Program Memorandum Intermediaries/Carriers

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

Transmittal AB-01-132 **Date: SEPTEMBER 21, 2001**

CHANGE REQUEST 1828

SUBJECT: Further Guidance Concerning Implementation of the Health Insurance Portability and Accountability Act (HIPAA) Transactions

This Program Memorandum (PM) provides carriers, Durable Medical Equipment Regional Carriers (DMERCs), intermediaries, and their standard systems further guidance regarding their implementation of version 4010 of the Accredited Standards Committee (ASC) X12N 837 Health Care Claim: Professional, X12N 837 Health Care Claim: Institutional, and X12N 835 Health Care Claim Payment/Advice.

Intermediary Free Billing Software Implementation Update

The implementation date for the HIPAA free billing software as directed in Transmittal A-01-20, dated February 5, 2001 has been extended to April 1, 2002. This extension is necessary since funding was not available for this effort in fiscal year 2001.

X12N Addenda Documentation

The Designated Standards Maintenance Organizations (DSMOs) developed a "fast track" process to address the changes to the X12N 4010 implementation guides that are required within the first year for compliance reasons. The DSMOs only considered changes that were necessary for compliance in the strictest sense of the word. All other change requests will be addressed as part of the regular DSMO process. The DSMOs categorized the change requests into three categories:

Changes necessary for industry compliance during the first 12 months;
Changes that are not necessary for compliance during the first 12 months; and
Changes that are maintenance to the implementation guides.

As part, of the "fast track" process, the DSMOs reviewed all change requests received as of March 1, 2001 and categorized the requests within one month. The DSMOs came to agreement on what will be included in the addendum and what will be modifications for the regular DSMO process. The addendum was posted to the DSMO website (see below). The DSMOs presented the consolidated list of approved changes to the National Committee on Vital and Health Statistics (NCVHS). The NCVHS approved the DSMO recommendations in June.

CMS will develop a proposed rule as close to October 1, 2001 as possible and expects to publish a final rule adopting the changes by February 2002. The changes that will be contained in the addendum are described in attachments to this PM. We are providing these for your information.

The final updated Designated Standards Maintenance Organizations (DSMO) addenda pages may be found at www.wpc-edi.com/addenda .

X12N 837 Professional Implementation Guide (IG) DSMO Addenda Items

Your standard system maintainer will be directed to make the necessary IG programming changes at a later time. If necessary, you will be notified of any updates to the addenda items in a future PM. The X12N-based flat file, available at www.hcfa.gov/medicare/edi/hipaadoc.htm , will be updated to reflect the IG changes by January 1, 2002. The changes that will require programming and/or X12N-based flat file updates are described in Attachment A. You will not need to retest your EDI submitters on version 4010 unless they request retesting. You will, however, need to support the two versions during initial testing of your EDI submitters.

X12N 837 Institutional IG DSMO Addenda Items

You will be directed to make IG programming changes at a later time (however, note that you have already implemented the changes for IG pages 227, 338, and 465 in Attachment B as recommended by the Electronic Data Interchange Intermediary Workgroup). If necessary, you will be notified of any updates to the addenda items in a future PM. The flat file and the Medicare edits document, available at www.hcfa.gov/medicare/edi/hipaadoc.htm, will be updated to reflect the IG changes by January 1, 2002. The changes that will require programming and/or flat file updates are described in Attachment B. CMS will work with you to ensure any amount of possible rework will be kept to a minimum. You will not need to retest your EDI submitters on version 4010 unless they request retesting. You will, however, need to support the two versions during initial testing of your EDI submitters.

