Program Memorandum Intermediaries

Department of Health and Human Services (DHHS)
HEALTH CARE FINANCING ADMINISTRATION (HCFA)

Transmittal A-00-98 | **Date: DECEMBER 21, 2000**

CHANGE REQUEST 1430

SUBJECT: Reporting of Outpatient Prospective Payment System (OPPS) and Home Health Prospective Payment System (HH PPS) Data in Provider Remittance Advice Transactions

The remittance advice reporting information in this Program Memorandum modifies and supercedes the remittance advice instructions included in transmittals A-00-36, Change Request 1229 and AB-00-65, Change Request 514. Changes from the prior instructions have been put in italics.

I. The following replaces the remittance advice instructions in A-00-36, Change Request 1229.

Standard Paper Remittance Advice Changes (not changed from A-00-36, Change Request 1229) **Attachment 1 contains the 2000 version of the Standard Paper Remittance (SPR) Advice. The following SPR changes are included in this version:**

- The reference to HCPCS changed to "procedure code" as other code sets such as the national Drug Code (NDC) may begin to be used in addition to HCPCS in the future.

- The DRG operating amount and the DRG capital amount will no longer be reported separately. A combined DRG operating and capital amount will now be reported in the SPR to correspond to reporting of this information in the 835.

- A summary data element has been added for transitional outpatient payments (TOP), a monthly provider payment which will be issued as warranted to supplement line item payments for services paid under OPPS.

- Date fields in the SPR have been expanded to enable reporting of the century. Some, but not all, SPR dates previously accommodated century reporting.

- Although previously implemented, the hemophilia add on has been added to the format document.

NOTE: Only the third bullet above is directly related to OPPS, but the remaining information must be included to reflect incremental modifications to the SPR.

As with inpatient PPS, only summary data will be reported in the SPR for OPPS. The standard systems maintainers will report detailed service line data only in version 3051.4A.01 and later 835 electronic remittance advice transactions. The Fiscal Intermediary Standard System (FISS) will continue to report claim level summary data without service line information in the version 3030M and 3051.3A 835 transactions. Providers on FISS who wish to receive service line data must upgrade to the 835 version 3051.4A.01 transaction format.

Attachment 2 contains field characteristics for the 2000 version of the SPR and maps the SPR to version 3051.4A.01 of the 835. The FISS maintainer must expand the flat files for the supported 835 versions at the claim or line levels as appropriate to include OPPS-specific data elements (described below). The FISS maintainer must furnish relevant mapping information between those data elements and the SPR and the supported versions of the 835 (see "FISS mapping required" notations in the implementation guide replacement pages in Attachment 4).

Electronic Remittance Advice Changes
Electronic remittance advice format requirements:

- *Report the amount of any outlier Pricer determines payable for the outpatient claim in a claim adjustment reason code segment (2-020-CAS) with reason code 70 (cost outlier) and a negative amount to reflect the additional payment supplementing the usual allowed rate.*

NOTE: *This modifies the prior instruction that an outpatient or home health outlier be reporte in an AMT segment. This applies to all supported versions of the 835. Continue to report inpatient outliers in a claim level AMT segment, pending further notice.*

- Substitute the replacement pages in Attachment 3 in your hard copy version 3051.4A.01 implementation guide. These changes have also been added to version 3051.4A.01 at www.hcfa.gov/medicare/edi/edi.htm, and include:

  - 2-062-AMT02 modified to allow reporting of either inpatient or partial hospitalization per diem.

