PROGRAM MEMORANDUM CARRIERS

Department of Health and Human Services

Health Care Financing Administration

Transmittal No. B-00-13 **Date MARCH 2000**

CHANGE REQUEST 1130

SUBJECT: Calculation of National Standard Format (NSF) for Electronic Remittance Advice (ERA) Amount Fields and Balancing of NSF Data; and Clarification to Claim NSF Field EAO 21 for Coordination of Benefits--Modification of Program Memorandum (PM) B-99-42 (CR1016) of December 1999

As result of efforts to program for PM B-99-42, it was discovered that, as result of fundamental differences in financial balancing for NSF version 1.04, some carrier systems could require significant reprogramming to apply the balancing changes in that PM to NSF version 1.04. This handicap does not, however, affect modification of the NSF versions 2.00 and 2.01 programming. Since completion of the NSF versions 2.00 and 2.01 modifications described in PM B-99-42 will accomplish the main objective to improve the internal flat file as a foundation for future implementation of the Health Insurance Portability and Accountability Act remittance advice standard, the Medicare implementation requirement is being modified.

This PM reissues the information in PM B-99-42 but excludes the requirement for NSF version 1.04 flat file balancing changes. Carriers are permitted and encouraged, however, to make these changes in NSF version 1.04 also if their system configuration would allow this to be accomplished without significant reprogramming.

1. NSF/ERA

An updated edition of the NSF for ERAs version 2.01 dated September 1, 1999, is now available for downloading under the title 2.01U from the HCFA electronic data interchange (EDI) website: www.hcfa.gov/medicare/edi/edi.htm. This update was prepared in response to requests for clarification received from a number of carriers due to some differences in interpretation by some carriers and standard systems regarding calculation of fields in NSF ERAs. Explanatory remarks have been added to each amount field to clarify how each amount is to be calculated to eliminate possible confusion and foster uniform use. Remarks have also been added to clarify which fields are used in balancing of payment information within NSF ERA transactions. The word “should” has been replaced with “must” in most cases to clarify expectations for use of certain fields.

The calculation formulas for 450-28 and 500-15 (line and claim level “Calculated Payment to Provider” fields) and 700-07 (provider adjustment amount) have been revised to clarify use of interest and late filing reductions in calculations, and that adjustments reported in a dedicated field, such as a deductible amount, cannot be repeated in a miscellaneous adjustment field with a reason code. Such dual reporting prevents balancing of remittance data.

Although X12 835 balancing rules have always applied to the NSF also, there was reportedly some residual confusion as to how the X12 rules apply to specific amount fields within the NSF. These clarifications should dispel that confusion.

Although only version 2.01 is being updated on the HCFA website, these clarifications and calculation adjustments also apply to the corresponding fields in version 2.00 of the NSF ERA. The same corrections must be made to programming for versions 2.00 and 2.01 of the NSF ERA. To the extent any of these programming changes would not be transparent to providers who have elected to receive an NSF ERA, you must furnish those providers at least 60 days advance notice of those changes prior to implementation.

Due to the number of pages to which remarks have been added, rather than issue "change pages" only, the entire NSF ERA version 2.01 has been reissued and redated as 9/1/99 to differentiate it from earlier editions.

Changes by Field Number

100-04 Requirement corrected from "O" to "R."
100-06 Requirement corrected from "O" to "R."
200-06 "Should" has been replaced by "must" in the validation.
200-10 "Should" has been replaced by "must" in the remark.
450-04 "Should" has been replaced by "must" in the remark.
450-10 Clarified that this filler is reserved for national use. Requirement corrected to "R."
450-11 Place of service 60, mass immunization center, added to the list of valid codes. (This had previously been added in another Medicare instruction, but the NSF page had not been updated.)
450-12 "Type of service" code is no longer required; this is established by HCPCS. This field has been converted to filler reserved for national use. Requirement changed to "R."
450-18 Calculation and balancing remarks added.
450-19 Remark added that not used to balance for Medicare.
450-20 Remark added that not used to balance for Medicare.
450-21 Remark added that used in balancing.
450-22 Remark added that used in balancing.
450-23 Remark added that used in balancing.
450-24 Remark added that not used to balance for Medicare.
450-25 Remark added that not required for Medicare nor used to balance for Medicare.
450-26 Remark added that required for Medicare when applicable, used to balance, and entry must correspond to amount on the Medicare Summary Notice (MSN).
450-27 Remark added that not used to balance for Medicare.
450-28 Remark added correcting prior calculation formula for this field and clarifying that it is used in balancing.
450-29 Remark added that not used to balance for Medicare.
450-30 Remark added that not used to balance for Medicare. May be reported for informational purposes only.
450-31 Remark added that not used to balance for Medicare.
450-32 Remark added that not used to balance for Medicare. May be reported for informational purposes only.
450-33 Remark added that used in balancing.
450-38 Remark added to identify website where all approved claim adjustment reason codes are maintained.
451-03 "Should" replaced by "must" in the remark.
451-04 "Should" replaced by "must" in the remark.
451-07 Remark added that not used to balance for Medicare, but must be reported for informational purposes if it applies.
451-10 Remark added that adjustments for which a dedicated reporting field exists must not be repeated in a miscellaneous adjustment field.
451-16 Remark added that remark codes must be used where applicable.
451-22 Remark added that adjustments for which a dedicated reporting field exists must not be repeated in a miscellaneous adjustment field.
451-23 Remark added that adjustments for which a dedicated reporting field exists must not be repeated in a miscellaneous adjustment field.
451-24 Remark added that not used to balance for Medicare.
500-05 Remark added that used in balancing.
500-06 Remark added that not used to balance for Medicare.
500-07 Remark added that not used to balance for Medicare.
500-08 Remark added that not used to balance for Medicare.
500-09 Remark added that not used to balance for Medicare.
500-10 Remark added that not used to balance for Medicare.
500-11 Remark added that not used to balance for Medicare, but must be reported for informational purposes if it applies.