Intermediary Implementation Guide Edits Document Update

Based on input from the Intermediaries, the Implementation Guide Edits Document has been updated to reflect the following:

LOOP	ELEMENT	DESCRIPTION	CHANGE
2010BC	N301	Payer Address Line	N - changed from Y
2300	REF	Repriced Claim Number	REF01/REF02 - updated edit logic
2300	HI02-1	Diagnosis Type Code	HI02-1 must be a value listed in Valid Values column - changed from BF to BJ and ZZ
2300	HI03-1	Diagnosis Type Code	HI03-1 must be a value listed in Valid Values column- changed from BF to BN
2310D	NM101	Entity Identifier Code	NM101 must be a value listed in Valid Values column - Must submit a 'DN' before you send a 'P3', and you can not submit 2 'DN's
2420A	REF	Attending Physician Secondary Identification	Max use 1
2420C	REF	Other Provider Secondary Identification	Max use 1
2420D	REF	Referring Provider Secondary Identification	Max use 1

GE02	Group Control Number	GE02 must = GS06 else reject the ISA-IEA envelope

The document is in an Excel spreadsheet format. The updated file can be downloaded from the following web site: www.hcfa.gov/medicare/edi/hipaadoc.htm. The name of the file is instedit.xls.

Professional X12N-based Flat File Updated

Based on input from the Electronic Data Interchange Functional Workgroup (EDIFWG), the X12N-based flat file has been updated to reflect the following:

- Loop repeats for the elements GS and ST can be greater than 1 (>1). This change represents a correction to the currently posted flat file. Your translators should already be capable of receiving more than one iteration of these loops; therefore, there is no impact to you.
- Expansion of the COBOL picture clause for PAT08 (patient weight "grams") in the 2000B loop from 9(4)v99 to 9(6)v99. This change was requested to accommodate the acceptance of 6 bytes for grams and which, when converted, will supply a 3-position pound amount.

The X12N-based flat file is in an Excel spreadsheet format. The updated file can be downloaded from the following web site: www.hcfa.gov/medicare/edi/hipaadoc.htm. The name of the file is 4010-1.xls. The revised X12N-based flat file is the version to be used for the October 1, 2001 release.

X12N 835 Health Care Claim Payment/Advice Remark and Reason Codes

New remark codes that impact Medicare are released as part of the implementation instruction for the Medicare policy change that resulted in the creation of the new codes, and must be implemented according to the schedule in those instructions. Although non-Medicare payers may also request new remark codes or modifications in existing remark codes which may or may not impact Medicare, traditionally the remark codes that impact Medicare are requested by Medicare staff in conjunction with a policy change. CMS is the national maintainer of Remittance Advice Remark Codes used by Medicare and other payers, and a committee outside of CMS maintains Remittance Advice Claim Adjustment Reason Codes. Both Claim Adjustment Reason Codes and Remittance Advice Remark Codes are updated approximately every four months.

In most cases reason code changes, additions and retirements are requested by entities other than Medicare and, therefor, would not routinely be reported in a Medicare instruction as part of a policy change. To provide a summary of changes introduced in the previous four months, a Program Memorandum (PM) will be issued if in the last four months a) any new remark or reason code is introduced; and/or b) an existing code is discontinued; and/or c) the wording for an existing code is modified, and these changes are perceived to impact Medicare. These PMs will establish the deadline for Medicare standard system and contractor changes to complete the reason and/or remark code changes that had not already been implemented as part of a previous Medicare policy change instruction.

The list of remark codes is updated as needed, and is available at http://www.wpc-edi.com/hipaa/ by selecting Code Lists/Remittance Advice Remark Codes. The posted list is updated on this web site in the month following each X12 trimester meeting. You can download the list from this website in the months of March, July and November to make sure that you are using the currently approved remark codes. In version 4010 835 transaction, Medicare Carriers and DMERCs may only use those current reason and/or remark codes posted on the above mentioned web site and any subsequent interim CMS updates. This applies to both electronic and paper remittance advice transactions. Remark codes will not be available on a CMS website nor will they be included in any other Medicare manuals. Remark codes may be used at either the claim or the line level as appropriate for the situation.

