level remark code applies. Mapped to ff record 42, field 32.
MIA22	Situational but required for Medicare if a fourth claim level remark code applies. Mapped to ff record 42, field 33.
MIA23	Situational but required for Medicare if a fifth claim level remark code applies. Mapped to ff record 42, field 34.
MIA24	Situational but required for Medicare if a PPS capital exception amount paid. Mapped to ff record 42, field 35.
MOA	Situational, but required for Medicare intermediaries if there has been other than inpatient care and at least one claim level remark code applies for that non-inpatient care.
MOA01	Situational, but required for Medicare if reimbursement rate reporting applies. Mapped to ff record 43, field 12.

Segment/ Data Elements	835 and Medicare Requirements/Notes
MOA02	Situational, but required for Medicare if any line items paid on a fee schedule basis. Mapped to ff record 43, field 13.
MOA03	Situational, but required for Medicare if at least one claim level remark code applies. Mapped to ff record 43, field 14.
MOA04	Situational, but required for Medicare if a second claim level remark code applies. Mapped to ff record 43, field 15.
MOA05	Situational, but required for Medicare if a third claim level remark code applies. Mapped to ff record 43, field 16.
MOA06	Situational, but required for Medicare if a fourth claim level remark code applies. Mapped to ff record 43, field 17.
MOA07	Situational, but required for Medicare if a fifth claim level remark code applies. Mapped to ff record 43, field 18.
MOA08	Situational, but required for Medicare if ESRD payment made. Mapped to ff record 43, field 19.
MOA09	Situational, but required for Medicare if professional component amount billed but not payable to this provider. Mapped to ff record 43, field 20.
REF (040.A)	Situational, but required for Medicare if provider submitted a proprietary identification number on the claim.
REF01	Required. Only “EA” applies to Medicare. Mapped to ff record 44, field 12.
REF02	Required. Mapped to ff record 44, field 13.
REF03-04	Not used.
REF (040.B)	Situational, but does not apply to Medicare intermediaries.
DTM (050)	Situational, but multiple loops required for Medicare.
DTM01	Required. “050" mapped to ff record 44, field 14. “232” mapped to ff record 44, field 16. “233” mapped to ff record 44, field 18.
DTM02	Required. Mapped to ff record 44, field 15 for 050. Mapped to ff record 44, field 17 for 232. Mapped to ff record 44, field 19 for 233.
DTM03-06	Not used.
PER (060)	Situational, but not used by Medicare.
AMT (062)	Situational, but required for Medicare if any of the qualifiers in AMT01 apply to the claim.
AMT01	Required. Use multiple loops if more than 1 qualifier applies. DY mapped to ff record 44, field 20; NL mapped to ff record 44, field 22; ZK for hemophilia add on to ff record 44, field 24; F5 to ff record 44, field 26; I to ff record 44,