NOTE: Make the same "pen and ink" change to the corresponding page in the version 3051.3A implementation guide. Since this is *a claim segment, this change applies to version 3051.3A, as well as version 3051.4A.01, but this segment is not available for use in version 3030M.*

  - 2-100.A-REF and REF02 modified to allow service line reporting of *an Ambulatory Surgical Center (ASC), Ambulatory Payment Classification (*APC), *or a* Health Insurance Prospective Payment System (HIPPS) code. (*This service level REF loop was not available for use in versions 3051.3A or 3030M.)*

  - 2-100.B-REF modified to allow service line reporting of any applicable *ASC, APC, or HIPPS* payment percentage. (*This service level REF loop was not available for use in versions 3051.3A or 3030M.)*

  - 2-110.A-AMT modified to allow service line reporting of the allowed amount for APC and HIPPS payments. (*This service level AMT segment was not available for use in versions 3051.3A or 3030M.)*

  - The standard provider level adjustment reason codes in Appendix B of the implementation guide have been expanded to include the X12 835 code BN, bonus, for reporting of a transitional outpatient payment.

NOTE: Make the same "pen and ink" change to the corresponding pages in your hard copies of the version 3051.3A and 3030M implementation guides to enable TOPs to be reported in the *PLB segment of every electronic remittance advice version supported by Medicare.*

- *Report the amount Pricer determines payable for an outpatient service (before addition of any outlier),* whether APC, AWP, *or other rate,* as the allowed amount for a service in version 3051.4A.01. The type of bill in CLP08 identifies whether a service is an outpatient hospital, community mental health center, home health, or other category of intermediary processed claim. In multiple payment option situations, Medicare routinely uses the highest rate permitted by law to determine payment. A remittance advice does not typically identify which of the possible cost bases is being used for payment.

- Report services for which Pricer does not report an APC number, but which are considered to be included in the payment for one or more APCs, with group code CO (contractual obligation) and reason code 97 (payment included in the allowance for another service/procedure) in version 3051.4A.01. If a non-APC service on the same claim is denied for another reason, such as not reasonable and necessary (CO 50), report the specific reason code that applies to that denial rather than CO 97.

- Use the 835 version 3051.4A.01 bundling methodology to report APC payment when multiple HCPCS are included in a single APC. When bundling services in an APC grouping, report service line information back to a provider in the same way as billed so the provider can automatically identify the services involved and post payment to patient accounts. Report each procedure code billed in a version 3051.4A.01 remittance advice, even if bundled for payment into a single APC. However, report the payment for all of the services in a single APC on the line for the first listed service in that APC. Since the payment for the entire APC will be higher than for that procedure code alone, enter group code OA (other adjustment) and reason code 94 (processed in excess of charges) for the amount of the excess (difference between the billed amount for the service and the allowed rate for the APC) as a negative amount to enable the line and claim to balance. Report the remaining procedures for that APC on subsequent lines of the remittance advice with group code CO and reason code 97 for each. Repeat the process if there are multiple APCs for the same claim.

The FISS maintainer must change the PC-print software to correspond to these changes to Medicare's version 3030M, 3051.3A, and 3051.4A.01 implementation guides as noted, and to the Medicare SPR. *PC-print must report the APC number for services for which an APC number is reported in version 3051.4A.01. Providers who use a pre-3051.4A.01 version of the 835 will not have any APC numbers reported by their PC-print.* The FISS maintainer must make the revised PC-print software available to all intermediaries for their internal testing and to share with providers who receive 835 transactions.

II. The following changes apply to the home health PPS remittance advice:

- *Enter 1 in 835 version 3051.4A.01 data element SVC05 as the covered units of service for the RAP.* (*This replaces R.2.A.4 of AB-00-65, CR 514.)*

- *Report the amount of any outlier Pricer determines payable for the home health claim in a claim adjustment reason code segment (2-020-CAS) with reason code 70 (cost outlier) and a negative amount to reflect the additional payment supplementing the usual allowed rate. Since this is a claim level segment, this must be reported in all supported versions of the 835, i.e., versions 3030M, 3051.3A and 3051.4A.01.*

NOTE: *This modifies the prior instruction that a home health outlier be reported in an AMT segment. This applies to all supported versions of the 835. (This replaces R.2.B.4 of AB-00-65, CR 514.)*

The *effective date* for this Program Memorandum (PM) is November 1, 2000.