Reason codes are also updated three times a year, in the month following each X12 trimester meeting (March, July, and November) and available at http://www.wpc-edi.com/hipaa/. New or modified reason codes are not version or mode of transmission (electronic or paper) specific, and can be used as soon as approved by the committee. Contractors and standard system maintainers must program accordingly to be able to use the new and/or modified codes that apply to Medicare. Before either new or modified reason and/or remark codes are used in production, Contractors must notify their providers of the use of the new and/or modified codes and their meanings in a provider bulletin or other instructional release.

If a reason code is determined to be duplicative or no longer applicable, the committee may decide to retire a code. A code is never retired retroactively; these changes are always effective with a specific future version of the 835 electronic remittance advice format. The Reason Code list should indicate what codes to be used in lieu of a duplicative code being retired.

Contractors and standard system maintainers using any of the retired codes must modify their programming as necessary when the specified future version is implemented. In some cases, Medicare may never implement the version specified in the effective note with the code change, but that retirement also applies to subsequent versions of the 835. Contractors and standard system maintainers are not required to retire codes prior to implementation of the specified future version, but they may if they determine it is more efficient to change at an earlier date - perhaps as part of some already planned programming change involving these codes.

The effective date of programming for use of new or modified reason and remark codes applicable to Medicare is the earlier of the date specified in the contractor manual transmittal or Program Memorandum requiring implementation of a policy change that led to the issuance of the new or modified message, or the date specified in the periodic PM announcing issuance of code changes (additions/deletions/modifications).

Changes in X12N 835 Flat File and Companion Document - Carriers

There have been a number of changes in the 835 Flat File and the companion document issued with Transmittal B-01-35, dated April 30, 2001. The changes have been made in conjunction with the Electronic Data Interchange Functional Work Group to correct any errors detected during analysis and to make the 835 Flat File more consistent with 837 Flat File. Subsequent adjustments may be issued, if necessary, to resolve further problems detected during programming or testing. Medicare carriers and DMERCs will continue to use flat files for their internal system programming. The flat file maps each flat file field to the corresponding X12N 835 version 4010 data element, and notes if/where each data element was reported in the last of the National Standard Format (NSF)-based remittance advice flat file (NSF 2.01U) The updated X12N version 4010 supportive remittance advice flat file is posted at http://www.hcfa.gov/medicare/edi/hipaadoc.htm under the file name B835v4010-1.xls. A list of all the changes made in the B 835 Flat File follows:

Element Identifier	Description of Change		
ISA	None		
GS	None		
ST	None		
BPR			
BPR02	Length = 18		PIC S9(7)V99
BPR03		Start = 39	
BPR04		Start = 40	
BPR05	Length = 10	Start = 43	
BPR06		Start = 53	
BPR07		Start = 55	
BPR08	Length = 3	Start = 67	
BPR09		Start = 70	
BPR10		Start = 105	

BPR12		Start = 115
BPR13		Start = 117
BPR14	Length = 3	Start = 129
BPR15		Start = 132
BPR16		Start = 167
TRN		
TRN01	Length = 2	
TRN02		Start = 21
TRN03		Start = 51
REF		
REF01	Length = 3	
REF02		Start = 22
DTM	None	
LOOP 1000A:		
N1		
N101	Length = 3	
N102	Length = 60	Start = 22
N103		Start = 82
N104	Length = 80	Start = 84
N3		
N301	Length = 55	
N302	Length = 55	Start = 74
N4		
N403	Length = 15	
N404		Start = 66
REF		
REF01	Length = 3	
REF02		Start = 22
PER		
PER02	Length = 60	
PER03		Start = 81
PER04	Length = 80	Start = 83
PER05		Start = 163
PER06	Length = 80	Start = 165
PER07		Start = 245
PER08	Length = 80	Start = 247
LOOP 1000B:		
N1		
N101	Length = 3	
N102	Length = 60	Start = 22
N103		Start = 82
N104	Length = 80	Start = 84
N3		
N301	Length = 55	
N302	Length = 55	Start = 74
N4		
N403	Length = 15	
N404		Start = 66
REF		
REF01	Length = 3	
REF02	Length = 30	Start = 22
LOOP 2000:		
LX		
LX01	Length = 6	
LOOP 2100:		
CLP		
CLP03		PIC S9(7)V99
CLP04		PIC S9(7)V99
CLP05		PIC S9(7)V99

