CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-20 One-Time Notification	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 577	**Date: October 16, 2009**
	Change Request 6589

Transmittal 550 is rescinded and replaced by Transmittal 577. The Implementation Date is changed to January 4, 2010 and April 5, 2010 for the VMS Shared System. All other material remains the same.

SUBJECT: Implementation of Health Insurance Portability and Accountability Act of 1996 (HIPAA) version 5010 for Transaction 835 - Health Care Claim Payment/Advice and Updated Standard Paper Remit (SPR)

I. SUMMARY OF CHANGES: This Change Request (CR) instructs the Medicare Administrative Contractors and the Shared System Maintainers to implement the changes in version 5010 of transaction 835 - Health Care Claim/Payment Advice and Updated Standard Paper Remit (SPR).

New / Revised Material
Effective Date: January 1, 2010
Implementation Date: January 4, 2010 for A/B MACs, DME MACs, and FISS
January 4, 2010 and April 5, 2010 for VMS
July 5, 2010 for MCS

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
N/A	

III. FUNDING:
SECTION A: For Fiscal Intermediaries and Carriers: Not Applicable

SECTION B: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the contracting officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the contracting officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

One-Time Notification

***Unless otherwise specified, the effective date is the date of service.**

Attachment – One-Time Notification

Pub. 100-20	Transmittal: 577	Date: October 16, 2009	Change Request: 6589

Transmittal 550 is rescinded and replaced by Transmittal 577. The Implementation Date is changed to January 4, 2010 and April 5, 2010 for the VMS Shared System. All other material remains the same.

SUBJECT: Implementation of Health Insurance Portability and Accountability Act of 1996 (HIPAA) version 5010 for Transaction 835 - Health Care Claim Payment/Advice and Updated Standard Paper Remit (SPR)

Effective Date: January 1, 2010

Implementation Date: January 4, 2010 for A/B MACs, DME MACs, and FISS
January 4, 2010 and April 5, 2010 for VMS
July 5, 2010 for MCS

I. GENERAL INFORMATION

A. Background: The Centers for Medicare and Medicaid Services (CMS) is in the process of implementing the next version of the Health Insurance Portability and Accountability Act Transaction 835 standard – referred to as 835v5010 in this document. The Secretary of the Department of Health and Human Services (DHHS) has adopted ASC X12 version 5010 and NCPDP version D.0 as the next HIPAA standard for HIPAA covered transactions. The final rule was published on January 16, 2009. Some of the important dates in the implementation process are:

Effective Date of the regulation:	March 17, 2009
Level I compliance by:	December 31, 2010
Level II Compliance by:	December 31, 2011
All covered entities have to be fully compliant on:	January 1, 2012

Level I compliance means "that a covered entity can demonstrably create and receive compliant transactions, resulting from the compliance of all design/build activities and internal testing."

Level II compliance means that a "covered entity has completed end-to-end testing with each of its trading partners, and is able to operate in production mode with the new versions of the standards".

The DHHS permits dual use of existing standards (4010A1 and 5.1) and the new standards (5010 and D.0) from the March 17, 2009, effective date until the January 1, 2012, compliance date to facilitate testing subject to trading partner agreement.

CMS shall be fully compliant on January 1, 2012, and complete Level I compliancy by December 31, 2010, and Level II compliancy by December 31, 2011. **The transition period when both versions would be allowed in production mode for Medicare will be from January 1, 2011 – December 31, 2011. The 835v4010A1 and the current Standard Paper Remittance (SPR) shall not be sent on or after January 1, 2012, irrespective of the date of receipt or date of service reported on the electronic or paper claim.**

This Change Request (CR) provides instructions to the Medicare Administrative Contractors (MACs) and the Shared System Maintainers (SSMs) to implement transaction 835 v5010 and update the Standard Paper Remittance Advice (SPR). Transaction 835 or SPR related CRs 6034 (Transmittal 508), 6460 (Transmittal 495), and 6376 (Transmittal 511) have already been published and implemented or are going to be implemented by January 2010. At this point among the A/B MACs only J1, J3, J4, J5, J10, J13,and J14 shall implement this CR. A similar CR will be issued at a later date for other A/B MACs.

B. Policy: The Administrative Simplification provisions of HIPAA Regulations require the Secretary of DHHS to adopt standard electronic transactions and code sets. The Secretary may also modify these standards periodically. ASC X12 005010 and NCPDP D.0 have been adopted by the Secretary as the next HIPAA standards. CMS shall be fully compliant and be ready on January 1, 2012, when all covered entities have to be fully compliant.

Business Assumptions:

1. CMS expects to implement the 835 version 5010 over multiple quarterly releases with a series of instructions in the form of CRs. The intent is for CMS to be ready to send 835 in version 5010 on or before January 1, 2012, after completing all internal and external testing.

2. CMS expects that during the transition period, contractors shall be ready to generate and send 835 in version 4010A1 in production mode as well as in version 5010 in either test or production mode. Contractors shall stop sending 835 in version 4010A1and the current SPR on the day version 5010 becomes mandatory – January 1, 2012. Some important dates for Medicare:

   1/1/2011 Medicare makes 835 version 5010 available for external testing with trading partners.

   1/1/2011 Medicare is ready to send 835 in production mode in versions 4010A1 as well as 5010.

   1/1/2012 Medicare stops sending 835 in version 4010A1irrespective of when and in what format the claim was received.

   1/1/2012 Medicare stops sending the current SPR irrespective of when and what format the claim was received.

3. All Shared Systems and MACs shall use the same updated X12 based flat file attached to this document.

4. Shared Systems shall send a flat file that will generate a balanced 835.

5. The Internet Only Manual will be updated at a later date.

6. The Medicare Administrative Contractors shall start sending the URL information and the specific claim adjustment reason code(s) required to populate the payer URL in the PER segment and the Health Care Policy Identifier (HCPI) field in the REF segment in 835 version 5010.

7. The updated SPR with the payer URL and the HCPI information shall be sent on or after January 1, 2012.

The purpose of this release is to communicate business requirements for MACs to be ready to generate 835 in version 5010 for testing with trading partners and/or for transitioning early adopters to the new HIPAA standard

for Transaction 835. This CR also includes some additional business requirements for the SSMs to implement 835 version 5010. These business requirements are based on the decisions made earlier through a series of conference calls between SSMs, MACs and other CMS components. This CR is the fourth 835/SPR CR in the series of instructions for full implementation – See Business Assumption # 1.

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers: FISS	Shared-System Maintainers: MCS	Shared-System Maintainers: VMS	Shared-System Maintainers: CWF	OTHER
6589.1	A/B MACs and CEDI shall generate and send 835s from the flat files that balance at the line, claim, and provider level received from one of the Shared Systems. Note: See attached flat file	X									CEDI
6589.1.1	FISS, MCS, and VMS shall generate 835 Flat Files that are balanced at the line, claim and provider level. Note I: See attached flat file Note II: All COBOL PICs must start at position 1.Amount fields - must be right justified zero filled for the first 10 positions, and space filled from 11-18 positions Note III: A follow-up CR shall update balancing instructions for the Shared Systems						X	X	X		
6589.1.2	FISS, MCS, and VMS shall continue to generate Out of Balance (OOB) reports to identify any out of balance situation for research and resolution.						X	X	X		
6589.1.3	A/B MACs and DME MACs shall monitor the Shared Systems generated OOB reports and research and work towards resolutions of issues that are resulting in OOB situations.	X	X								
6589.2	A/B MACs and DME MACs shall provide the additional contact information to populate 835 Loop 1000A new segment PER (Payer Technical Contact Information) data to provide Medicare technical contact information. Note: See BR 6034.2	X	X								
6589.3	A/B MACs and DME MACs shall provide the URL information to populate the 835 Loop 1000A new PER (Payer Website) segment. Note: See BR 6034.3	X	X								
6589.4	A/B MACs and DME MACs shall select the appropriate Claim Adjustment Reason Code (CARC) when the adjustment is related to Medicare local coverage determination (LCD) or national coverage determination (NCD) policy. Note: The appropriate CARC must have the following phrase as part of the code text: “Refer to the 835Healthcare Policy Identification Segment, if sent”.	X	X								