The *implementation date* for this PM is December 1, 2000.

The changes included in this PM have already been included in programming for the Fiscal Intermediary Standard System and do not require reprocessing or reprogramming on the part of intermediaries. These adjustments were implemented to rectify remittance advice balancing problems, and correct documentation in prior PMs. While the intermediaries should be aware of these changes, there is no need for reprocessing of previously processed claims.

These instructions should be implemented within your OPPS and HH PPS implementation budgets.

This PM may be discarded after December 31, 2002.

If you have any questions, contact Kathy Simmons at 410-786-6157.

3 Attachments

Attachment 1

INTERMEDIARY NAME/ADDRESS/CITY/STATE/ZIP/PHONE NUMBER

PROVIDER NUMBER/NAME PART A PAID DATE: MM/DD/CCYY REMIT#: 1234567890 PAGE 1

PATIENT NAME	PATIENT CNTRL #	RC	REM	DRG#	DRG OUT AMT	COINS	PAT RFND	CONTRCT ADJ
HIC #	ICN	RC	REM	OUTCD CAPCD		COVD CHGS	ESRD NET ADJ	PER DIEM RTE
FROM DT THRU DT	NACHG HICHG TOB	RC	REM	PROF COMP	MSP PAYMT	NCOVD CHGS	INTEREST	PROC CD AMT
CLM STATUS	COST COVDY NCOVDY	RC	REM	DRG AMT	DEDUCTIBLES	DENIED CHGS		NET REIMB
123456789012345678 1 1	12345678901234567890	123	1234	123	1234567.89	1234567.89	1234567.89	1234567.89
1234567890123456789	12345678901234567890	123	1234	1 1		1234567.89	1234567.89	1234567.89
12345678 12345678	12 1 123	123	1234	1234567.89	1234567.89	1234567.89	1234567.89	1234567.89
12	1234 1234 1234	123	1234	1234567.89	1234567.89	1234567.89		1234567.89
SUBTOTAL FISCAL	MMCCYY				12345678.90	12345678.90	12345678.90	12345678.90
YEAR					12345678.90	12345678.90	12345678.90	12345678.90
				12345678.90	12345678.90	12345678.90	12345678.90	12345678.90
	12345 12345 12345			12345678.90	12345678.90	12345678.90		12345678.90
SUBTOTAL PART A					123456789.01	123456789.01	123456789.01	123456789.01
					123456789.01	123456789.01	123456789.01	123456789.01
				123456789.01	123456789.01	123456789.01	123456789.01	123456789.01
	123456 123456 123456			123456789.01	123456789.01	123456789.01		123456789.01

2000 version

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INTERMEDIARY NAME/ADDRESS/CITY/STATE/ZIP/PHONE NUMBER

PROVIDER NUMBER/ NAME PART B PAID DATE: MM/DD/CCYY REMIT#: 1234567890 PAGE 2

PATIENT NAME	PATIENT CNTRL #	RC	REM	DRG#	DRG OUT AMT	COINS	PAT RFND	CONTRCT ADJ
HIM #	ICN	RC	REM	OUTCD CAPCD		COVD CHGS	ESRD NET ADJ	PER DIEM RTE
FROM DT THRU DT	NACHG HICHG TOB	RC	REM	PROF COMP	MSP PAYMT	NCOVD CHGS	INTEREST	PROC CD AMT
CLM STATUS	COST COVDY NCOVDY	RC	REM	DRG AMT	DEDUCTIBLES	DENIED CHGS		NET REIMB
123456789012345678 1 1	12345678901234567890	123	1234	123	1234567.89	1234567.89	1234567.89	1234567.89
1234567890123456789	12345678901234567890	123	1234	1 1		1234567.89	1234567.89	1234567.89
12345678 12345678	12 1 123	123	1234	1234567.89	1234567.89	1234567.89	1234567.89	1234567.89
12	1234 1234 1234	123	1234	1234567.89	1234567.89	1234567.89		1234567.89
SUBTOTAL FISCAL	MMCCYY				12345678.90	12345678.90	12345678.90	12345678.90
YEAR					12345678.90	12345678.90	12345678.90	12345678.90
				12345678.90	12345678.90	12345678.90	12345678.90	12345678.90
	12345 12345 12345			12345678.90	12345678.90	12345678.90		12345678.90
SUBTOTAL PART B					123456789.01	123456789.01	123456789.01	123456789.01
					123456789.01	123456789.01	123456789.01	123456789.01
				123456789.01	123456789.01	123456789.01	123456789.01	123456789.01
	123456 123456 123456			123456789.01	123456789.01	123456789.01		123456789.01