500-12 Remark added that used in balancing.
500-13 Remark added that where this applies, it must be reported at the service level and not at the claim level.
500-14 Remark added that not used to balance for Medicare.
500-15 Remark added correcting the prior calculation formula for this field and clarifying that it is used in balancing.
500-16 Remark added that not used to balance for Medicare.
500-17 Remark added that used in balancing and equivalent to OA B13 entries in an 835.
500-18 Remark added that used in balancing.
500-19 Remark added that it may be reported for informational purposes, but is not used to balance for Medicare.
500-20 Remark added that it may be reported for informational purposes, but is not used to balance for Medicare.
500-22 Remark added that it is not used to balance for Medicare.
500-23 Remark added that it is not used to balance for Medicare.
500-26 Term "PayerID" replaced by "PlanID."
500-28 Term "PayerID" replaced by "PlanID."
500-30 Remark added to identify website where all approved claim adjustment reason codes are maintained, and to clarify that at least one reason code must be reported at the claim level. Requirement for -30 corrected to "R."
500-33 Remark added that if applicable, required for Medicare, and used in balancing.
700-07 Remarks added that used in balancing, not permissible to repeat any adjustment at the provider level already reported at the line or claim level, and requiring reporting of any type of interest at the provider level for balancing purposes.
700-08 Example of FCN added to the definition.
800-09 Remark added that not required for Medicare.
800-10 Remark added that not required for Medicare.
800-14 Calculation remark added. Definition amended to specify that the interest referred to is claims processing timeliness interest.
800-15 Calculation remark added.
800-16 Calculation remark added.
800-17 Calculation remark added.
800-18 Calculation remark added.
800-19 Remark added that not required for Medicare.
800-20 Calculation remark added.
800-21 Calculation remark added.
800-22 Clarifications added for the use of AJ and OF provider adjustment codes in the calculation of this field.
800-23 Calculation remark added.
800-28 Calculation remark added.
800-29 Calculation remark added.
900-10 Remark added that not required for Medicare.
900-11 Remark added that not required for Medicare.
900-12 Calculation remark added.
900-13 Calculation remark added.
900-14 Calculation remark added.
900-15 Calculation remark added. Definition amended to specify that the interest referred to is claims processing timeliness interest.
900-16 Calculation remark added.
900-17 Calculation remark added.
900-18 Calculation remark added.
900-19 Calculation remark added.
900-20 Remark added that not required for Medicare.
900-21 Calculation remark added.
900-22 Calculation remark added.
900-23 Calculation remark added.
900-24 Calculation remark added.
900-25 Calculation remark added.
900-26 Calculation remark added.

900-27 Calculation remark added.
900-29 COBOL picture corrected.

Update to the NSF 2.01 to 835 Version 3051.4B Mapping

See attachment 1. The following changes have been made:

100-05 1-080.A-N104 added to the map for the 835.
100-07 Mapped to 835 1-080.A-N102.
100-09 Noted that the NSF version number is not used in the 835.
400-04 Mapped to 835 1-040-TRN02.
400-05 Mapped to 835 1-020-BPR16.
400-28 Noted that applies when code 74 in the 835 2-030.A-NM101.
450-12 Corrected to "Filler" in the NSF.
450-24 Cross-reference changed to 700-07.
500-11 Noted found in 835 AMT02 when I in AMT01.
500-18 OA 100 added to the 835 map.
500-31 Map changed 2-020-CAS05.
500-32 Map changed to 2-020-CAS08.
500-34 Map changed to 2-020-CAS06.
500-35 Map changed to 2-020-CAS09.