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6589.5	FISS, MCS and VMS shall populate 835 Loop 1000A new PER (Payer Website) segment and Loop 2110 new REF (Healthcare Policy Identification) segment when: 1. the Claim Adjustment Reason Code selected by the A/B MACs and DME MACs includes the following phrase: "Refer to the 835 Healthcare Policy Identification Segment, if sent" and 2. the LCD /NCD code is found on the detail line of service.						X	X	X		
6589.6	FISS, MCS and VMS shall populate 835 Loop 1000A new PER (Payer Website) segment and Loop 2110 new REF (Healthcare Policy Identification) segment when: 1. the Claim Adjustment Reason Code selected by the A/B MACs and DME MACs does not include the following phrase: "Refer to the 835 Healthcare Policy Identification Segment, if sent" but 2. the LCD/NCD code is found on the detail line of service.						X	X	X		
6589.7	FISS, MCS, and VMS shall generate a report when the LCD/NCD code is found on the detail line of service but the appropriate CARC with the phrase "Refer to the 835 Healthcare Policy Identification Segment, if sent" has not been selected by the MAC. Note: This report will be used to track and correct MAC selection of appropriate CARC when adjustment is related to Medicare LCD/NCD policy.						X	X	X		
6589.8	FISS, MCS and VMS shall **not** populate 835 Loop 1000A new PER (Payer Website) segment and Loop 2110 new REF (Healthcare Policy Identification) segment when: 1. the Claim Adjustment Reason Code selected by the A/B MACs and DME MACs includes the following phrase: "Refer to the 835 Healthcare Policy Identification Segment, if sent" but 2. the LCD/NCD code is **not** found on the detail line of service.						X	X	X		
6589.9	Starting on January 1, 2012, MCS and VMS shall report the Payer Website and Health Care Policy Identifier							X	X		

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	(HCPI) on the SPR when the LCD/NCD code is found on the detail line of service.										

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6589.10	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X									CEDI

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below: N/A

Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
	N/A

Section B: For all other recommendations and supporting information, use this space: N/A

V. CONTACTS

Pre-Implementation Contact(s): Sumita Sen (410) 786-5755 or sumita.sen@cms.hhs.gov

Post-Implementation Contact(s): Sumita Sen (410) 786-5755 or sumita.sen@cms.hhs.gov

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),* and/or *Carriers,* use only one of the following statements:

N/A

Section B: *For Medicare Administrative Contractors (MACs)*, include the following statement:

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the contracting officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the contracting officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

Attachment

(For alternate format, please contact the CR author)

835 Flat File - TR3 5010

835 TR3 5010																			
	X12 Element Attributes--									**X12 Flat File----------**						**18**			
Element Identifier			**ID**	**Min/Max**	**Usage Req**	**Loop**	**Loop Repeat**		**Values**	**Page #**	**Loop ID**	**Loop Seq**	**Seg ID**	**Seg. Seq.**	**Start**	**Length**	**Record Repeat**		**Comment**
											6	4	4	4					
ISA	**Interchange Control Header**			**1**	**405**	**--------**	**1**						**ISA**		**1**	**18**	**1**		
ISA01	Authorization Information Qualifier		ID	2--2	R				00						19	2			
ISA02	Authorization Information		AN	10--10	R				Blank						21	10			
ISA03	Security Information Qualifier		ID	2--2	R				00						31	2			
ISA04	Security Information		AN	10--10	R				Blank						33	10			
ISA05	Interchange ID Qualifier		ID	2--2	R				01,14,20,27,28, 29,30,33,ZZ						43	2			
ISA06	Interchange Sender ID		AN	15--15	R				Interchange Sender ID						45	15			
ISA07	Interchange ID Qualifier		ID	2--2	R				01,14,20,27,28, 29,30,33,ZZ						60	2			
ISA08	Interchange Receiver ID		AN	15--15	R				Interchange Receiver ID						62	15			
ISA09	Interchange Date		DT	6--6	R				(Translator Generated)						77	6			
ISA10	Interchange Time		TM	4--4	R				(Translator Generated)						83	4			
ISA11	Repetition Separator		ID	1--1	R				(Translator Generated)						87	1			
ISA12	Interchange Control Version Number		ID	5--5	R				*00501*						88	5			
ISA13	Interchange Control Number		N0	9--9	R				YJJJ00000 where Y is the last digit						93	9			
ISA14	Acknowledgement Requested		ID	1--1	R				0						102	1			
ISA15	Usage Indicator		ID	1--1	R				P,T						103	1			
ISA16	Component Element Separator			1--1	R				Translator Generated						104	1			
GS	**Functional Group Header**			**1**	**R**	**-----------**	**1**						**GS**		**1**	**18**	**1**		
GS01	Functional Identifier Code		ID	2--2	R				HP						19	2			
GS02	Application Sender's Code		AN	2--15	R				Application Sender's Code						21	15			
GS03	Application Receiver's Code		AN	2--15	R				Application Receiver's Code						36	15			
GS04	Date		DT	8--8	R				See ISA08						51	8			
GS05	Time		TM	4--8	R				See ISA09						59	8			
GS06	Group Control Number		N0	1--9	R				Increament by one; beginning at						67	9			

All COBOL PICs must start at position 1.Amount fields - must be right justified zero filled for the first 10 positions, and space filled from 11-18 positions

835 TR3 5010																			
	X12 Element Attributes---									X12 Flat File----------						18			
Element Identifier			**ID**	**Min/Max**	**Usage Req**	**Loop**	**Loop Repeat**		**Values**	**Page #**	**Loop ID**	**Loop Seq**	**Seg ID**	**Seg. Seq.**	**Start**	**Length**	**Record Repeat**		**Comment**
GS07	Responsible Agency Code		ID	1--2	R				X						76	2			
GS08	Version/Release/Industry ID code		AN	1--12	R				005010X221						78	12			
ST	**Transaction Set Header**			**1**	**R**	**------------**	**1**			68			**ST**		**1**	**18**	**1**		
ST01	Transaction Set Identifier Code		ID	3--3	R				835						19	3			
ST02	Transaction Set Control Number		AN	4--9	R				=SE02						22	9			
BPR	**Financial Information**			**1**	**R**	**-----------**	**1**			69			**BPR**		**1**	**18**	**1**		
BPR01	Transaction Handling Code		ID	1--2	R				C, D, H, I ,P, U, X						19	2			
BPR02	Total Actual Provider Payment Amt S9(8)V99		R	1--18	R										21	18			
BPR03	Credit or Debit Flag Code		ID	1--1	R				C						39	1			
BPR04	Payment Method Code		ID	3--3	R				ACH,CHK,NON						40	3			
BPR05	Payment Format Code		ID	1--10	S				CCP,CTX						43	10			
BPR06	DFI ID # Qualifier		ID	2--2	S				01						53	2			
BPR07	Sender DFI Identifier		AN	3--12	S										55	12			
BPR08	Acct # Qualifier		ID	1--3	S				DA						67	3			
BPR09	Sender Bank Acct #		AN	1--35	S										70	35			
BPR10	Payer Identifier		AN	10--10	S										105	10			
BPR11	Originating Co Supplemental Code		AN	9--9	S				=TRN04						115	9			Not used by Part B
BPR12	DFI ID # Qualifier		ID	2--2	S				01						124	2			
BPR13	Receiver or Provider Bank ID #		AN	3--12	S										126	12			
BPR14	Acct # Qualifier		ID	1--3	S				DA,SG						138	3			
BPR15	Receiver or Provider Acct #		AN	1--35	S										141	35			
BPR16	Check Issue or EFT Effective Date		DT	8--8	R										176	8			
BPR17-	Not Used																		
-BPR21																			