2000 version

Attachment 1 (Cont.)

INTERMEDIARY NAME/ADDRESS/CITY/STATE/ZIP/PHONE NUMBER

PROVIDER NUMBER/NAME | PAID DATE: MM/DD/CCYY | REMIT#: 1234567890 | SUMMARY | PAGE 3

CLAIM DATA:		PASS THRU AMOUNTS:			
		CAPITAL:	123,456,789.01	PROVIDER PYMNT RECAP:	
DAYS:		RETURN ON EQUITY:	123,456,789.01		
COST :	1234567	DIRECT MEDICAL EDUCATION:	123,456,789.01	PAYMENTS;	
COVDY :	1234567	KIDNEY ACQUISITION:	123,456,789.01	DRG OUT AMT:	123,456,789.01
NCOVDY:	1234567	BAD DEBT:	123,456,789.01	INTEREST:	123,456,789.01
		NON-PHYSICIAN ANESTHETISTS:	123,456,789.01	PROC CD AMT:	123,456,789.01
CHARGES:		TOTAL PASS THRU:	123,456,789.01	NET REIMB:	123,456,789.01
COVD :	12,345,678.90	HEMOPHILIA ADD ON:	123,456,789.01	TOTAL PASS THRU:	123,456,789.01
NCOVD :	12,345,678.90	PIP PAYMENT:	123,456,789.01	PIP PAYMENTS:	123,456,789.01
DENIED :	12,345,678.90	SETTLEMENT PAYMENTS:	123,456,789.01	SETTLMNT PYMTS:	123,456,789.01
		ACCELERATED PAYMENTS:	123,456,789.01	ACCLRATED PYMT:	123,456,789.01
		REFUNDS:	123,456,789.01	REFUNDS:	123,456,789.01
PROF COMP:	12,345,678.90	PENALTY RELEASE:	123,456,789.01	PENALTY RELEASE:	123,456,789.01
MSP PAYMT:	12,345,678.90	TRANS OUTP PYMT:	123,456,789.01	TRANS OUTP PYMT:	123,456,789.01
DEDUCTIBLES:	12,345,678.90			HEMOPHILIA AD0N:	123,456,789.01
COINSURANCE:	12,345,678.90				
PAT REFUND:	12,345,678.90	WITHHOLD FROM PAYMENTS:		WITHHOLD:	123,456,789.01
INTEREST:	12,345,678.90	CLAIM ACCOUNTS RECEIVABLE:	123,456,789.01	NET PROV PYMT:	123,456,789.01
CONTRACT ADJ:	12,345,678.90	ACCELERATED PAYMENTS:	123,456,789.01	(PAYMENT MINUS WITHHOLD)	
PROC CD AMOUNT:	12,345,678.90	PENALTY:	123,456,789.01		
NET REIMB:	12,345,678.90	SETTLEMENT:	123,456,789.01	CHECK/EFT NUMBER:	1234567890
		TOTAL WITHHOLD:	123,456,789.01		