Segment/ Data Elements	835 and Medicare Requirements/Notes
	field 28; ZZ for inpatient outlier payment to ff record 44, field 30; AU to ff record 44, field 32. The other qualifiers do not apply to Medicare at this time. **NOTE**: Pre-4010, NJ was reported in the AMT segment to report the gross amount of payment made by the primary payer on the claim. NJ is not approved for use in 4010 In 4010, primary payment reporting will be limited to the use of claim adjustment reason code 23 to convey the amount of the primary payment that impacted the Medicare payment calculation. This may be less than the gross payment made by the primary payer. Since Medicare would be primary in this instance, the provider would already have been notified of the gross amount of the primary's payment by that payer. This is not considered an essential data element for a secondary payer's remittance advice.
AMT02	Required. Inpatient or partial hospitalization per diem amount (DY) mapped to ff record 44, field 21. NL mapped to ff record 44, field 23. Hemophilia add on (ZK) mapped to ff record 44, field 25. F5 mapped to ff record 44, field 27. I mapped to ff record 44, field 29. Any inpatient outlier payment (ZZ) mapped to ff record 44, field 31. AU mapped to ff record 44, field 33. The other qualifiers do not apply to Medicare at this time.
AMT03	Not used.
QTY (064)	Situational, but required for Medicare if any of the QTY01 qualifiers apply. Use multiple loops if more than 1 qualifier applies.
QTY01	Required. CA mapped to ff record 44, field 34; NA mapped to ff record 44, field 36; LA to ff record 44, field 38; CD to ff record 44, field 40; ZK mapped to ff record 44, field 42; and OU mapped to ff record 44, field 44.
QTY02	Required. CA mapped to ff record 44, field 35. NA mapped to ff record 44, field 37. LA mapped to ff record 44, field 39. CD mapped to ff record 44, field 41. ZK is mapped to ff record 44, field 43. OU is mapped to ff record 44, field 45. The other qualifiers in the implementation guide do not apply to Medicare at this time. **NOTE 1**: VS, visits, had been reported at the service level for covered and non-covered HHA visits prior to version 4010. With HH PPS, it will only be necessary to report HHA visits if there are 4 or fewer visits during an episode. In version 4010, the number of visits, when 4 or less, will be reported as the line adjustment quantity (SVC level CAS04, 07, 10, 13, 16, or 19) for the final HHA bill for the episode. The HHA will still be paid on a per visit basis in that situation. **NOTE 2**: Pre-4010, FL was used to report the approved units for hemophilia add on. FL is not available for use in the 4010 implementation guide. Use ZK to report the hemophilia covered units in version 4010.
SVC	Situational, but required for Medicare when service level detail included on the incoming claim. A separate loop is required for each procedure.
SVC01-1	Required. Only HC, NU, N4 and ZZ apply to Medicare intermediaries. HC mapped to ff record 50, field 12; NU mapped to ff record 50, field 12; ZZ mapped to ff record 50, field 12; N4 mapped to ff record 50, field 14. HC and Z would not apply to the same line, but NU and HC or NU and ZZ could apply t the same line. When more than one applies to the same line, enter the HC or ZZ in SVC01-1 and the NU in SVC04. ZZ will be used to report HIPPS codes if used in SNF or HHA billing. (Contrary to the implementation guide

Segment/ Data Elements	835 and Medicare Requirements/Notes
	note which only mentions SNF billing.) N4 will not be used until Medicare begins usage of NDC codes for drugs.
SVC01-2	Required. HC mapped to ff record 50, field 13. NU mapped to ff record 50, field 13. ZZ mapped to ff record 50, field 13. N4 mapped to ff record 50, field 15.
	NOTE: When a service is being denied due to submission of an invalid HCPCS, HIPPS, NDC or revenue code, the invalid submitted code must be entered in this data element. This is a necessary exceptionto the HIPAA requirement for use of valid medical codes.
SVC01-3	Situational, but required for Medicare if HC applies and at least one modifier was reported on the claim for the service. Modifiers do not apply to and may not be reported for other procedure code types. Mapped to ff record 50, field 16.
SVC01-4	Situational, but required for Medicare if HC applies and a second modifier was reported on the claim for the service. Mapped to ff record 50, field 17.
SVC01-5	Situational, but required for Medicare if HC applies and a third modifier was reported on the claim for the service. Mapped to ff record 50, field 18.
SVC01-6	Situational, but required for Medicare if HC applies and a fourth modifier was reported on the claim for the service. Mapped to ff record 50, field 19.
SVC01-7	Situational, but Medicare will not report text language in a remittance advice.
SVC02	Required. Mapped to ff record 50, field 20.
SVC03	Required. Mapped to ff record 50, field 21.
SVC04	Situational, but required for Medicare if both a HCPCS or NDC, and a revenue code, were reported on the claim for the same service. Mapped to ff record 50, field 22.
SVC05	Situational, but required for Medicare. Mapped to ff record 50, field 23.
SVC06-1	Situational, but required if the procedure or drug code has been changed during adjudication.
SVC06-2	Required. HC mapped to ff record 50, field 24. N4 mapped to ff record 50, field 26. Medicare would not change a NU (revenue code) or ZZ (HIPPS code) during adjudication.
SVC06-3	Situational, but required for Medicare if the first modifier was changed during adjudication. Mapped to ff record 50, field 28.
SVC06-4	Situational, but required for Medicare if the second modifier was changed during adjudication. Mapped to ff record 50, field 29.
SVC06-5	Situational, but required for Medicare if the third modifier was changed during adjudication. Mapped to ff record 50, field 30.
SVC06-6	Situational, but required for Medicare if the fourth modifier was changed during adjudication. Mapped to ff record 50, field 31.