Update of the Standard Paper Remittance to NSF 2.01 Map

See attachment 2. The following changes have been made:

PREV PD	Added NSF title for filed 500-18.
Total Other Adjs	Corrected the NSF references to 451-10--14, 22, 23.
FCN or Adjustment Reason	Separated into individual lines in the map.

2. NSF/Claims

There has been some confusion regarding field 21 of the EAO record that was added to the NSF Coordination of Benefits (COB) format version 3.00. This field was added for COB to report the referring provider UPIN. When NSF version 3.01 was later released, it included EAO.21. All COB data elements were identified in the "remarks" area for each detailed description of the data element as well as in the general list of revisions. EAO.21 was identified as a COB data element in the general list, but not in the "remarks" area of the detailed data element description, leading to the confusion. Attachment 3 includes the words "Required for COB if services were referred" under "Remarks" for EAO.21 to clarify its usage.

The certification record for ambulance, GAO field 15, was never updated to include the value "E" to indicate that a patient was transferred to a rehabilitation facility. This change occurred in the ANSI X12 837 (version 3B.01), but was not initially mapped to GAO.15. Attachment 4 includes the code "E" in the code values allowed for GAO.15.

Update your copy of NSF 3.01 with these replacement pages. Since these are minor changes, there will not be a new version release of the NSF for claims.

The effective date for this Program Memorandum (PM) is October 1, 1999. Do not reopen previously processed claims and ERAs to apply this information.

The implementation date for this PM is April 1, 2000.

These instructions should be implemented within your current operating budget.

This PM may be discarded after December 31, 2000.

Contact person for this PM is Kathleen Simmons (410) 786-6157 for NSF/ERA issues and Joy Glass (410) 786-6125 for NSF/claims issues.

4 Attachments

NSF 2.01 to 835 version 3051.4B Map

100-01.0	RECORD ID "100"	Do Not Use
100-02.0	PAYOR ID	1-020-BPR10
		1-080.A-N104
		1-040-TRN03
100-03.0	RECEIVER ID	1-060.B-REF02(EV)
100-04.0	RESERVED (100-04.0)	Do Not Use
100-05.0	SUBMITTER ID	1-040-TRN03
		1-020-BPR10
		1-080.A-N104
100-06.0	RESERVED (100-06.0)	Do Not Use
100-07.0	SUBMITTER NAME	1-080.A-N102
100-08.0	FILE CREATION DATE	Translator Generated
100-09.0	VERSION CODE-NATIONAL	Do Not Use
100-10.0	FILLER-NATIONAL	Do Not Use
200-01.0	RECORD ID "200"	Do Not Use
200-02.0	PAYOR ID	1-020-BPR10
		1-080.A-N104
		1-040-TRN03
200-03.0	SOURCE OF PAYMENT	Do Not Use
200-04.0	EMC PROV ID	Do Not Use
200-05.0	BATCH NO	1-010-ST02/SE02(835)
200-06.0	PROVIDER NAME	1-080B-N102(PE)
200-07.0	PROVIDER NO	1-080B-N104(MP)
200-08.0	CHECK NO\EFT TRACE NO	1-040-TRN02(1)
200-09.0	CHECK\EFT ISSUE DATE	1-020-BPR16
200-10.0	PAYOR PROCESS DATE	1-070-DTM02/DTM05 (405)
200-11.0	RECVR/PROV BANK ID NO	1-020-BPR13(01)
200-12.0	RECVR/PROV ACCT NO	1-020-BPR15(DA,SG)
200-13.0	SENDER/PAYOR BANK ID NO	1-020-BPR07(01)
200-14.0	SENDER/PAYOR ACCT NO	1-020-BPR09(DA)
200-15.0	TRANS HANDLING CODE	1-020-BPR01
200-16.0	PAYMENT METHOD CODE	1-020-BPR04
200-17.0	PAYMENT FORMAT CODE	1-020-BPR05
200-18.0	RECVR/PROV TYPE OF ACCT	1-020-BPR14
200-19.0	ASSIGNED/	
	UNASSIGNED INDICATOR	2-003.A-LX01
		2 -003.B-LX01
200-20.0	NATIONAL-FILLER	Do Not Use
400-01.0	RECORD ID "400"	Do Not Use
400-02.0	PAYOR ID	1-020-BPR10
		1-080.A-N104
		1-040-TRN03
400-03.0	PAT CONTROL NO	2-010-CLP01
400-04.0	CHECK NO/EFT TRACER NO	1-040-TRN02
400-05.0	CHECK/EFT ISSUE DATE	1-020-BPR16
400-06.0	GROUP POLICY NO	Do Not Use
400-07.0	INSURED ID NO	2-030A-NM109(HN)
400-08.0	CORRECTED INSURED ID IND	2-030A-NM109(C)
400-09.0	INSURED LAST NAME	Do Not Use
400-10.0	INSURED FIRST NAME	Do Not Use
400-11.0	INSURED MI	Do Not Use
400-12.0	EMPLOYEE ID	Do Not Use
400-13.0	PATIENT LAST NAME	2-030A-NM103(1)(QC)
400-14.0	PATIENT FIRST NAME	2-030A-NM104(1)(QC)
400-15.0	PATIENT MIDDLE INITIAL	2-030A-NM105(1)(QC)
400-16.0	PATIENT SEX	Do Not Use
400-17.0	PATIENT DATE OF BIRTH	Do Not Use
400-18.0	COMP INSURANCE FLAG	2-010-CLP02
400-19.0	CLAIM STATUS	2-010-CLP02
400-20.0	PAYOR PHONE NO	Do Not Use
400-21.0	MEDICAL RECORD NO	Do Not Use
400-22.0	PAYOR CLAIM CONTROL NO	2-010-CLP07
400-23.0	CLAIM REMARK CODE1	2-035-MOA03
400-24.0	CLAIM REMARK CODE2	2-035-MOA04
400-25.0	CLAIM REMARK CODE3	2-035-MOA05
400-26.0	CLAIM REMARK CODE4	2-035-MOA06
400-27.0	CLAIM REMARK CODE5	2-035-MOA07
400-28.0	CORRECTED PATIENT NAME	2-030.A-NM101(74)
400-29.0	FILLER-NATIONAL	Do Not Use