NM1(patient name)			
NM101	Length = 3		
NM102		Start = 22	
NM103		Start = 23	
NM104		Start = 58	
NM105	Length = 25	Start = 83	
NM107		Start = 108	
NM108		Start = 118	
NM109		Start = 120	
NM1(corrected patient/insured name)			
NM101	Length = 3		
NM102		Start = 22	
NM103		Start = 23	
NM104		Start = 58	
NM105		Start = 83	
NM107		Start = 108	
NM108		Start = 118	
NM109	length = 80	Start = 120	
NM1(service provider name)			
NM101	Length = 3		
NM102		Start = 22	
NM103	Length = 35	Start = 23	
NM104	Length = 25	Start = 58	
NM105	Length = 25	Start = 83	
NM107	Length = 10	Start = 108	
NM108		Start = 118	
NM109		Start = 120	
NM1 (crossover carrier name)			
NM101	Length = 3		
NM102		Start = 22	
NM103		Start = 23	
NM104	Length = 25	Start = 58	
NM105	Length = 25	Start = 83	
NM107	Length = 10	Start = 108	
NM108		Start = 118	
NM109		Start = 120	
NM1(corrected priority payer name)			
NM101	Length = 3		
NM102		Start = 22	
NM103		Start = 23	
NM104	Length = 25	Start = 58	
NM105	Length = 25	Start = 83	
NM107	Length = 10	Start = 108	
NM108		Start = 118	
NM109		Start = 120	
MOA			
MOA01	Length = 10	Start = 19	PIC S9(7)V99
MOA02	Length = 18	Start = 29	PIC S9(7)V99
MOA03	Length = 30	Start = 47	
MOA04	Length = 30	Start = 77	
MOA05	Length = 30	Start = 107	
MOA06	Length = 30	Start = 137	
MOA07	Length = 30	Start = 167	
MOA08	Length = 18	Start = 197	PIC S9(7)V99
MOA09	Length = 18	Start = 215	PIC S9(7)V99
DTM	None		
PER			
PER04	Length = 80		
PER05		Start = 163	

PER06	Length = 80	Start = 165	
PER07		Start = 245	
PER08	Length = 80	Start = 247	
AMT			
AMT01	Length = 3		
AMT02	Length = 18	Start = 22	PIC S9(7)V99
LOOP 2110			
SVC SVC01-2	Length = 48		
SVC01-3		Start = 69	
SVC01-4		Start = 71	
SVC01-5		Start = 73	
SVC01-6		Start = 75	
SVC02		Start = 77	PIC S9(7)V99
SVC03		Start = 95	PIC S9(7)V99
SVC05		Start = 113	
SVC06-01		Start = 128	
SVC06-02	Length = 48	Start = 130	
SVC06-03		Start = 178	
SVC06-04		Start = 180	
SVC06-05		Start = 182	
SVC06-06		Start = 184	
SVC07		Start = 186	PIC S9(7)V9
DTM	None		
CAS	Record Repeat = 99		
CAS03			PIC S9(7)V99
CAS04	Length = 15	Start = 44	PIC S9(3)V9
CAS05		Start = 59	
CAS06		Start = 64	PIC S9(7)V99
CAS07	Length = 15	Start = 82	PIC S9(3)V9
CAS08		Start = 97	
CAS09		Start = 102	PIC S9(7)V99
CAS10	Length = 15	Start = 120	PIC S9(3)V9
CAS11		Start = 135	
CAS12		Start = 140	PIC S9(7)V99
CAS13	Length = 15	Start = 158	PIC S9(3)V9
CAS14		Start = 173	
CAS15		Start = 178	PIC S9(7)V99
CAS16	Length = 15	Start = 196	PIC S9(3)V9
CAS17		Start = 211	
CAS18		Start = 216	PIC S9(7)V99
CAS19	Length = 15	Start = 234	PIC S9(3)V9
REF (service identification)		Record Repeat = 7	
REF01	Length = 3		
REF02		Start = 22	
REF (rendering provider info)		Record Repeat = 10	
REF01	Length = 3		
REF02		Start = 22	
AMT	Record Repeat = 12		