835 TR3 5010																			
	X12 Element Attributes--									**X12 Flat File----------**						**18**			
Element Identifier			**ID**	**Min/Max**	**Usage Req**	**Loop**	**Loop Repeat**		**Values**	**Page #**	**Loop ID**	**Loop Seq**	**Seg ID**	**Seg. Seq.**	**Start**	**Length**	**Record Repeat**		**Comment**
TRN	**Reassociation Trace Number**			**1**	**R**	**-----------**	**1**			77			**TRN**		**1**	**18**	**1**		
TRN01	Trace Type Code		ID	1--2	R				1						19	2			
TRN02	Check or EFT Trace #		AN	1--50	R										21	50			
TRN03	Payer Identifier		AN	10--10	R										71	10			
TRN04	Originating Co Supplemental Code		AN	1--30	S				=BPR011						81	30			
CUR	**Foreign Currency Information**			**1**	**S**	**-----------**	**1**		**N/A**	79			**CUR**						Medicare does not use this segment
REF	**Reference Identification**			**1**	**S**	**-----------**	**1**						**REF**		**1**	**18**	**1**		
REF01	Receiver ID Qualifier		ID	2--3	R				EV	82					19	3			
REF02	Receiver Identifier		AN	1--50	R										22	50			
REF03-	Description		AN	1-80	N/U														
-REF04																			
REF	**Version Identification**			**1**	**S**	**-----------**	**1**						**REF**		**1**	**18**	**1**		
REF01	Receiver ID Qualifier		ID	2--3	R				F2	84					19	3			
REF02	Version ID Code		AN	1--50	R										22	50			
REF03-	Description		AN	1-80	NU														
-REF04																			
DTM	**Production Date**			**1**	**S**	**-----------**	**1**			85			**DTM**		**1**	**18**	**1**		
DTM01	Date Time Qualifier		ID	3--3	R				405						19	3			
DTM02	Production Date		DT	8--8	R				CCYYMMDD						22	8			
DTM03-	Not Used																		
-DTM06																			

835 TR3 5010																		
	X12 Element Attributes---									**X12 Flat File----------**						**18**		
Element Identifier			**ID**	**Min/Max**	**Usage Req**	**Loop**	**Loop Repeat**		**Values**	**Page #**	**Loop ID**	**Loop Seq**	**Seg ID**	**Seg. Seq.**	**Start**	**Length**	**Record Repeat**	**Comment**
N1	**Payer Identification**			**1**	**R**	**1000A**	**1**			87	**1000A**		**N1**		**1**	**18**	**1**	
N101	Entity Identifier Code		ID	2--3	R				PR						19	3		
N102	Payer Name		AN	1--60	R										22	60		All names expanded to 60 per HIGLAS
N103	ID Code Qualifier		ID	1--2	S				XV						82	2		
N104	Payer Identifier		AN	2--80	S										84	80		
N105-	Not Used		ID	2--2														
-NM106																		
N3	**Payer Address**			**1**	**R**	**1000A**				89	**1000A**		**N3**		**1**	**18**	**1**	
N301	Payer Address Line		AN	1--55	R										19	55		
N302	Payer Address Line		AN	1--55	S										74	55		
N4	**Payer City, State, Zip**			**1**	**R**	**1000A**				90	**1000A**		**N4**		**1**	**18**	**1**	
N401	Payer City Name		AN	2--30	R										19	30		
N402	Payer State Code		ID	2--2	R										49	2		
N403	Payer Postal Zone or ZIP Code		ID	3--15	R										51	15		
N404	Country Code		ID	2--3	S										66	3		
N405-					NU													
-N406																		
N407	Country Subdivision Code		ID	1--3	S										69	3		
REF	**Additional Payer Identification**			**4**	**S**	**1000A**				92	**1000A**		**REF**		**1**	**18**	**4**	
REF01	Reference Identification Qualifier		ID	2--3	R				2U						19	3		
REF02	Additional Payer ID		AN	1--50	R										22	50		
REF03-	Not Used		AN	1--80														

835 TR3 5010																
	X12 Element Attributes---								**X12 Flat File----------**					**18**		
Element Identifier		**ID**	**Min/Max**	**Usage Req**	**Loop**	**Loop Repeat**	**Values**	**Page #**	**Loop ID**	**Loop Seq**	**Seg ID**	**Seg. Seq.**	**Start**	**Length**	**Record Repeat**	**Comment**
-REF04																
PER	**Payer Business Contact Information**		**1**	**S**	**1000A**			94	**1000A**		**PER**		**1**	**18**	**1**	
PER01	Contact Function Code	ID	2--2	R			CX						19	2		
PER02	Payer Contact Name	AN	1-60	S									21	60		All names expanded to 60 per HIGLAS
PER03	Communication # Qualifier	ID	2--2	S			EM,FX,TE						81	2		
PER04	Payer Contact Communication #	AN	1-256	S									83	256		
PER05	Communication Number Qualifier 2	ID	2--2	S			EM,EX,FX,TE						339	2		
PER06	Payer Contact Communication #	AN	1-256	S									341	256		
PER07	Communication Number Qualifier 3	ID	2--2	S			EX						597	2		
PER08	Payer Contact Communication #	AN	1-256	S									599	256		
PER09	Contact Inquiry Reference	AN	1-20	N/U												
PER	**Payer Technical Contact Information**		**1**	**R**	**1000A**			97	**1000A**		**PER**		**1**	**18**	**1**	
PER01	Contact Function Code	ID	2--2	R			BL						19	2		
PER02	Payer Contact Name	AN	1-60	S									21	60		All names expanded to 60 per HIGLAS
PER03	Communication # Qualifier	ID	2--2	S			EM, TE, UR						81	2		
PER04	Payer Contact Communication #	AN	1-256	S									83	256		
PER05	Communication Number Qualifier 2	ID	2--2	S			EM, EX, FX, TE, UR						339	2		
PER06	Payer Contact Communication #	AN	1-256	S									341	256		
PER07	Communication Number Qualifier 3	ID	2--2	S			EM, EX, FX, UR						597	2		
PER08	Payer Contact Communication #	AN	1-256	S									599	256		
PER09	Contact Inquiry Reference	AN	1-20	N/U												
PER	**Payer Web Site**		**1**	**S**	**1000A**			100	**1000A**		**PER**		**1**	**18**	**1**	
PER01	Contact Function Code	ID	2--2	R			IC						19	2		

835 TR3 5010																			
	X12 Element Attributes--									X12 Flat File----------						18			
Element Identifier			**ID**	**Min/Max**	**Usage Req**	**Loop**	**Loop Repeat**		**Values**	**Page #**	**Loop ID**	**Loop Seq**	**Seg ID**	**Seg. Seq.**	**Start**	**Length**	**Record Repeat**		**Comment**
PER02	Name		AN	1-60	NU										*21*	*60*			
PER03	Communication # Qualifier		ID	2--2	R				UR						*81*	*2*			
PER04	Payer Contact Communication #		AN	1-256	R										*83*	*256*			
PER05	Communication Number Qualifier 2		ID	2--2	NU										*339*	*2*			
PER06	Payer Contact Communication #		AN	1-256	NU										*341*	*256*			
PER07	Communication Number Qualifier 3		ID	2--2	NU										*597*	*2*			
PER08	Payer Contact Communication #		AN	1-256	NU										*599*	*256*			
PER09	Contact Inquiry Reference		AN	1-20	N/U														
N1	**Payee Identification**			**1**	**R**	**1000B**	**1**			102	**1000B**		**N1**		**1**	**18**	**1**		
N101	Entity Identifier Code		ID	2--3	R				PE						19	**3**			
N102	Payee Name		AN	1--60	R										22	60			All names expanded to 60 per HIGLAS
N103	Identification Code Qualifier		ID	1--2	R				XX, FI, XV						82	2			
N104	Payee ID Code		AN	2--80	R										84	80			
N105-	Not Used		ID	2--2															
-N106																			
N3	**Payee Address**			**1**	**S**	**1000B**				104	**1000B**		**N3**		**1**	**18**	**1**		
N301	Payee Address Line		AN	1--55	R										19	55			
N302	Payee Address Line		AN	1--55	S										74	55			
N4	**Payee City,State,Zip**			**1**	**R**	**1000B**				105	**1000B**		**N4**		**1**	**18**	**1**		
N401	Payee City Name		AN	2--30	R										19	30			
N402	Payee State Code		ID	2--2	S										49	2			
N403	Payee Postal Zone or ZIP Code		ID	3-15	S										51	15			
N404	Country Code		ID	2--3	S										66	3			