450-01.0	RECORD ID "450"	Do Not Use
450-02.0	PAYOR ID	1-020-BPR10
		1-080.A-N104
		1-040-TRN03
450-03.0	PAT CONTROL NO	2-010-CLP01
450-04.0	LINE CONTROL NO	2-100.D-REF02
450-05.0	SERVICE LINE NO	Do Not Use
450-06.0	LINE ITEM STATUS CODE	Do Not Use
450-07.0	SERVICE FROM DATE	2-080.A-DTM02/
		DTM05 (150/472)
450-08.0	SERVICE TO DATE	2-080.B-DTM02 (151)/
		DTM05
450-09.0	PAYOR RECEIPT DATE	2-050-DTM02 (050)/
		DTM05
450-10.0	RESERVED	Do Not Use
450-11.0	PLACE OF SERVICE	2-100.A-REF02(LU)
450-12.0	FILLER--NATIONAL	Do Not Use
450-13.0	PROCEDURE CODE	2-070-SVC01*-02 (HC)
450-14.0	HCPCS MODIFIER 1	2-070-SVC01*-03
450-15.0	HCPCS MODIFIER 2	2-070-SVC01*-04
450-16.0	HCPCS MODIFIER 3	2-070-SVC01*-05
450-17.0	UNITS OF SERVICE	2-070-SVC05
450-18.0	SUBMITTED LINE CHARGE	2-070-SVC02
450-19.0	DISALLOWED COST CONTAIN	Do Not Use
450-20.0	DISALLOWED/NONCOVERED	Do Not Use
450-21.0	ALLOWED/CONTRACT AMOUNT	2-110.A-AMT02
450-22.0	DEDUCTIBLE AMOUNT	2-090-CAS03 (PR1)
450-23.0	COINSURANCE AMOUNT	2-090-CAS03 (PR2)
450-24.0	INTEREST AMOUNT	Do Not Use
		(See record 700-07)
450-25.0	GRAMM-RUDMAN REDUCTION	Do Not Use
		(See record 500)
450-26.0	AMT PAID BY OTHER PAYOR	2-090-CAS03 (OA71)
450-27.0	PROV ADJUSTMENT	Do Not Use
450-28.0	CALC PAY TO PROV	2-070-SVC03
450-29.0	CALC PAY TO PAYEE	Do Not Use
450-30.0	PREV PAY TO PROV	Do Not Use
450-31.0	PREV PAY TO PAYEE	Do Not Use
450-32.0	ACTUAL PAY TO PROV	Do Not Use
450-33.0	ACTUAL PAY TO PAYEE	2-090-CAS03 (OA100)
450-34.0	PAYMENT LEVEL BY PERCENT	Do Not Use
450-35.0	PPO/HMO IND	Do Not Use
450-36.0	FACILITY/SUPPLIER ID	2-100.C-REF02(1J)
450-37.0	PERFORMING PROV ID	2-100.B-REF02(1C)
450-38.0	GROUP AND REASON CODE 1	2-090-CAS01/CAS02
		(NOTE: Group is always CAS01)
450-39.0	GROUP AND REASON CODE 2	2-090-CAS01/CAS05
450-40.0	GROUP AND REASON CODE 3	2-090-CAS01/CAS08
450-41.0	GROUP AND REASON CODE 4	2-090-CAS01/CAS11
450-42.0	GROUP AND REASON CODE 5	2-090-CAS01/CAS14
450-43.0	GROUP AND REASON CODE 6	2-090-CAS01/CAS17
450-44.0	GROUP AND REASON CODE 7	2-090-CAS01/CAS02 (2nd loop)
450-45.0	PAYOR CLAIM CONTROL NO	2-010-CLP07
450-46.0	MODIFIER 4	Do Not Use
450-47.0	FILLER-NATIONAL	Do Not Use