2000 version

Attachment 2

MEDICARE STANDARD PAPER REMITTANCE (SPR) ADVICE DATA DIRECTORY AND 835 VERSION 3051.4A.01 MAP

Full Description (In order of appearance)	SPR ID	SPR FIELD SIZE CHARACTERISTICS	835 LOCATION
Intermediary name/ address/city/state/ zip/phone number	as written	AN 132 characters	Name=1-080.A-N102 Other data elements (DE) are fiscal intermediary (FI) generated.
Provider number	as written	AN 13	1-080.B-N104
Provider name	as written	AN 25	1-080.B-N102
Literal Value: Part A	as written	AN 06	Determined by bill type in 2-005-TS302
Literal Value: Part B	as written	AN 06	
Paid date	as written	N MM/DD/CCYY	1-020-BPR16
Remittance advice	REMIT	N 9(l 0)	Fl generated.
Literal Value: Page	as written	AN 06	Fl generated.
Pages 1&2			
Patient Last Name	PATIENT NAME	AN 18	2-030.A-NM103
Patient First Name		AN 01	2-030.A-NM104
Patient Mid. Initial		AN 01	2-030.A-NM105
Health insurance claim number	HIM#	AN 19	2-030.A-NM109
Statement covers period--start	FROM DT	N MMDDCCYY	2-050.A-DTM02
Statement covers period--end	THRU DT	N MMDDCCYY	2-050.B-DTM02
Claim status code	CLM STATUS	AN02	2-010-CLP02
Patient control #	PATIENT CNTRL #	AN 20	2-010-CLP01
Internal control #	ICN	AN 23	2-010-CLP07
Patient name change	NACHG	AN 02	2-030.A-NM101 if 74
HIM change	HICHG	AN 01	2-030.A-NM108 if C
Type of bill	TO	AN 03	2-010-CLP08
Cost report days	COST	N S9(3)	2-033-MIA15
Covered days/ visits	COVDY	N S9(3)	2-064-QTY02 when CA in prior DE

Full Description (In order of appearance)	SPR ID	SPR FIELD SIZE CHARACTERISTICS	835 LOCATION
Noncovered days	NCOVDY	N S9(3)	2-064-QTY02 when NA in prior DE
Remark code (4 occurrences)	REM	AN 05	Inpatient: 2-033-MIA 05, 20, 21, 22 Outpatient: 2-035-MOA03, 04, 05, 06
DRG #	as written	N 9(3)	2-010-CLP11
Outlier code	OUTED	AN 02	2-062-AMT01 if ZZ
Capital code	CAPCD	AN 01	2-033-MIA08
Professional component	PROF COMP	N S9(7).99	Total of amounts in 2-020 or 2-090 CAS03, 06, 09, 12, 15 or 18 when 89 in prior DE
DRG operating and capital amount	DRG AMT	N S9(7).99	2-033-MIA04
DRG outlier amount	DRG OUT	AMT N S9(7).99	2-062-AMT02 when ZZ in prior DE
MSP primary	MSP PAYMT	N S9(7).99	2-062-AMT02 amount when NJ in prior DE
Cash deductible/ Blood deductible	DEDUCTIBLES	N S9(7).99	Total of 2-020 or 2-090-CAS03, 06, 09, 12, 15 or 18 when 2 in prior DE
Coinsurance amount	COINSURANCE	N S9(7).99	Total of 2-020 or 2-090-CAS03, 06, 09,12,15 or 18 when 2 in prior DE
Covered charges	COVD CHGS	N S9(7).99	2-060-AMT02 when AU in prior DE
Noncovered charges	NCOVD CHGS	N S9(7).99	2-010-CLP03 minus 2-060-AMT02 when AU in prior DE
Denied charges	DENIED CHGS	N S9(7).99	Total of 2-020 or 090-CAS 03, 06, 09, 12, 15 or 18
Patient Refund amount	PAT REFUND	N S9(7).99	2-020 or 2-090-CAS 03, 06 ,09,12, 15 or 18 when 100 in prior DE