AMT01	Length = 3		
AMT02		Start = 22	PIC S9(7)V99
LQ	Record Repeat = 99		
LQ01	Length = 3		
LQ02	Length = 30	Start = 22	
PLB	Included under Segment ID		
PLB04			PIC S9(7)V99
PLB06			PIC S9(7)V99
PLB08			PIC S9(7)V99
PLB10			PIC S9(7)V99
PLB12			PIC S9(7)V99
PLB14			PIC S9(7)V99
SE	Included under Segment ID		
GE	None		
IEA	None (moved after GE)		

During preliminary programming, the need was detected for a small number of modifications to the companion document that was published as an attachment to Transmittal B-01-35 dated April 30, 2001. The companion document (Attachment C) is being reprinted in full, with the revisions italicized to highlight the changes. Changes have been made to the following segments/data element notes:

NM1 (4th 030 loop repeat for claim rendering provider)
NM108 (4th 030 loop repeat for rendering provider)
SVC06-2
REF (2nd 100 loop repeat for service rendering provider)
PLB03-2

Changes in X12N 835 Flat File - Intermediaries

Intermediaries will continue to use flat files for their internal system programming. 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 A835v4010-1.xls. Subsequent adjustments may be issued, if necessary, to resolve further problems detected during programming or testing. The flat file maps each field to the corresponding 835 version 4010 data element. The following list explains the changes made in A 835 Flat File.

ALL RECORDS

Field 9 (filler) was changed from PIC of X14 to X11 and the "TO" changed from 120 to 117.
Inserted a new field "Line Sequence Number" PIC X3, L, From 118, TO 120. This new field is used to appropriately sequence records 50 and 51.
Renumbered all fields after number 9.
Renamed "Sequence Number" to be "Claim Sequence Number," was field 11 became field 12.

Record One

Field 3, 4, 5, 6, and 7 removed the values listed in Loop ID, Segment, Element and Requirement columns.
Field 13 – 33 renumbered the From and To columns.

Record Twenty One

Field 20 after Field 29 is renumbered as 30

Record Thirty

Field 7 added Loop ID 2100.
Field 22 was incorrectly numbered.

Record Forty

Field 6 added the Loop ID, Segment, Element and Requirement information.

Record Thirty One

Field 36 corrected numbering to 252.

Record Forty-two

Field 36 corrected From column.

Record Forty-Four

Field 46 was incorrectly numbered.

Record Fifty

Field 24 added L in L/R column.
Field 34 changed from X2 to X3 (qualifier is 3 positions)
Field 38 – 60 renumbered the From and To columns.
Field 45, 47, 49, 51, 53, 55, 57, and 59 corrected number to reflect 2-9.
Field 60 corrected the PIC.

Record Fifty-One

Field 9 removed x2 from filler.

There has been no change in the Companion Document (Attachment 1 - Transmittal A-01-57 dated April 30, 2001) on the Intermediary side.

Standard System Implementation Timeline Update

Contractors are not required to begin provider/submitter testing of the inbound 837 (4010) claim transaction on October 1, 2001, as previously specified. Contractors should complete testing of their standard system release of the inbound 837 (4010) and begin provider/submitter testing of the inbound 837 (4010) claim no later than January 2, 2002. Revised Standard System release dates for the HIPAA standard transactions will be published in a subsequent PM.

The effective date and implementation date for the DSMO addenda items will be established by a future PM. The remaining items in this PM will be effective September 21, 2001.

These instructions should be implemented within your current spending plan.

This PM may be discarded after December 1, 2002.

If you have any questions contact:

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Matt Klischer (410) 786-7488 or mklischer@cms.hhs.gov for the X12N 837: Institutional.