451-01.0	RECORD ID "451"	Do Not Use
451-02.0	PAYOR ID	1-020-BPR10
		1-080.A-N104
		1-040-TRN03
451-03.0	PAT CONTROL NO	2-010-CLP01
451-04.0	LINE CONTROL NO	Do Not Use
451-05.0	SERVICE LINE NO	Do Not Use
451-06.0	PAYOR CLAIM CONTROL NO	2-010-CLP07
451-07.0	LATE FILING REDUCTION	2-110.B-AMT02
451-08.0	AMOUNT PATIENT OWES	Do Not Use
451-09.0	ORIGINAL PROCEDURE CODE	2-070-SVC06*-02(HC)
451-10.0	DOLLAR AMOUNT 1	2-090-CAS03
451-11.0	DOLLAR AMOUNT 2	2-090-CAS06
451-12.0	DOLLAR AMOUNT 3	2-090-CAS09
451-13.0	DOLLAR AMOUNT 4	2-090-CAS12
451-14.0	DOLLAR AMOUNT 5	2-090-CAS15
451-10.0	DOLLAR AMOUNT 1	2-090-CAS03
451-11.0	DOLLAR AMOUNT 2	2-090-CAS06

Field	Description	Mapping
451-12.0	DOLLAR AMOUNT 3	2-090-CAS09
451-15.0	NATIONAL DRUG CODE	Do Not Use
451-16.0	LINE REMARK CODE 1	2-130-LQ02
451-17.0	LINE REMARK CODE 2	2-130-LQ02
451-18.0	LINE REMARK CODE 3	2-130-LQ02
451-19.0	LINE REMARK CODE 4	2-130-LQ02
451-20.0	LINE REMARK CODE 5	2-130-LQ02
451-21.0	LINE REMARK CODE DATE	2-130-LQ02
451-22.0	DOLLAR AMOUNT 6	2-090-CAS18
451-23.0	DOLLAR AMOUNT 7	2-090-CAS03 (2nd loop)
451-24.0	AMOUNT PATIENT PAID	Do Not Use
451-25.0	ORIGINAL UNITS OF SERVICE	2-070-SVC07
451-26.0	FILLER-NATIONAL	Do Not Use

Field	Description	Mapping
500-01.0	RECORD ID "500"	Do Not Use
500-02.0	PAYOR ID	1-020-BPR10
		1-080.A-N104
		1-040-TRN03
500-03.0	PAT CONTROL NO	2-010-CLP01
500-04.0	CT LINE ITEMS	Do Not Use
500-05.0	CT SUBMITTED CHARGES	2-010-CLP03
500-06.0	CT DISALLOW-COST CONT	Do Not Use
500-07.0	CT DISALLOW/NONCOVER	Do Not Use
500-08.0	CT ALLOWED	Do Not Use
500-09.0	CT DEDUCTIBLE	Do Not Use
500-10.0	CT COINSURANCE	Do Not Use
500-11.0	CT INTEREST PAID	2-062-AMT02 (I)
500-12.0	CT GRAMM-RUDMAN RED	2-020-CAS03 (CO43)
500-13.0	CT AMT PAID BY OTHER PAYOR	Do Not Use
500-14.0	CT PROV ADJUSTMENT	Do Not Use
500-15.0	CT CALC PAY TO PROV	2-010-CLP04
500-16.0	CT CALC PAY TO PAYEE	Do Not Use
500-17.0	CT PREV PAY TO PROV	2-020-CAS03 (0A B13)
500-18.0	CT PREV PAY TO PAYEE	2-020-CAS03 (OA 100)
500-19.0	CT ACTUAL PAY TO PROV	Do Not Use
500-20.0	CT ACTUAL PAY TO PAYEE	Do Not Use
500-21.0	PAYOR CLAIM CONTROL NO	2-010-CLP07
500-22.0	CT LATE FILING REDUCTION	Do Not Use
500-23.0	CT AMOUNT PATIENT OWES	2-010-CLP05
500-24.0	CLAIM FILING INDICATOR	Do Not Use
500-25.0	CARRIER/SUPPLEMENTAL	2-030.B-NM103
	INSURER NAME1	
500-26.0	IDENTIFICATION NUMBER1	2-030.B-NM109
500-27.0	CARRIER/SUPPLEMENTAL	2-030.C-NM103
	INSURER NAME2	
500-28.0	IDENTIFICATION NUMBER2	2-030.C-NM109
500-29.0	CT AMOUNT PATIENT PAID	2-062-AMT02
500-30.0	CLAIM ADJ REASON CODE1	2-020-CAS02
500-31.0	CLAIM ADJ REASON CODE2	2-020-CAS05
500-32.0	CLAIM ADJ REASON CODE3	2-020-CAS08
500-33.0	CLAIM DOLLAR AMOUNT1	2-020-CAS03
500-34.0	CLAIM DOLLAR AMOUNT2	2-020-CAS06
500-35.0	CLAIM DOLLAR AMOUNT3	2-020-CAS09
500-36.0	FILLER-NATIONAL	Do Not Use