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	X12 Element Attributes--									X12 Flat File----------						18			
Element Identifier			ID	Min/Max	Usage Req	Loop	Loop Repeat		Values	Page #	Loop ID	Loop Seq	Seg ID	Seg. Seq.	Start	Length	Record Repeat		Comment
N405-	Not Used		ID	2--2	NU														
-N406																			
N407	Country Subdivision Code		ID	1--3	S										69	3			Payee Subdivision code per HIGLAS request
REF	**Payee Additional Identification**			**>1**	**S**	**1000B**				107	**1000B**		**REF**		**1**	**18**	**>1**		
REF01	Reference Identification Qualifier		ID	2--3	R				TJ						19	3			
REF02	Additional Payee ID #		AN	1--50	R										22	50			
REF03-	Not Used		AN	1__80															
-REF04																			
RDM	Remittance Delivery Method			1	S	**1000B**				109					**1**	**18**			
RDM01	Report Transmission Code		ID	1--2					BM, EM, FT, OL						19	2			
RDM02	Name		AN	1--60											21	60			
RDM03	Communication Number		AN	1--256											81	256			
RDM04	Not Used				N/U														
-RDM05																			
LX	**Header Number**			**1**	**S**	**2000**	**>1**			111	**2000**		**LX**		**1**	**18**	**1**		
LX01	Assigned #		N0	1--6	R				0,1, TTYYMM						19	6			FISS uses TTYYMM - Facility Code/year/Month. MCS uses 1 for assigned and 0 for non-assigned
TS3	**Provider Summary Information**			**1**	**S**	**2000**	**1**			112	**2000**		**TS3**		**1**	**18**	**1**		
TS301	Provider Identifier		AN	1--50	R				NPI						19	50			
TS302	Facility Code Value		AN	1--2	R				11,99, Type of Bill						69	2			Part B will use either 11 or 99
TS303	Date		DT	8--8	R				CCYYMMDD						71	8			
TS304	Total Claim Count 9(6)		R	1--15	R										79	15			
TS305	Total Claim Change Amount S9(8)V99		R	1--18	R										94	18			

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	X12 Element Attributes---									**X12 Flat File----------**						**18**			
Element Identifier			**ID**	**Min/Max**	**Usage Req**	**Loop**	**Loop Repeat**		**Values**	**Page #**	**Loop ID**	**Loop Seq**	**Seg ID**	**Seg. Seq.**	**Start**	**Length**	**Record Repeat**		**Comment**
TS306	Total Covered Charge Amount				N/U														
TS307	Total Noncovered Charge Amount				N/U														
TS 308	Total Denied Charge Amount				N/U														
TS 309	Total Provider Amount				N/U														
TS 310	Total Interest Amount				N/U														
TS 311	Total Contractual Adjustment Amount				N/U														
TS312	Total Gramm-Rudman Reduction Amount				N/U														
TS313	Total MSP Payer Amount S9(8)V99		R	1--18	S										112	18			Only Part A
TS314	Total Blood Deductible Amount S9(8)V99		R	1--18	N/U														
TS315	Total Non-Lab Charge Amount S9(8)V99		R	1--18	S										130	18			Only Part A
TS316	Total Coinsurance Amount S9(8)V99				N/U														
TS317	Total HCPCS Reported Charge Amount S9(8)V99		R	1--18	S										148	18			Only Part A
TS318	Total HCPCS Payable Amount S9(8)V99		R	1--18	S										166	18			Only Part A
TS319	Total Deductible Amount S9(8)V99		R	1--18	N/U														
TS320	Total Professional Component Amount S9(8)V99		R	1--18	S										184	18			Only Part A
TS321	Total MSP Patient Liability Met Amount S9(8)V99		R	1--18	S										202	18			Only Part A
TS322	Total Patient Reimbursement Amount S9(8)V99		R	1--18	S										220	18			Only Part A
TS323	Total PIP Claim Count 9(6)		R	1--15	S										238	15			Only Part A
TS324	Total PIP Adjustment Amount S9(8)V99		R	1--18	S										253	18			Only Part A
TS2	**Provider Supplemental Summary Info**			1	**S**	**2000**				117	**2000**		**TS2**		**1**	**18**	**1**		N/U for Part B
TS201	Total DRG Amount S9(8)V99		R	1--18	S										19	18			
TS202	Total Federal Specific Amount S9(8)V99		R	1--18	S										37	18			
TS203	Total Hospital Specifc Amount S9(8)V99		R	1--18	S										55	18			
TS204	Total Disproportionate Amount S9(8)V99		R	1--18	S										73	18			
TS205	Total Capital Amount S9(8)V99		R	1--18	S										91	18			

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	X12 Element Attributes---										**X12 Flat File----------**					**18**			
Element Identifier			**ID**	**Min/Max**	**Usage Req**	**Loop**	**Loop Repeat**		**Values**	**Page #**	**Loop ID**	**Loop Seq**	**Seg ID**	**Seg. Seq.**	**Start**	**Length**	**Record Repeat**		**Comment**
TS206	Total Indirect Medical Education Amount S9(8)V99		R	1--18	S										109	18			
TS207	Total Outlier Day Count 9(6)		R	1--15	S										127	15			
TS 208	Total Day Outlier Amount S9(8)V99		R	1--18	S										142	18			
TS 209	Total Cost Outlier Amount S9(8)V99		R	1--18	S										160	18			
TS 210	Average DRG Length of Stay 9(6)		R	1--15	S										178	15			
TS 211	Total Discharge Count 9(6)		R	1--15	S										193	15			
TS212	Total Cost Report Day Count 9(6)		R	1--15	S										208	15			
TS213	Total Covered Day Count 9(6)		R	1--15	S										223	15			
TS214	Total Noncovered Day Count 9(6)		R	1--15	S										238	15			
TS215	Total MSP Pass-Through Amount S9(8)V99		R	1--18	S										253	18			
TS216	Average DRG Weight		R	1--15	S										271	15			
TS217	Total PPS Capital FSP DRG Amount S9(8)V99		R	1--18	S										286	18			
TS218	Total PSP Capital HSP DRG Amount S9(8)V99		R	1--18	S										304	18			
TS219	Total PPS DSH DRG Amount S9(8)V99		R	1--18	S										322	18			
CLP	**Claim Level Data**			**1**	**R**	**2100**	**>1**			123	**2100**		**CLP**		**1**	**18**	**1**		
CLP01	Patient Control #		AN	1--38	R										19	38			
CLP02	Claim Status Code		ID	1--2	R				1,2,3,4, 19, 20, 21, 22, 23						57	2			
CLP03	Total Claim Charge Amount S9(8)V99		R	1--18	R										59	18			
CLP04	Claim Payment Amount S9(8)V99		R	1--18	R										77	18			
CLP05	Patient Responsibility Amount S9(8)V99		R	1--18	S										95	18			
CLP06	Claim Filling Indicator Code		ID	1--2	R				MA/MB						113	2			
CLP07	Payer Claim Control #		AN	1--50	S										115	50			
CLP08	Facility Code Value		AN	1--2	S										165	2			
CLP09	Claim Frequency Code (3rd position of TOB)		ID	1--1	S										167	1			Required when the information was received on the original claim
CLP10	Patient Status Code		ID	1-2	N/U														