Brian Reitz (410) 786-5001 or breitz@cms.hhs.gov for the X12N 837: Professional.

ATTACHMENT A

X12N 837 (Inbound/Outbound) Professional IG DSMO Addenda Items

IG Page	Description of Change	Standard System Action
66	The value of REF02 is changed to "004010X098DA" for pilot mode and "0004010X098A" for production mode.	IG edits must be modified to accept the new values.
70, 76, 87, 102, 120, 133, 142, 149, 160, 287, 295, 306, 315, 353, 362, 506, 517, 525, 532 & 546	All N2 segments used to report additional name data were removed.	IG edits are to be removed.
79	The provider specialty segment requirement has been modified to include two requirements that must be met if the information is sent.	Do not need to send on COB, if not present on claim.
115 & 156	Data element PAT06 requirement has been modified to include two requirements that must be met if the information is sent. The "GR" (grams) qualifier in the PAT07 data element is replaced by qualifier "01" (pounds).	IG edits must be modified to allow for the new qualifier. It is not necessary to convert grams into pounds.
115 &156	Data element PAT08 requirement has been modified to delete the requirement to report the weight for patients less than 29 days old.	No action required.
116 & 156	Data element PAT09 note slightly modified.	No action required.
119	Data element NM109 subscriber identifier requirement has been modified to be required if patient is the subscriber, or if not, only send if identifier is know.	IG edits must be modified to not reject if the identifier is not present and the subscriber is not the patient.
128 & 168	Property and Casualty number requirement revised to state not required for HIPAA.	ID edits may be removed. Data does not need to be stored and forwarded for COB.
173	CLM05-3 data element note and codes were removed.	IG edits are to be revised to edit codes from code source 235.
176	Data element CLM11-2 and 3: code "AB" (abuse) was removed.	IG edits must be modified to remove edit on code "AB".
178	Note added to data element CLM12 to require code "01" for Medicaid.	No action required.

180, 184 & 199	Data segments for order date, referral date and estimated birth date were removed.	IG edits are to be removed.
186	Note changed to state Medicare requirement for date last seen.	No action required.
201 & 203	Disability begin and end dates revised to state not required for HIPAA.	IG edits may be removed. Data does not need to be stored and forwarded for COB.
221	Expanded requirement to require amount for vision claims.	No action required.
226	Changed requirement to eliminate Medicare specific requirement and to indicate that the segment is required when a certified mammography provider renders the service.	No action required.
285	Referring provider specialty note changed to state it is required if adjudication is known to be impacted.	Do not need to send on COB, if not present on claim..
293	Rendering provider specialty requirement changed from “required” to “situational” and note added to state it is required if adjudication is known to be impacted.	IG edits are to be modified to not reject if data is not present.
299	Purchased service provider name data element NM103 usage changed from “not used” to “situational” and note added to state required if the identifier is not NM109 or in the REF segment.	IG edits are to be modified to reject if name is not present and the identifier is not in NM109 or the corresponding REF segment.
401	Note added to the data element SV101-1 product service qualifier to state that the HIEC codes are not used under HIPAA. The NDC code formats N1, N2, and N3 were removed. Note added to the NDC ‘N4” qualifier to state that the NDC is to be used if J Codes are not allowed under HIPAA.	No action required.
403	Data element SV103 note added to Clarify that qualifier ‘MJ’ (minutes) is to be used for anesthesia claims.	No action required.
406	Data element SV109 usage changed from “required” to “situational”. Note added that element is required if the service is known to be an emergency by the provider. Definition of emergency added. Code value ‘N’ (no) was removed.	IG edits are to be modified to not reject if data is not present.
408	Segment SV4 was removed.	IG edits are to be removed.