Field	Description	Mapping
700-01.0	RECORD ID "700"	Do Not Use
700-02.0	PAYOR ID	1-020-BPR10
		1-080.A-N104
		1-040-TRN03
700-03.0	SEQUENCE NO	Do Not Use
700-04.0	HIC NO	3-010-PLB03
		(Positions 20 - 30)
700-05.0	PATIENT ACCT NO	Do Not Use
700-06.0	ADJUSTMENT REASON	3-010-PLB03
		(Positions 1 - 2)
700-07.0	ADJUSTMENT AMOUNT	3-010-PLB04
700-08.0	FINANCIAL CONTROL NO	3-010-PLB03
		(Positions 3 - 19)
700-09.0	FILLER-NATIONAL	Do Not Use

Field	Description	Mapping
800-01.0	RECORD ID "800"	Do Not Use
800-02.0	PAYOR ID	1-020-BPR10 1-080.A-N104 1-040-TRN03
800-03.0	SOURCE OF PAYMENT	Do Not Use
800-04.0	EMC PROV ID	Do Not Use
800-05.0	BATCH NO	1-010-ST02/SE02(835)
800-06.0	BT CLAIM RECORDS	Do Not Use
800-07.0	BT SERV DATA REC	Do Not Use
800-08.0	BT SUBMITTED CHARGES	Do Not Use
800-09.0	BT DISALLOW-COST CONT	Do Not Use
800-10.0	BT DISALLOW/NONCOVER	Do Not Use
800-11.0	BT ALLOWED	Do Not Use
800-12.0	BT DEDUCTIBLE	Do Not Use
800-13.0	BT COINSURANCE	Do Not Use
800-14.0	BT INTEREST PAID	Do Not Use
800-15.0	BT GRAMM-RUDMAN RED	Do Not Use
800-16.0	BT AMT PAID OTHER PAYOR	Do Not Use
800-17.0	BT PROV ADJUSTMENT	Do Not Use
800-18.0	BT CALC PAY TO PROV	Do Not Use
800-19.0	BT CALC PAY TO PAYEE	Do Not Use
800-20.0	BT PREV PAY TO PROV	Do Not Use
800-21.0	BT PREV PAY TO PAYEE	Do Not Use
800-22.0	BT ACTUAL PAY TO PROV	1-020-BPR02
800-23.0	BT ACTUAL PAY TO PAYEE	Do Not Use
800-24.0	BT LATE FILING REDUCTION	Do Not Use
800-25.0	BT AMOUNT PATIENT OWES	Do Not Use
800-26.0	FILLER	Do Not Use
800-27.0	BT TOTAL PROV ADJUST RECS	Do Not Use
800-29.0	BT AMOUNT PATIENT PAID	Do Not Use
800-30.0	FILLER-NATIONAL	Do Not Use