Full Description (In order of appearance)	SPR ID	SPR FIELD SIZE CHARACTERISTICS	835 LOCATION
Claim ESRD reduction	ESRD NET ADJ	N S9(7).99	2-020 or 2-090-CAS 03, 06, 09, 12, 15 or 18 when 118 in prior DE
Interest	INTEREST	N S9(6).99	2-060-AMT02 when IN in prior DE
Contractual Adjustment	CONTRACT ADJ	N S9(7).99	Total of 2-020 or 2-090-CAS03, 06, 09, 12, 15 or 18 when CO in CAS01
Per Diem rate	PER DIEM RTE	N S9(7).99	2-062-AMT02 when DY in prior DE
Procedure code amount	PROC CD AMT	N S9(7).99	2-035-MOA02
Net reimbursement	NET REIMB	N S9(7).99	2-010-CLP04
Page 3 Claim Data			
Cost report days	DAYS COST	N S9(3)	Total of claim level SPR COST.
Covered days/visits	DAYS COVDY	N S9(4)	Total of claim level SPR COVDY.
Noncovered days	DAYS NCOVDY	N S9(4)	Total of claim level SPR NCOVDY.
Covered charges	CHARGES COVD	N S9(7).99	Total of claim level SPR COVD CHGS.
Noncovered charges	CHARGES NCOVD	N S9(7).99	Total of claim level SPR NCOVD CHGS.
Denied charges	CHARGES DENIED	N S9(7).99	Total of claim level SPR DENIED CHGS.
Professional component	PROF COMP	N S9(7).99	Total of claim level SPR PROF COMP.
MSP primary	MSP PAYMT	N S9(7).99	Total of claim amount Level SPR MSP PAYMENT.
Cash deductible/ blood deductibles	DEDUCTIBLES	N S9(7).99	Total of claim level SPR DEDUCTIBLES.
Coinsurance amount	COINSURANCE	N S9(7).99	Total of claim level SPR COINSURANCE.

Full Description (In order of appearance)	SPR ID	SPR FIELD SIZE CHARACTERISTICS	835 LOCATION
Patient refund	PAT REFUND	N S9(7).99	Total of claim amount level SPR PAT REFUND.
Interest	INTEREST	N S9(7).99	Total of claim level SPR INTEREST.
Contractual adjustment	CONTRACT ADJ	N S9(7).99	Total of claim level SPR CONTRACT ADJ.
Procedure code payable amount	PROC CD AMT	N S9(7).99	Total of claim level SPR PROC CD AMT.
Claim payment	NET REIMB	N S9(7).99	Total of claim level amount SPR NET REIMB.
Summary Data Pass Thru amounts			3-010-PLB04, 06, 08 or 10 when:
Capital pass thru	CAPITAL	N S9(7).99	... CP in prior DE
Return on equity	as written	N S9(7).99	...RE in prior DE
Direct medical education	as written	N S9(7).99	... DM in prior DE
Kidney acquisition	as written	N S9(7).99	...KA in prior DE
Bad debt	as written	N S9(7).99	...BD in prior DE
Non-physician anesthetists	as written	N S9(7).99	...CR in prior DE
Hemophilia add on	as written	N S9(7).99	... ZZ in prior DE
Total pass thru	as written	N S9(7).99	Total of the above pass thru amounts.
Non-Pass Thru Amounts			3-010-PLB04, 06, 08 or 10 when:
PIP payment	as written	N S9(7).99	... PP in prior DE
Settlement amounts	SETTLEMENT PAYMENTS	N S9(7).99	... FP in prior DE
Accelerated payments	as written	N S9(7).99	... AP in prior DE
Refunds	as written	N S9(7).99	...RF in prior DE
Penalty release	as written	N S9(7).99	...RS in prior DE