409A	Segment SV5 added.	IG edits are to be modified to edit for the SV5 segment and related data elements.
415	Additional note added to CR2 indicating usage for Medicare Part B only.	No action required.
416, 417, 418 & 419	Usage for the following elements is changed from "required to "not used": CR201, CR202, CR203, CR204, CR205, CR206, CR207, and CR209.	IG edits are to be removed for these elements.
420	CR212 usage changed from "required" to "situational". Note added "Required for service dates prior to January 1, 2000".	IG edits do no need to reject if data is not present for services after 1/1/2000.
462	Segment QTY was removed.	IG edits are to be removed
464	Replaced note #1 on MEA segment to clarify the proper usage for dialysis claims and what qualifiers are valid. Added notes #2 and 3, which clarifies the proper usage for oxygen therapy and what qualifiers are valid. Added note #4, which clarifies the proper usage for DMERC claims and what qualifiers are valid.	No action required.
465	Deleted qualifier "CON" in MEA02.	IG edits are to be modified to remove edit on qualifier "CON".
474	Note replaced to eliminate specific Medicare requirement and to indicate that segment is required when a certified mammography provider renders the service.	No action required.
489	Replaced note #2, which specifies that the segment is required when purchased service charge amounts are necessary for processing. Added note #3 that clarifies segment is used on vision claims.	No action required.
500A, 500B, 500C	New loop added, 2410 (Drug Identification). New segments added to loop are LIN (Drug Identification), CTP (Drug Pricing), and REF (Prescription Number).	IG edits to be developed to edit segments and data elements if the loop is present and move to store and forward repository for COB.
504	Rendering provider specialist usage changed from "required" to "situational" and note added to provide the specialty information if adjudication is known to be impacted.	No action required.

555 & 556	Note added to the data element SVD03-1 product service qualifier to state that the HIEC codes are not used under HIPAA. The NDC code formats N1, N2, and N3 were removed. Note added to the NDC 'N4" qualifier to state that the NDC is to be used if J Codes are not allowed under HIPAA.	No action required.
557	Industry name and Alias replaced for SVD06 to read "Bundled Line Number" for both. Note replaced to reflect new Industry Name and Alias.	No action required.
B.8	Replaced example for GS segment.	No action required.
B.9	Code value in GS08 was changed to "004010X098A" to reflect new addendum version.	Translator and IG edits must be modified to accept the new value.

ATTACHMENT B

X12N 837 Institutional IG DSMO Addenda Items

IG Page	Description of Change	Standard System/FI Action
60	The value of REF02 is changed to "004010X096DA" for pilot mode and "0004010X096A" for production mode.	IG edits must be modified to accept the new values.
71	The provider specialty segment requirement has been modified to include two requirements that must be met if the information is sent.	No action required. Medicare does not use this information for claims processing.
107	The usage of data elements PAT07 and PAT08 was changed from SITUATIONAL to NOT USED.	IG edits are to be removed. Flat file must be updated.
144	The usage of data elements PAT07, PAT08, and PAT09 was changed from SITUATIONAL to NOT USED.	IG edits are to be removed. Flat file must be updated.
155	Property and Casualty number requirement revised to state not required for HIPAA.	ID edits may be removed. Data does not need to be stored and forwarded for COB. Flat file must be updated.
161	The usage of data composite CLM11 was changed from SITUATIONAL to NOT USED.	IG edits are to be removed. Flat file must be updated.
163	The usage of data element CLM12 was changed from SITUATIONAL to NOT USED.	IG edits are to be removed. Flat file must be updated.
189	Documentation Identification Code repeat was changed from 1 to 2.	IG edits are to be updated. Flat file must be updated.
227	Principal, admitting, e-code and patient reason for visit diagnosis information requirement changed from "required" to "situational" and note added to clarify when required.	IG edits are to be modified to not reject if data is not present. IG edits are also to be modified to meet 'when required' criteria.
324	Attending provider specialty note added to state it is required if adjudication is known to be impacted.	No action required.
331	Operating provider specialty note added to state it is required if adjudication is known to be impacted.	No action required.
338	Other provider specialty requirement changed from "required" to "situational" and note added to state it is required if adjudication is known to be impacted.	IG edits are to be modified to not reject if data is not present.
342 - 348	Data segments for referring provider information were removed.	IG edits are to be removed. Flat file must be updated.