All COBOL PICs must start at position 1.Amount fields - must be right justified zero filled for the first 10 positions, and space filled from 11-18 positions

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	X12 Element Attributes---									**X12 Flat File-----------**						**18**			
Element Identifier			**ID**	**Min/Max**	**Usage Req**	**Loop**	**Loop Repeat**		**Values**	**Page #**	**Loop ID**	**Loop Seq**	**Seg ID**	**Seg. Seq.**	**Start**	**Length**	**Record Repeat**		**Comment**
CLP11	DRG Code		ID	1--4	S										*168*	4			Part A only
CLP12	DRG Weight S9(3)V9999		R	1--15	S										*172*	15			Part A only
CLP13	Discharge Fraction S9(4)V999		R	1--10	S										*187*	10			
CLP14	Yes/No Condition or Response Code		ID	1--1	NU														
CAS	**Claim Adjustment**			**99**	**S**	**2100**				129	**2100**		**CAS**		**1**	**18**	**99**		
CAS01	Claim Adjustment Group Code		ID	1--2	R				CO, OA, PR						19	2			Group code CR has been deleted
CAS02	Adjustment Reason Code		ID	1--5	R										21	5			
CAS03	Adjustment Amount S9(8)V99		R	1--18	R										26	18			
CAS04	Adjustment Quantity S9(7)		R	1--15	S										44	15			
CAS05	Adjustment Reason Code		ID	1--5	S										59	5			
CAS06	Adjustment Amount S9(8)V99		R	1--18	S										64	18			
CAS07	Adjustment Quantity S9(7)		R	1--15	S										82	15			
CAS08	Adjustment Reason Code		ID	1--5	S										97	5			
CAS09	Adjustment Amount S9(8)V99		R	1--18	S										102	18			
CAS10	Adjustment Quantity S9(7)		R	1--15	S										120	15			
CAS11	Adjustment Reason Code		ID	1--5	S										135	5			
CAS12	Adjustment Amount S9(8)V99		R	1--18	S										140	18			
CAS13	Adjustment Quantity S9(7)		R	1--15	S										158	15			
CAS14	Adjustment Reason Code		ID	1--5	S										173	5			
CAS15	Adjustment Amount S9(8)V99		R	1--18	S										178	18			
CAS16	Adjustment Quantity S9(7)		R	1--15	S										196	15			
CAS17	Adjustment Reason Code		ID	1--5	S										211	5			
CAS18	Adjustment Amount S9(8)V99		R	1--18	S										216	18			
CAS19	Adjustment Quantity S9(7)		R	1--15	S										234	15			

All COBOL PICs must start at position 1.Amount fields - must be right justified zero filled for the first 10 positions, and space filled from 11-18 positions

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	X12 Element Attributes---									**X12 Flat File----------**						**18**		
Element Identifier			**ID**	**Min/Max**	**Usage Req**	**Loop**	**Loop Repeat**		**Values**	**Page #**	**Loop ID**	**Loop Seq**	**Seg ID**	**Seg. Seq.**	**Start**	**Length**	**Record Repeat**	**Comment**
NM1	**Patient Name**			**1**	**R**	**2100**				137	**2100**		**NM1**		**1**	**18**	**1**	
NM101	Entity Identifier Code		ID	2--3	R				QC						19	3		
NM102	Entity Type Qualifier		ID	1--1	R				1						22	1		
NM103	Patient Last Name		AN	1--60	S										23	60		All names expanded to 60 per HIGLAS
NM104	Patient First Name		AN	1--35	S										83	35		All last names expanded to 35 per HIGLAS
NM105	Patient Middle Name		AN	1--25	S										118	25		
NM106	Name Prefix		AN	1-10	N/U													
NM107	Patient Name Suffix		AN	1--10	S				NU						143	10		
NM108	ID Code Qualifier		ID	1--2	S				HN						153	2		
NM109	Patient Identifier		AN	2--80	S				HIC #						155	80		
NM110-	Not Used		ID	2--2	NU													
-NM112																		
NM1	**Insured's Name**			**1**	**S**	**2100**			**N/A**	140	**2100**							Not used by Medicare
NM1	**Corrected Patient/Insured Name**			**1**	**S**	**2100**				143	**2100**		**NM1**		**1**	**18**	**1**	
NM101	Entity Identifier Code		ID	2--3	R				74						19	3		
NM102	Entity Type Qualifier		ID	1--1	R				1						22	1		
NM103	Corrected Patient/Ins Last Name		AN	1--60	S										23	60		All names expanded to 60 per HIGLAS
NM104	Corrected Patient/Ins First Name		AN	1--35	S										83	35		All last names expanded to 35 per HIGLAS
NM105	Corrected Patient/Ins Middle Name		AN	1--25	S										118	25		
NM106	Name Prefix		AN	1-10	N/U													
NM107	Corrected Patient Name Suffix		AN	1--10	S										143	10		
NM108	Identification Code Qualifier		ID	1--2	S				C						153	2		
NM109	Corrected Ins Identification Indicator		AN	2--80	S										155	80		
NM110-	Not Used		ID	2--2														

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	X12 Element Attributes---									**X12 Flat File----------**						**18**			
Element Identifier			**ID**	**Min/Max**	**Usage Req**	**Loop**	**Loop Repeat**		**Values**	**Page #**	**Loop ID**	**Loop Seq**	**Seg ID**	**Seg. Seq.**	**Start**	**Length**	**Record Repeat**		**Comment**
-NM111																			
NM1	**Service Provider Name**			**1**	**S**	**2100**				146	**2100**		**NM1**		**1**	**18**	**1**		
NM101	Entity Identifier Code		ID	2--3	R				82						19	3			
NM102	Entity Type Qualifier		ID	1--1	R				2						22	1			
NM103	Rendering Provider Last/Org Name		AN	1-60	S										23	60			All names expanded to 60 per HIGLAS
NM104	Rendering Provider First Name		AN	1-35	S				NA						83	35			All last names expanded to 35 per HIGLAS
NM105	Rendering Provider Middle Name		AN	1--25	S				NA						118	25			
NM106	Name Prefix		AN	1-10	N/U				NA										
NM107	Rendering Provider Name Suffix		AN	1--10	S				NA						143	10			
NM108	ID Code Qualifier		ID	1--2	R				XX						153	2			
NM109	Rendering Provider Identifier		AN	2--80	R				NPI						155	80			
NM110-	Not Used		ID	2--2															
-NM111																			
NM1	**Crossover Carrier Name**			**1**	**S**	**2100**				150	**2100**		**NM1**		**1**	18	**1**		
NM101	Entity Identifier Code		ID	2--3	R				TT						19	3			
NM102	Entity Type Qualifier		ID	1--1	R				2						22	1			
NM103	COB Carrier Name		AN	1-60	R										23	60			All names expanded to 60 per HIGLAS
NM104	First name		AN	1-35	N/U														
NM105	Middle name		AN	1-25	N/U														
NM106	Name Prefix		AN	1-10	N/U														
NM107	Name suffix		AN	1-10	N/U														
NM108	ID Code Qualifier		ID	1--2	R				PI,XV						83	2			
NM109	COB Carrier Identifier		AN	2--80	R										85	80			
NM110-	Not Used		ID	2--2															