Full Description (In order of appearance)	SPR ID	SPR FIELD SIZE CHARACTERISTICS	835 LOCATION
Transitional outpatient payment	TRANS OP PYMT	N S9(7).99	... BN in prior DE
Withhold from Payment			3-010-PLB04, 06, 08 or 10 when:
Claims accounts receivable	as written	N S9(7).99	... AA in prior DE
Accelerated payments	as written	N S9(7).99	...AW in prior DE
Penalty	as written	N S9(7).99	...PW in prior DE
Settlement	as written	N S9(7).99	...OR in prior DE
Total withholding	TOTAL WTHLD	N S9(7).99	Total of the above withholding amounts.
Provider Payment Recap			
Payments and withhold previously listed			
Net provider payment	as written	N S9(7).99	1-020-BPR02
Check/EFT number	as written	AN 10	1-040-TRN02

See 835 implementation guides for data element definitions, completion and use.

AMT02	**0782**	Monetary Amount	
R 1	15 M	**Total Covered Charges**	**AU=43-10**
		Per Diem Amount (Inpatient and Partial Hospitalization Only)	**DY=22-09**
		Patient Paid Amount	**F5=23-04**
		Interest Amount	**I=40-03**
		MSP Liability Amount Met	**NJ=42-11**
		Negative Reimbursement	**NL=22-08**
		Hemophilia Add-on Amount	**ZK=22-10**
		Outlier Amount *(inpatient)*	**ZZ=42-04**
AMT03	0478	Credit/Debit Flag Code **Not Used**	

X12 Segment Name: **REF** Reference Numbers
Name: **ASC, APC or HIPPS Group Number**
Loop: SVC
Max. Use: 1
X12 Purpose: To specify identifying numbers.
Purpose: **To provide the Ambulatory Surgical Center (ASC), Ambulatory Patient Code (APC), or the Health Insurance Prospective Payment System (HIPPS) code assigned to this service.**
Usage: **Conditional**
Example: **REF*1S*1~**
Comments: **The ASC and APC numbers are generated by the Medicare Pricer program. The HIPPS number is submitted on the claim. The applicable number must be reported for a Medicare service paid under the ASC, outpatient PPS, or *HIPPS* payment methodology.**

Syntax Note: 0203 - At least one of REF02 or REF03 must be present

Element Attributes		Data Element Usage	**Flat File Map**
REF01 ID 2	0128 3 M	Reference Number Qualifier Code qualifying the Reference number Codes: **1S Ambulatory Patient Group (APG) Number**	Translator Generated (TG)
REF02 AN 1	0127 30 M	Reference Number Reference number or identification number as defined for a particular Transaction Set or as specified by the Reference Number Qualifier. **ASC, *APC or HIPPS* Number**	**30-15 ASC** FISS to furnish APC & HIPPS # maps

NOTE: Pricer supplies the APC only for a single HCPCS included in that APC. No APC is generated for the other HCPCS included in that APC.

REF03	0352	Description **Not Used**	

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X12 Segment Name: **REF** Reference Numbers

Name: **ASC, APC or HIPPS Rate (percent)**
Loop: SVC
Max. Use: 1
X12 Purpose: To specify identifying numbers.
Purpose: **To convey the ASC, *APC or HIPPS* percentage rate.**
Usage: **Conditional**
Example: **Ref*RB*100~**
Comments: **This segment must be sent for Medicare ASC and HIPPS claims, *and if an special rate applies, for APC claims.***

Syntax Note: 0203 - At least one of REF02 or REF03 must be present

Element Attributes		Data Element Usage	**Flat File Map**
REF01	0128	Reference Number Qualifier	Translator
ID 2	3 M	Code qualifying the Reference number Codes: **RB Rate Code Number**	Generated (TG)
REF02	0127	Reference Number	**30-16 ASC**
AN 1	30 M	Reference number or identification number as defined for a particular Transaction Set or as specified by the Reference Number Qualifier.	FISS to furnish HIPPS rate map
REF03	0352	Description **Not Used**	