Segment/ Data Elements	835 and Medicare Requirements/Notes
SVC06-7	Situational, but text will not be reported by Medicare.
SVC07	Situational, but required for Medicare if the paid units of service is different than the billed units of service. Mapped to ff record 50, field 32.
DTM (080)	Situational, but required for Medicare when service level data is reported on the claim.
DTM01	Required. Only 472 applies to intermediaries. 472 mapped to ff record 50, field 33.
DTM02	Required. Mapped to ff record 50, field 34.
DTM03-06	Not used.
CAS (090)	Situational, but required for Medicare whenever the amount paid for a service does not equal the amount billed. Medicare intermediaries are required to separately report every adjustment made to a service. It is necessary to use separate loops if more than 1 group code applies, or if there are more than 6 adjustment codes per group.
CAS01	Required. PI does not apply to Medicare. Mapped to ff record 51, field 12.
CAS02	Required. Mapped to ff record 51, field 13.
CAS03	Required. Mapped to ff record 51, field 14.
CAS04	Situational, but required for Medicare. Mapped to ff record 51, field 15.
CAS05	Situational, but required for Medicare if there is a second service level adjustment. Mapped to ff record 51, field 16.
CAS06	Situational, but required for Medicare if there is a second service level adjustment. Mapped to ff record 51, field 17.
CAS07	Situational, but required for Medicare if there is a second service level adjustment. Mapped to ff record 51, field 18.
CAS08	Situational, but required for Medicare if there is a third service level adjustment. Mapped to ff record 51, field 19.
CAS09	Situational, but required for Medicare if there is a third service level adjustment. Mapped to ff record 51, field 20.
CAS10	Situational, but required for Medicare if there is a third service level adjustment. Mapped to ff record 51, field 21.
CAS11	Situational, but required for Medicare if there is a fourth service level adjustment. Mapped to ff record 51, field 22.
CAS12	Situational, but required for Medicare if there is a fourth service level adjustment. Mapped to ff record 51, field 23.

Segment/ Data Elements	835 and Medicare Requirements/Notes
CAS13	Situational, but required for Medicare if there is a fourth service level adjustment. Mapped to ff record 51, field 24.
CAS14	Situational, but required for Medicare if there is a fifth service level adjustment. Mapped to ff record 51, field 25.
CAS15	Situational, but required for Medicare if there is a fifth service level adjustment. Mapped to ff record 51, field 26.
CAS16	Situational, but required for Medicare if there is a fifth service level adjustment. Mapped to ff record 51, field 27.
CAS17	Situational, but required for Medicare if there is a sixth service level adjustment. Mapped to ff record 51, field 28.
CAS18	Situational, but required for Medicare if there is a sixth service level adjustment. Mapped to ff record 51, field 29
CAS19	Situational, but required for Medicare if there is a sixth service level adjustment. Mapped to ff record 51, field 30.
REF (100.A)	Situational, but required for Medicare if any of the qualifiers apply. Multiple loops required if more than 1 qualifier applies.
REF01	Required. 1S mapped to ff record 50, field 35; RB mapped to ff record 50, field 35. 1S and RB would not apply to the same line simultaneously. 6R does not apply to Medicare intermediaries, as indicated in the implementation guide note for the standard, this situational segment "is used to provide additional information used in the process of adjudicating this service." Since intermediary claims are not subject to splitting, provider control number is not used for Medicare adjudication and is not needed by providers to reassociate lines for split claims. None of the other qualifiers currently apply to intermediaries.
REF02	Required. 1S mapped to ff record 50, field 36. RB mapped to ff record 50, field 37 when a rate code factored in the payment. The APC number will only be reported with the first HCPCS, and not for subsequent HCPCS, in that APC.
REF03-04	Not used.
REF (100.B)	Situational, but does not apply to Medicare intermediaries.
AMT (110)	Situational, but required for Medicare intermediaries if any of the qualifiers apply. Multiple loops must be used if more than 1 qualifier applies.
AMT01	Required. Only DY and B6 currently apply to Medicare intermediaries. DY mapped to ff record 50, field 38. B6 mapped to ff record 50, field 40.
AMT02	Required. DY mapped to ff record 50, field 39. B6 mapped to ff record 50, field 41.
AMT03	Not used.