Field	Description	Mapping
900-01.0	RECORD ID "900"	Do Not Use
900-02.0	PAYOR ID	1-020-BPR10 1-080.A-N104 1-040-TRN03
900-03.0	RECEIVER ID	1-060.B-REF02(EV)
900-04.0	RESERVED (900-04.0)	Do Not Use
900-05.0	SUBMITTER ID	1-040-TRN03, 1-020-BPR-10
900-06.0	RESERVED (900-06.0)	Do Not Use
900-07.0	FT BATCHES	Do Not Use
900-08.0	FT PATIENT RECORDS	Do Not Use
900-09.0	FT SUBMITTED CHARGES	Do Not Use
900-10.0	FT DISALLOW-COST CONT	Do Not Use
900-11.0	FT DISALLOW/NONCOVER	Do Not Use
900-12.0	FT ALLOWED	Do Not Use
900-13.0	FT DEDUCTIBLE	Do Not Use
900-14.0	FT COINSURANCE	Do Not Use
900-15.0	FT INTEREST PAID	Do Not Use
900-16.0	FT GRAMM-RUDMAN RED	Do Not Use
900-17.0	FT AMT PAID OTHER PAYOR	Do Not Use
900-18.0	FT PROV ADJUSTMENT	Do Not Use
900-19.0	FT CALC PAY TO PROV	Do Not Use
900-20.0	FT CALC PAY TO PAYEE	Do Not Use
900-21.0	FT PREV PAY PROV	Do Not Use
900-22.0	FT PREV PAY PAYEE	Do Not Use
900-23.0	FT ACTUAL PAY TO PROV	Do Not Use
900-24.0	FT ACTUAL PAY TO PAYEE	Do Not Use
900-25.0	FT LATE FILING REDUCTION	Do Not Use
900-26.0	FT AMOUNT PATIENT OWES	Do Not Use
900-27.0	FT AMOUNT PATIENT PAID	Do Not Use
900-28.0	FILLER	Do Not Use
900-29.0	FT TOTAL PROV ADJUST RECS	Do Not Use
900-30.0	FT TOTAL PROV ADJUST AMT	Do Not Use
900-31.0	FILLER-NATIONAL	Do Not Use

Some Specific CAS Mappings

The left column in this chart shows the NSF position. The type of adjustment is specified in the center column. The right column shows, reading left to right, the 835 position (2-090, etc.), the functional group code in the CAS01 element (i.e., PR), and the reason code in the CAS02 element that would be used to represent the adjustment listed in the center column.

NSF position	Adjustment	835 position / CAS01 / CAS02
450-22.0	Deductible	2-090 (PR)(1)
450-23.0	Coinsurance	2-090 (PR)(2)
450-33.0	Payment to beneficiary	2-090 (OA)(100)
500-12.0	Gramm-Rudman reduction	2-020 (CO)(43)

ATTACHMENT 2

STANDARD PAPER REMITTANCE TO NSF 2.01 MAP

Remittance Field	NSF 2.1 Field	NSF Field Number	Field Length
CARRIER NAME	Submitter Name	100-07	X(33)
PROVIDER NAME	Provider Name	200-06	X(33)
PROVIDER ADDRESS 1			
PROVIDER ADDRESS 2			
PROVIDER CITY			
PROVIDER STATE			
PROVIDER ZIP			
PROVIDER #	Provider Number	200-07	X(15) - X(10) used
DATE	Check / EFT Issue Date	200-09	X(08) - use MM/DD/YY
CHECK / EFT #	Check Number / EFT Trace Number	200-08	X(15)
BENEFICIARY LAST NAME	Patient Last Name	400-13	X(20) - X(12) used
BENEFICIARY FIRST NAME	Patient First Name	400-14	X(12) - X(08) used
HIC	Insured Identification Number	400-07	X(25) - X(12) used
ACNT	Patient Control Number	400-03	X(17)
ICN	Payor Claim Control Number	400-22	X(17)
ASG (ASSIGNMENT)	Claim Filing Indicator	500-24	X(01)
MOA CODES	Claim Remark Code 1 thru Claim Remark Code 5	400-23 thru 400-27	X(05)
PERF PROV	Performing Provider Identification	450-37	X(15) - X(10) used
SERV DATE (FROM)	Service From Date	450-07	X(08) - use MMDD
SERV DATE (THRU)	Service To Date	450-08	X(08) - use MMDDYY
POS	Place of Service	450-11	X(02)
NUM	Units of Service	450-17	9(03)V9 - 9(03) used
PROC	Procedure Code	450-13	X(05)

Remittance Field	NSF 2.01 Field	NSF Field Number	Field Length
MODS	HCPCS Modifier 1 thru HCPCS Modifier 3	450-14 thru 450-16	X(02)
SUBMITTED PROCEDURE CODE	Original Procedure Code	451-09	X(05)
BILLED	Submitted Line Charge	450-18	S9(05)V99 *
ALLOWED	Allowed / Contract Amount	450-21	S9(05)V99 *
DEDUCT	Deductible Amount	450-22	S9(05)V99 use S9(04)V99
COINS	Coinsurance Amount	450-23	S9(05)V99
PROV PD	Calculated Payment to Provider	450-28	S9(05)V99 *
RC-AMT (REASON CODES)	Group and Reason Code 1 thru Group and Reason Code 7	450-38 thru 450-44	X(06)
RC-AMT (REASON CODES AMOUNTS)	Dollar Amount 1 thru Dollar Amount 5 Dollar Amount 6 thru Dollar Amount 7	451-10 thru 451-14 451-22 thru 451-23	S9(05)V99 S9(05)V99
REM	Line Remark Code 1 thru Line Remark Code 5	451-16 thru 41-20	X(05)
PT RESP	CT Amount Patient Owes	500-23	S9(05)V99 *
BILLED (CLAIM - LEVEL)	CT Submitted Charges	500-05	S9(05)V99 *
ALLOWED (CLAIM - LEVEL)	CT Allowed	500-08	S9(05)V99 *
DEDUCT (CLAIM - LEVEL)	CT Deductible	500-09	S9(05)V99 use S9(04)V99
COINS (CLAIM - LEVEL)	CT Coinsurance	500-10	S9(05)V99
PROV PD (CLAIM - LEVEL)	CT Calculated Payment to Provider	500-15	S9(05)V99 *
NET	CT Actual Payment to Provider	500-19	S9(05)V99
PREV PD	CT Previous Payment to Provider CT Previous Payment to Payee	500-17 - 500-18	S9(05)V99
PD TO BENE	CT Actual Payment to Payee	500-20	S9(05)V99
INT	CT Interest Paid	500-11	S9(05)V99
MSP	CT Amount Paid by Other Payor	500-13	S9(05)V99