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	X12 Element Attributes---									**X12 Flat File----------**						**18**			
Element Identifier			**ID**	**Min/Max**	**Usage Req**	**Loop**	**Loop Repeat**		**Values**	**Page #**	**Loop ID**	**Loop Seq**	**Seg ID**	**Seg. Seq.**	**Start**	**Length**	**Record Repeat**		**Comment**
-NM111																			
NM1	**Corrected Priority Payer Name**			**1**	**S**	**2100**				153	**2100**		**NM1**		**1**	**18**	**1**		
NM101	Entity Identifier Code		ID	2--3	R				PR						19	3			
NM102	Entity Type Qualifier		ID	1--1	R				2						22	1			
NM103	Corrected Priority Payer Name		AN	1--60	R										23	60			All names expanded to 60 per HIGLAS
NM104	First name		AN	1-35	N/U														
NM105	middle name		AN	1-25	N/U														
NM106	Name Prefix		AN	1-10	N/U														
NM107	Name suffix		AN	1-10	N/U														
NM108	ID Code Qualifier		ID	1--2	R				PI,XV						83	2			
NM109	Corrected Priority Payer ID		AN	2--80	R										85	80			
NM110-	Not Used																		
-NM112																			
NM1	Other Subscriber Name								N/A	156									Not used by Medicare
MIA	**Inpatient Adjudication Information**			**1**	**S**	**2100**				159	**2100**		**MIA**		**1**	**18**	**1**		N/U for Part B. Use either MIA or MOA but not both
MIA01	Covered Days or Visits Count S9(3)		R	1--15	R										19	15			
MIA02	PPS Operating Outlier Amount S9(8)V99		R	1--18	S										34	18			
MIA03	Lifetime Psychiatric Days Count S9(3)		R	1--15	S										52	15			
MIA04	CLAIM DRG AMOUNT S9(8)V99		R	1--18	S										67	18			
MIA05	CLAIM PAYMENT REMARK CD		AN	1--50	S										85	50			
MIA06	CLAIM DSH AMOUNT S9(8)V99		R	1--18	S										135	18			
MIA07	CLAIM MSP PASS THRU AMT S9(8)V99		R	1--18	S										153	18			
MIA08	CLAIM PPS CAPITAL AMOUNT S9(8)V99		R	1--18	S										171	18			

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	X12 Element Attributes---										**X12 Flat File----------**					**18**			
Element Identifier			**ID**	**Min/Max**	**Usage Req**	**Loop**	**Loop Repeat**		**Values**	**Page #**	**Loop ID**	**Loop Seq**	**Seg ID**	**Seg. Seq.**	**Start**	**Length**	**Record Repeat**		**Comment**
MIA09	PPS CAPITAL FSP DRG AMT S9(8)V99		R	1--18	S										189	18			
MIA10	PPS CAPITAL HSP DRG AMT S9(8)V99		R	1--18	S										207	18			
MIA11	PPS CAPITAL DSH DRG AMT S9(8)V99		R	1--18	S										225	18			
MIA12	OLD CAPITAL AMOUNT S9(8)V99		R	1--18	S										243	18			
MIA13	PPS CAPITAL IME AMOUNT S9(8)V99		R	1--18	S										261	18			
MIA14	PPS OPER HSP SPEC DRG AMT S9(8)V99		R	1--18	S										279	18			
MIA15	COST REPORT DAY COUNT S9(3)		R	1--15	S										297	15			
MIA16	PPS OPER FSP SPEC DRG AMT S9(8)V99		R	1--18	S										312	18			
MIA17	CLAIM PPS OUTLIER AMOUNT S9(8)V99		R	1--18	S										330	18			
MIA18	CLAIM INDIRECT TEACHING S9(8)V99		R	1--18	S										348	18			
MIA19	NON PAY PROF COMP AMT S9(8)V99		R	1--18	S										366	18			
MIA20	CLAIM PAYMENT REMARK CD X(5)		AN	1--50	S										384	50			
MIA21	CLAIM PAYMENT REMARK CD X(5)		AN	1--50	S										434	50			
MIA22	CLAIM PAYMENT REMARK CD X(5)		AN	1--50	S										484	50			
MIA23	CLAIM PAYMENT REMARK CD X(5)		AN	1--50	S										534	50			
MIA24	PPS CAPITAL EXCEPTION AMT S9(8)V99		R	1--18	S										584	18			
MOA	**Outpatient Adjudication Information**			**1**	**S**	**2100**				166	**2100**		**MOA**		**1**	**18**	**1**		N/U for Medicare Inpatient Claims. Use either MIA or MOA but not both
MOA01	Reimbursement Rate S9(4)V9999		R	1--10	S										19	10			N/U for Part B
MOA02	Claim HCPCS Payable Amount S9(8)V99		R	1--18	S										29	18			N/U for Part B
MOA03	CLAIM PAYMENT REMARK CD X(5)		AN	1--50	S										47	50			
MOA04	CLAIM PAYMENT REMARK CD X(5)		AN	1--50	S										97	50			
MOA05	CLAIM PAYMENT REMARK CD X(5)		AN	1--50	S										147	50			
MOA06	CLAIM PAYMENT REMARK CD X(5)		AN	1--50	S										197	50			
MOA07	CLAIM PAYMENT REMARK CD X(5)		AN	1--50	S										247	50			
MOA08	Claim ESRD Payment Amount S9(8)V99		R	1--18	S										297	18			

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	X12 Element Attributes--									X12 Flat File----------						18			
Element Identifier			**ID**	**Min/Max**	**Usage Req**	**Loop**	**Loop Repeat**		**Values**	**Page #**	**Loop ID**	**Loop Seq**	**Seg ID**	**Seg. Seq.**	**Start**	**Length**	**Record Repeat**		**Comment**
MOA09	Nonpayable Professional Comp Amt S9(8)V99		R	1--18	S										315	18			
REF	**Other Claim-Related Identification**			**5**	**S**	**2100**				169	**2100**		**REF**		**1**	**18**			N/U by Part B
REF01	Reference ID Qualifier/(Medical Record ID #)		ID	2--3	R				EA, 6P, 28						19	3			
REF02	Other Claim Related ID/(Medical Record #)		AN	1--50	R										22	50			
REF	**Rendering Provider Identification**			**10**	**S**	**2100**			**N/A**	171	**2100**		**REF**						N/U by Medicare
DTM	**Statement From or To Date**			**2**	**S**	**2100**				173	**2100**		**DTM**		**1**	**18**	**2**		
DTM01	Date Time Qualifier		ID	3--3	R				232, 233						19	3			
DTM02	Claim Date		DT	8--8	R				CCYYMMDD						22	8			
DTM03-	Not Used																		
-DTM06																			
DTM	**Coverage Expiration Date**			**1**	**S**	**2100**				175	**2100**		**DTM**		**1**	**18**	**1**		
DTM01	Date/Time Qualifier		ID	3--3	R				036						19	3			
DTM02	Date		DT	8--8	R				CCYYMMDD						22	8			
DTM03-					NU														
-DTM06																			
DTM	**Claim Received Date**			**1**	**S**	**2100**				177	**2100**		**DTM**		**1**	**18**	**1**		
DTM01	Date/Time Qualifier		ID	3--3	R				050						19	3			
DTM02	Date		DT	8--8	R				CCYYMMDD						22	8			
DTM03-					NU														
-DTM06																			

835 TR3 5010																			
	X12 Element Attributes--										**X12 Flat File----------**					**18**			
Element Identifier			**ID**	**Min/Max**	**Usage Req**	**Loop**	**Loop Repeat**		**Values**	**Page #**	**Loop ID**	**Loop Seq**	**Seg ID**	**Seg. Seq.**	**Start**	**Length**	**Record Repeat**		**Comment**
PER	**Claim Contact Information**			**2**	**S**	**2100**				179	**2100**		**PER**		1	**18**	**2**		
PER01	Contact Function Code		ID	2--2	R				CX						19	2			
PER02	Claim Contact Name		AN	1--60	S										21	60			
PER03	Communication # Qualifier		ID	2--2	R				EM,FX,TE						81	2			
PER04	Claim Contact Communication #		AN	1--256	R										83	256			
PER05	Communication # Qualifier		ID	2--2	S				EM,EX,FX,TE						339	2			
PER06	Claim Contact Communication #		AN	1--256	S										341	256			
PER07	Communication # Qualifier		ID	2--2	S				EX						597	2			
PER08	Communication # Extension		AN	1--256	S										599	256			
PER09	Not Used																		
AMT	**Claim Supplemental Information**			**13**	**S**	**2100**				182	**2100**		**AMT**		**1**	**18**	**13**		
AMT01	Amount Qualifier Code		ID	1--3	R				AU, F5, I, NL, ZK, ZL, ZM, ZN, ZO						19	3			
AMT02	Claim Supplemental Information Amt S9(8)V99		R	1--18	R										22	18			
AMT03	Not Used				NU														
QTY	**Claim Supplemental Infor Quantity**			**14**	**S**	**2100**				184	**2100**		**QTY**		**1**	**18**	**14**		
QTY01	Quantity Qualifier		ID	2--2	R				CA, CD, LA, OU ZK, ZL, ZM, ZN, ZO						19	2			
QTY02	Quantity Qualifier		R	1--15	R										21	15			
QTY03-					N/U									N/U					
-QTY04																			
SVC	**Service Payment Information**			**1**	**S**	**2110**	**999**			186	**2110**		**SVC**		**1**	**18**	**1**		
SVC01	Composite Medical Procedure Identifier				R														
-01-1	Product or Service ID Qualifier		ID	2--2	R				HC, HP, N4, NU						19	2			