ASC, *APC or* HIPPS Rate (percent)

ASC Codes:	HIPPS Codes:	*APC Codes:*
0 Zero percent	**0 Zero percent**	***Applicable percent***
50 50 percent	**50 50 percent**	
100 100 percent	**60 60 percent**	
150 150 percent	**100 100 percent**	

X12 Segment Name: **AMT** Monetary Amount

Name: **ASC, APC or HIPPS Priced Amount**
Loop: SVC
Max. Use: 1
X12 Purpose: To indicate the total monetary amount.
Purpose: **To convey the ASC, APC, or HIPPS priced amount (the allowed amount generated by Pricer).**
Usage: **Conditional**
Example: **AMT*B6*467~**
Comments: **This segment must be sent on Medicare ASC and APC remittances, and on remittances for home health HIPPS sent at the end of a 60-day benefit period. (I report for the payment at the beginning of a home health 60-day benefit period.)**

Element Attributes		Data Element Usage	Flat File Map
AMT01 ID 1 2 M	0522	Amount Qualifier Code Code to qualify amount: Codes: **B6 Allowed Amount - Actual Amount**	Translator Generated (TG)
AMT02 R 1	0782 15 M	Monetary Amount **ASC, APC or *HIPPS* priced amount**	**30-17 APC** (when entries in 30-15 and 30-16) FISS to furnish the APC and HIPPS maps
AMT03	0478	Credit/Debit Flag Code **Not Used**	

STANDARD PROVIDER LEVEL ADJUSTMENT (PLB) REASON CODES

The PLB segment carries provider level financial adjustment data which is not related to the adjustment data for the claims addressed in a specific 835 transaction. As with the CAS financial adjustment segments, positive numbers in monetary amount elements have a negative arithmetic value in the balancing routines, while negative numbers have a positive arithmetic value in the balancing routines.

PLB Code Value	Message
AA	Receivable today
AW	Accelerated payment withholding
AP	Accelerated payment amount
BD	Bad debt pass-thru amount
BF	Balance forward; a negative balance to be carrier forward and applied in a subsequent billing cycle.
BN	Bonus; used to report a Medicare Transitional Outpatient PPS payment.
CA	Manual claims adjustment; approved claims payments calculated outside normal processing.
CO	Carryover; a negative balance amount which has been carried forward from a previous billing cycle and applied in the current billing cycle.
CP	Capital pass-thru amount
CR	Nurse anesthetist pass-thru amount (CRNA)
CW	Claim withholding
CX	Total cancel claim amount
DM	Direct medical education pass-thru amount
DS	Disproportionate share amount
FS	Final settlement amount (cost report)
GM	Graduate medical education pass-thru amount
IM	Indirect medical education pass-thru amount
IN	Interest paid
IP	Interest assessed on late-filed cost reports and/or delinquent refunds
IR	Interim rate lump sum adjustment
KA	Organ acquisition pass-thru amount
LR	Late cost report penalty amount
NP	Non-physician pass-thru amount
OA	Part A offset for affiliated provider
OB	Part B offset for affiliated provider
OR	Overpayment recovery; overpayment amount not fully satisfied in prior cycles.
OS	Outside recovery; money withheld for external organizations, e.g., IRS
PA	Adjustment for claims paid after PIP effective date. (This amount must be multiplied by negative 1 [-1].)
PL	PIP lump sum adjustment
PO	Other pass-thru amount
PP	PIP payment
PR	Provider refund adjustment (To be used for credit balance reconciliation.)
PS	Pass-thru lump sum adjustment
PW	Penalty withholding
RA	Check received from the provider for credit balancing for Part A amounts due.
RB	Check received from the provider for credit balancing for Part B amounts due.
RE	Return on equity
RF	Refunds
RI	Reissued check amount
RS	Penalty release amount
SW	Penalty withhold amount
TR	Retroactive adjustment (cost report)
TS	Tentative settlement (cost report)