Remittance Field	NSF 2.01 Field	NSF Field Number	Field Length
OTHER (REASON CODES)	Claim Adjustment Reason Code 1 - Claim Adjustment Reason Code 3	500-30 thru 500-32	X(06)
OTHER (REASON CODE AMOUNTS)	Dollar Amount 1 - Dollar Amount 3	500-33 thru 500-35	S9(05)V99
INSURER TO WHICH CLAIM IS FORWARDED OR TRANSFERRED **	Carrier / Supplemental Insurer Name	500-25	X(33)
TOTAL CLAIMS	BT Claim Records	800-06	9(05)
TOTAL BILLED	BT Submitted Charges	800-08	S9(07)V99
TOTAL ALLOWED	BT Allowed	800-11	S9(07)V99
TOTAL DEDUCT	BT Deductible	800-12	S9(07)V99
TOTAL COINS	BT Coinsurance	800-13	S9(07)V99
TOTAL PROV PD	BT Calculated Payment to Provider	800-18	S9(07)V99
TOTAL PREV PD	BT Previous Payment to Provider	800-20 - 800-21	S9(07)V99
TOTAL PD TO BENE	BT Calculated Payment to Payee	800-19	S9(07)V99
TOTAL INT	BT Interest Paid	800-14	S9(07)V99
TOTAL MSP	BT Amount Paid by Other Payor	800-16	S9(07)V99
TOTAL OFFSET	Computed from the sum of all offset amount fields (700-7)	Computed	S9(07)V99
TOTAL OTHER ADJS	Computed from the sum of all reason code amount fields (451-10--14, 22, 23)	Computed	S3(07)V99
AMOUNT OF CHECK	BT Actual Payment to Provider	800-22	S9(07)V99
FCN	Financial Control Number	700-08	X(17)
ADJUSTMENT REASON	Provider Adjustment Reason	700-06	X(02)
HIC (OFFSET DETAIL)	Health Insurance Claim Number	700-04	X(25)
AMOUNT (OFFSET DETAIL)	Adjustment Amount	700-07	S9(05)V99 *

* These fields are defined as S9(05) .99 in the NSF documentation, but S9(07) .99 will be used for the paper remittance advice.

** The need for the claim forwarded/transferred message can be triggered by a value of "Y" in 400-18 (forwarded) or values 05-09 in 400-19 (transferred).

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: CLAIM RECORD "CLAIM DATA"   RECORD/FIELD: EA0-21.0

DATA ELEMENT: REFER PROV UPIN

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
21.0	X(15)	LEFT	SPACES	95	109	C

DEFINITION: The Referring Provider's UPIN.

CODE VALUES: N/A

VALIDATION: See GENERAL INSTRUCTIONS for "Identification Number" entry.

FORM LOCATION: N/A

REMARKS: Required for COB if services were referred.

ELECTRONIC MEDIA CLAIMS NATIONAL STANDARD FORMAT

RECORD NAME: AMBULANCE CERT RECORD RECORD/FIELD: GA0-15.0

DATA ELEMENT: Transported To/For

FIELD	COBOL PICTURE	JUSTIFY	INITIAL	FROM	THRU	REQ
15.0	X(01)	N/A	SPACE	52	52	C

DEFINITION: A code to indicate whether the patient was transported to the nearest facility or for other considerations.

CODE VALUES: Patient was transported:

A = To nearest facility for care of symptoms and/or complaints.

B = For the benefit of a preferred physician.

C = For the nearness of family members.

D = For the care of a specialist or for availability of specialized equipment.

E = Patient Transferred to Rehabilitation Facility.

VALIDATION: Must be entered if required by payor.

If entered, must be a valid code from above list.

FORM LOCATION: N/A

REMARKS: N/A