835 TR3 5010																			
	X12 Element Attributes---									**X12 Flat File----------**						**18**			
Element Identifier			**ID**	**Min/Max**	**Usage Req**	**Loop**	**Loop Repeat**		**Values**	**Page #**	**Loop ID**	**Loop Seq**	**Seg ID**	**Seg. Seq.**	**Start**	**Length**	**Record Repeat**		**Comment**
-01-2	Adjudicated Procedure Code		AN	1--48	R										21	48			
-01-3	Procedure Modifier		AN	2--2	S										69	2			
-01-4	Procedure Modifier		AN	2--2	S										71	2			
-01-5	Procedure Modifier		AN	2--2	S										73	2			
-01-6	Procedure Modifier		AN	2--2	S										75	2			
-01-7	Procedure Code Description		AN	1--80	NU														
-01-8	Product/Service ID		AN	1--48	NU														
SVC02	Line Item Charge Amount S9(8)V99		R	1--18	R										77	18			
SVC03	Line Item Provider Payment S9(8)V99		R	1--18	R										95	18			
SVC04	NUBC Revenue Code		AN	1--48	S										113	48			
SVC05	Units of Service Paid Count S9(7)V999		R	1--15	S										161	15			
SVC06	Composite Medical Procedure Identifier				S														
-06-1	Product or Service ID Qualifier		ID	2--2	R				HC, HP, N4, NU						176	2			
-06-2	Procedure Code		AN	1--48	R										178	48			
-06-3	Procedure Modifier		AN	2--2	S										226	2			
-06-4	Procedure Modifier		AN	2--2	S										228	2			
-06-5	Procedure Modifier		AN	2--2	S										230	2			
-06-6	Procedure Modifier		AN	2--2	S										232	2			
-06-7	Procedure Code Description		AN	1--80	S										234	80			Mediare will populate if received on the claim and the code is a NOC code
-06-8	Product/Service ID		AN	1--48															
SVC07	Original Units of Service Count S9(7)V999		R	1--15	S										314	15			
DTM	**Service Date**			**2**	**S**	**2110**				194	**2110**		**DTM**		**1**	**18**	**2**		
DTM01	Date Time Qualifier		ID	3--3	R				150, 151, 472						19	3			
DTM02	Service Date		DT	8--8	R				CCYYMMDD						22	8			
DTM03-	Not Used		TM	4--8															

835 TR3 5010																			
	X12 Element Attributes---									**X12 Flat File----------**						**18**			
Element Identifier			**ID**	**Min/Max**	**Usage Req**	**Loop**	**Loop Repeat**		**Values**	**Page #**	**Loop ID**	**Loop Seq**	**Seg ID**	**Seg. Seq.**	**Start**	**Length**	**Record Repeat**		**Comment**
-DTM06																			
CAS	**Service Adjustment**			**99**	**S**	**2110**				196	**2110**		**CAS**		**1**	**18**	**99**		
CAS01	Claim Adjustment Group Code		ID	1--2	R				CO,OA,PR						19	2			Group Code CR has been deleted
CAS02	Adjustment Reason Code		ID	1--5	R										21	5			
CAS03	Adjustment Amount S9(8)V99		R	1--18	R										26	18			
CAS04	Adjustment Quantity S9(7)		R	1--15	S										44	15			
CAS05	Adjustment Reason Code		ID	1--5	S										59	5			
CAS06	Adjustment Amount S9(8)V99		R	1--18	S										64	18			
CAS07	Adjustment Quantity S9(7)		R	1--15	S										82	15			
CAS08	Adjustment Reason Code		ID	1--5	S										97	5			
CAS09	Adjustment Amount S9(8)V99		R	1--18	S										102	18			
CAS10	Adjustment Quantity S9(7)		R	1--15	S										120	15			
CAS11	Adjustment Reason Code		ID	1--5	S										135	5			
CAS12	Adjustment Amount S9(8)V99		R	1--18	S										140	18			
CAS13	Adjustment Quantity S9(7)		R	1--15	S										158	15			
CAS14	Adjustment Reason Code		ID	1--5	S										173	5			
CAS15	Adjustment Amount S9(8)V99		R	1--18	S										178	18			
CAS16	Adjustment Quantity S9(7)		R	1--15	S										196	15			
CAS17	Adjustment Reason Code		ID	1--5	S										211	5			
CAS18	Adjustment Amount S9(8)V99		R	1--18	S										216	18			
CAS19	Adjustment Quantity S9(7)		R	1--15	S										234	15			
REF	**Service Identification**			**8**	**S**	**2110**				204	**2110**		**REF**		**1**	**18**	**8**		
REF01	Reference ID Qualifier		ID	2--3	R				LU, 1S, APC, RB						19	3			LU - required if the specific site of service affected the payment of the claim
REF02	Reference Identification		AN	1--50	R										22	50			

835 TR3 5010																			
	X12 Element Attributes--									X12 Flat File----------						18			
Element Identifier			ID	Min/Max	Usage Req	Loop	Loop Repeat		Values	Page #	Loop ID	Loop Seq	Seg ID	Seg. Seq.	Start	Length	Record Repeat		Comment
REF03-	Not Used		AN	1--80															
-REF04																			
REF	**Line Item Control Number**			**1**	**S**	**2110**				206	**2110**		**REF**		**1**	**18**	**1**		
REF01	Reference ID Qualifier		ID	2--3	R				6R						19	3			
REF02	Line Item Control Number		AN	1--50	R										22	50			
REF03-			aN	1--80	NU														
-REF04																			
REF	**Rendering Provider Information**			**10**	**S**	**2110**				207	**2110**		**REF**		**1**	**18**	**10**		
REF01	Reference ID Qualifier		ID	2--3	R				HPI, SY, TJ, 1C, 1G						19	3			
REF02	Rendering Provider ID		AN	1--50	R										22	50			
REF03-	Not Used		AN	1--80															
-REF04																			
REF	**Health Care Policy Identification**			**5**	**S**	**2110**				209	**2110**		**REF**		**1**	**18**	**5**		
REF01	Reference ID Qualifier		ID	2--3	R				0K						19	3			
REF02	Healthcare Policy ID		AN	1--50	R										22	50			
REF03-			AN	1--80	NU														
-REF04																			
AMT	**Service Supplemental Amount**			**9**	**S**	**2110**				211	**2110**		**AMT**		**1**	**18**	**12**		
AMT01	Amount Qualifier Code		ID	1--3	R				B6, KH, ZK, ZL, ZM, ZN, ZO						19	3			
AMT02	Service Supplemental Amount S9(8)V99		R	1--18	R										22	18			
AMT03	Not Used		ID	1--1	NU														