436 - 439	Data segments for other payer referring provider information were removed.	IG edits are to be removed. Flat file must be updated.
446 - 447	Note added to the data element SV202-1 product service qualifier to state that the HIEC codes are not used under HIPAA. The NDC code formats N1, N2, and N3 were removed. Note added to the NDC 'N4" qualifier to state that the NDC is to be used if J Codes are not allowed under HIPAA.	No action required.
450	Segment SV4 was removed.	IG edits are to be removed. Flat file must be updated.
456	Service line date note added to state that it is not used if Assessment date is used.	IG edits are to be modified to reflect note requirement.
458	Assessment date note added to state that it is not used if Service line date is used.	IG edits are to be modified to reflect note requirement.
461A, 461B, 461C	New loop added, 2410 (Drug Identification). New segments added to loop are LIN (Drug Identification), CTP (Drug Pricing), and REF (Prescription Number).	IG edits to be developed to edit segments and data elements if the loop is present and move to store and forward repository for COB. Flat file must be updated.
462	Attending physician name note added to state that it is required if adjudication is known to be impacted.	No action required.
465	Attending physician specialty requirement changed from "required" to "situational" and note added to state it is required if adjudication is known to be impacted.	IG edits are to be modified to not reject if data is not present.
469	Operating physician name note changed to state it is required if adjudication is known to be impacted.	No action required.
472	Operating physician specialty note added to state that it is required if adjudication is known to be impacted.	No action required.
476	Other provider name note changed to state that it is required if adjudication is known to be impacted.	No action required.
479	Other provider specialty note changed to state that it is required if adjudication is known to be impacted.	No action required.
483 - 489	Data segments for referring provider information were removed.	IG edits are to be removed. Flat file must be updated.

491	Note added to the data element SVD03-1 product service qualifier to state that the HIEC codes are not used under HIPAA. The NDC code formats N1, N2, and N3 were removed. Note added to the NDC 'N4" qualifier to state that the NDC is to be used if J Codes are not allowed under HIPAA.	No action required.
493A	New segment HCP (Line Pricing/Repricing Information).	IG edits to be developed to edit segments and data elements if the segment is present and move to store and forward repository for COB. Flat file must be updated.
B.8	Replaced example for GS segment.	No action required.
B.9	Code value in GS08 was changed to "004010X096A" to reflect new addendum version.	Translator and IG edits must be modified to accept the new value.

ATTACHMENT C

MEDICARE X12N 835 VERSION 4010
HIPAA COMPANION DOCUMENT FOR CARRIERS
(Updated July 2001)

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 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 4010 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 required for Medicare prior to the effective date of the NPI.
N103	Required. Always enter "FI" until the NPI is effective. After that date, always enter "XX."
N104	Required.
N105-106	Not used.
N3 (080)	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. Prior to that date, use 1C (Medicare provider number) or 1G (UPIN) for Medicare. 0B, 1A, 1B,1D, 1E, 1F, 1H, D3, G2, N5 and PQ do not apply to Medicare.
REF02	Required.
REF03-04	Not used.

Table 2 - Detail Data

LX	Situational, but required for Medicare.
LX01	Required.
TS3	Situational. Not used by Medicare carriers, only by intermediaries.
TS2	Situational. Not used by Medicare carriers, 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 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. 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.
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. R*endering 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. *Until the NPI is effective, always enter "UP" for Medicare when there is a UPIN. If no UPIN, enter FI. When the NPI is effective, always enter "XX." BD, BS, MC, PC, and SL do not apply to Medicare.*
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.

MOA	Situational, but required for Medicare 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.*
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. Prior to the NPI effective date, always enter "1C" (the flat file does not differentiate between a UPIN and any other Medicare provider number) in this loop. After the NPI is effective, enter "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.
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, and IR 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.* NOTE: The note in the implementation guide is misphrased. 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.