Segment/ Data Elements	835 and Medicare Requirements/Notes
QTY	Situational, but does not apply to Medicare intermediaries in version 4010. Used to report covered and non-covered HHA visits in prior versions. Most HHA care will now be paid under HH PPS. In those cases where individual HHA visit payments are made, the number of covered visits will be reported in SVC05, the quantity data element for the HHA visits HCPCS ad with the VS qualifier in a claim level QTY segment. The number of non-covered visits will be shown as a quantity adjustment in the CAS segment for the HHA visits HCPCS.
LQ	Situational, but required for Medicare whenever any service level remark codes apply. Multiple loops must be used if more than 1 service level remark code applies. The flat file can record up to 19 remark codes per service.
LQ01	Required. Only "HE" applies to Medicare intermediaries. 1 st HE mapped to ff record 50, field 42; 2nd to field 44; 3rd to field 46; 4th to field 48; 5th to field 50; 6th to field 52; 7th to field 54; 8th to field 56; and 9th to field 58..
LQ02	Required. 1st mapped to ff record 50, fields 43, and succeeding to fields 45, 47, 49, 51, 53, 55, 57, and 59 respectively..

Table 3, Summary Data

PLB	Situational, but required for Medicare whenever there have been any provider-level adjustments.
PLB01	Required. Mapped to ff record 1, field 3.
PLB02	Required. Mapped to ff record 1, field 4.
PLB03-1	Required. The X12N provider adjustment code must be reported in 03-1, and the Medicare provider adjustment code in 03-2. The first X12N provider adjustment code is mapped to ff record 60, field 12. **NOTE:** Outpatient PPS instructions had directed intermediaries to identify Transitional Outpatient Payments (TOPs) with BN in this data element, but some providers associate BN with managed care only and not with fee for service payments. For Medicare's use of version 4010, report TOPs with IS, interim settlement, in PLB03-1 and BN in the first 2 positions of PLB03-2.
PLB03-2	Situational, but required for Medicare. Positions 1-2=the first Medicare provider adjustment code (mapped to ff record 60, field 14). Contrary to the misphrased note in the implementation guide, intermediaries should not report any additional data in positions 3-30 of this data element. Nor may intermediaries report anything other than the Medicare provider adjustment code in positions 1-2 of this data element.
PLB04	Required. Mapped to ff record 60, field 14.
PLB05	Situational, but required if there is a second provider level adjustment. Mapped to ff record 60, field 15.
PLB05-2	Situational, but required for Medicare if there is a second provider level adjustment. Mapped to ff record 60, field 16.

Segment/ Data Elements	835 and Medicare Requirements/Notes
PLB06	Situational, but required for Medicare if there is a second provider level adjustment. Mapped to ff record 60, field 17.
PLB07-1	Situational, but required if there is a third provider level adjustment. Mapped to ff record 60, field 18.
PLB07-2	Situational, but required for Medicare if there is a third provider level adjustment. Mapped to ff record 60, field 19.
PLB08	Situational, but required for Medicare if there is a third provider level adjustment. Mapped to ff record 60, field 20.
PLB09-1	Situational, but required if there is a fourth provider level adjustment. Mapped to f record 60, field 21.
PLB09-2	Situational, but required for Medicare if there is a fourth provider level adjustment. Mapped to ff record 60, field 22.
PLB10	Situational, but required for Medicare if there is a fourth provider level adjustment. Mapped to ff record 60, field 23.
PLB11-1	Situational, but required for Medicare if there is a fifth provider level adjustment. Mapped to ff record 60, field 24.
PLB11-2	Situational, but required for Medicare if there is a fifth provider level adjustment. Mapped to ff record 60, field 25.
PLB12	Situational, but required for Medicare if there is a fifth provider level adjustment. Mapped to ff record 60, field 26.
PLB13-1	Situational, but required for Medicare if there is a sixth provider level adjustment. Mapped to ff record 60, field 27.
PLB13-2	Situational, but required for Medicare if there is a sixth provider level adjustment. Mapped to ff record 60, field 28.
PLB14	Situational, but required for Medicare if there is a sixth provider level adjustment. Mapped to ff record 60, field 29.
GE	Required.
GE01	Required. TG
GE02	Required. Must equal GS06. TG
SE	Required.
SE01	Required. The transaction segment count is computed by the carrier system. TG
SE02	Required. Must equal ST02. TG