835 TR3 5010																			
	X12 Element Attributes---									**X12 Flat File----------**						**18**			
Element Identifier			**ID**	**Min/Max**	**Usage Req**	**Loop**	**Loop Repeat**		**Values**	**Page #**	**Loop ID**	**Loop Seq**	**Seg ID**	**Seg. Seq.**	**Start**	**Length**	**Record Repeat**		**Comment**
QTY	**Service Supplemental Quantity**			**6**	**S**	**2110**			**N/A**	213	**2110**		**QTY**						Not used by Medicare
LQ	**Health Care Remarks Codes**			**99**	**S**	**2110**				215	**2110**		**LQ**		**1**	**18**	**99**		
LQ01	Code List Qualifier Code		ID	1--3	R				HE						19	3			
LQ02	Remark Code X(5)		AN	1--30	R										22	30			
PLB	**Provider Level Adjustment**			**>1**	**S**	**-------**	**1**			217			**PLB**		**1**	**18**	**1**		
PLB-01	Provider Identifier		AN	1--50	R				NPI						19	50			
PLB02	Fiscal Period Date		DT	8--8	R				CCYYMMDD						69	8			
PLB03	Adjustment Identifier				R														
-03-1	Adjustment Reason Code		ID	2--2	R				50, 51, 72, AP, B2, B3, BD, BN, C5, CS, CV, DM, E3, FB, GO, HM, IP, IS, IR, J1, L3, L6, LE, LS, OA, OB, PI, PL, RE, SL, WO, WU						77	2			
-03-2	Provider Adjustment Identifier		AN	1--50	S										79	50			
PLB04	Provider Adjustment Amount S9(8)V99		R	1--18	R										129	18			
PLB05	Adjustment Identifier				S														
-05-1	Adjustment Reason Code		ID	2--2	R				50, 51, 72, AP, B2, B3, BD, BN, C5, CS, CV, DM, E3, FB, GO, HM, IP, IS, IR, J1, L3, L6, LE, LS, OA, OB, PI, PL, RE, SL, WO, WU						147	2			
-05-2	Provider Adjustment Identifier		AN	1--50	S										149	50			
PLB06	Provider Adjustment Amount S9(8)V99		R	1--18	S										199	18			
PLB07	Adjustment Identifier				S														

835 TR3 5010																			
	X12 Element Attributes--										X12 Flat File----------					18			
Element Identifier			ID	Min/Max	Usage Req	Loop	Loop Repeat		Values	Page #	Loop ID	Loop Seq	Seg ID	Seg. Seq.	Start	Length	Record Repeat		Comment
-07-1	Adjustment Reason Code		ID	2--2	R				50, 51, 72, AP, B2, B3, BD, BN, C5, CS, CV, DM, E3, FB, GO, HM, IP, IS, IR, J1, L3, L6, LE, LS, OA, OB, PI, PL, RE, SL, WO, WU						217	2			
-07-2	Provider Adjustment Identifier		AN	1--50	S										219	50			
PLB08	Provider Adjustment Amount S9(8)V99		R	1--18	S										269	18			
PLB09	Adjustment Identifier				S														
-09-1	Adjustment Reason Code		ID	2--2	R				50, 51, 72, AP, B2, B3, BD, BN, C5, CS, CV, DM, E3, FB, GO, HM, IP, IS, IR, J1, L3, L6, LE, LS, OA, OB, PI, PL, RE, SL, WO, WU						287	2			
-09-2	Provider Adjustment Identifier		AN	1--50	S										289	50			
PLB10	Provider Adjustment Amount S9(8)V99		R	1--18	S										339	18			
PLB11	Adjustment Identifier				S														
-11-1	Adjustment Reason Code		ID	2--2	R				50, 51, 72, AP, B2, B3, BD, BN, C5, CS, CV, DM, E3, FB, GO, HM, IP, IS, IR, J1, L3, L6, LE, LS, OA, OB, PI, PL, RE, SL, WO, WU						357	2			
-11-2	Provider Adjustment Identifier		AN	1--50	S										359	50			
PLB12	Provider Adjustment Amount S9(8)V99		R	1--18	S										409	18			
PLB13	Adjustment Identifier				S														
-13-1	Adjustment Reason Code		ID	2--2	R				50, 51, 72, AP, B2, B3, BD, BN, C5, CS, CV, DM, E3, FB, GO, HM, IP, IS, IR, J1, L3, L6, LE, LS, OA, OB, PI, PL, RE, SL, WO, WU						427	2			

835 TR3 5010																			
	X12 Element Attributes--									**X12 Flat File----------**						**18**			
Element Identifier			**ID**	**Min/Max**	**Usage Req**	**Loop**	**Loop Repeat**		**Values**	**Page #**	**Loop ID**	**Loop Seq**	**Seg ID**	**Seg. Seq.**	**Start**	**Length**	**Record Repeat**		**Comment**
-13-2	Provider Adjustment Identifier		AN	1--50	S										429	50			
PLB14	Provider Adjustment Amount S9(8)V99		R	1--18	S										479	18			
SE	**Transaction Set Trailer**			**1**	**R**	**----**	**1**			228			**SE**		**1**	**18**	**1**		
SE01	Transition Segment Count		N0	1--10	R										19	10			
SE02	Transition Set Control #		AN	4--9	R				=ST02						29	9			
GE	**Functional Group Trailer**			**1**	**R**	**---**	**1**						**GE**		**1**	**18**	**1**		
GE01	# Transaction Sets Included		N0	1-6	R				Total transaction sets (ST-SE pairs)						19	6			
GE02	Group Control #		N0	1-9	R				Same Value as in GS06						25	9			
IEA	**Interchange Control Trailer**			**1**	**R**	**----**	**1**						**IEA**		**1**	**18**	**1**		
IEA01	# Included Functional Groups		N0	1-5	R				Total functional groups (GS-GE pairs)						19	5			
IEA02	Interchange Control #		N0	9-9	R				Same value as in ISA13						24	9			

Date	Loop	Data Element	Change	Reason for Change
6/9/08	-	ISA 11	1. Change Description 2. No Value	Changed in 5010. Repetition Separator is a delimeter and not a data element
6/9/08	-	GS08	One line instead of two	
6/9/08	-	PLB03-2 PLB05-2 PLB07-2 PLB09-2 PLB11-2 PLB13-2	Add Treasury Telephone #	Providers are to call the Treasury directly if there is any Treasury withholding for Federal Debt
6/30/08	2000	TS301	Min-Max changed to 1--50 from 1--60	Per IG Max is 50
8/5/08	2100	MOA03-MOA07	Min-Max changed to 1--50 from 1--30	Per IG Max is 50
9/17/08	2100	MOA03-MOA07 and MIA20-MIA23	Pic Clause X(5) added	To reflect Medicare decision
10/28/08		ISA12	005010	To reflect current version
10/28/08	2100/2110	All REF02 fields are same length	50	Consistency
10/28/08	2100/2110	All PER 04/06/08 are same length	256	Consistency
10/28/08		LX01 values added to cover MCS	Added 1 and 0	Correction per MCS
10/28/08	2100	CLP 06	"MB" added as a possible value	To cover Part B
10/28/08	2110	CLP 08	The description changed	To cover Part B
1/23/2009		ISA12	00501 from 005010	Field length is only 5
1/23/2009		BPR05-BPR16	Values in the "Start" column changed	To reflect the field lengths correctly
1/23/2009	1000A	PER - Payer Web Site	Values added under field length column for PER02, PER05, PER06, PER07, and PER08 although they are not used	To be consistent with other PER segments within 835
1/23/2009	2100	CLP07	Field length changed to 50 from 30	Max is 50 in 5010
1/23/2009	2100	CLP08-CLP13	Values in the "Start" column changed	As a result of changing the field length for CLP05 to 50
1/23/2009		PLB12-PLB14	Values in the "Start" column changed	To reflect the field lengths correctly
2/9/2009	1000A	PER - Payer Web Site/PER01	Value changed from 1C to IC	To reflect the value correctly per TR3

7/21/09	2100	**Inpatient Adjudication Information**	Length changed from 18 and 15 to 15 and 18 for MIA01 and MIA02 respectively.	To follow the max length in the TR3