Program Memorandum
Carriers

Transmittal B-01-35

Date: APRIL 30, 2001

CHANGE REQUEST 1523

SUBJECT: Health Insurance Portability and Accountability Act of 1996 (HIPAA) Administrative Simplification - Implementation of Version 4010 of the Accredited Standards Committee X12 835 (Payment/Remittance Advice) Transaction Standard Format.

The Secretary of Health and Human Services has established version 4010 of the X12N 835 (provider remittance advice), 837 (claim, encounter and coordination of benefit (COB)), 270/271 (eligibility query/response), 276/277 (claim status/query response) and 278 (prior authorization) implementation guides as national standards for use by all health care plans in the United States, including carriers and durable medical equipment regional carriers (DMERCs). This fulfills certain requirements of the administrative simplification provisions of HIPAA. Further information on the HIPAA standards requirements in general may be obtained at *http://aspe.hhs.gov/admnsimp.* This Program Memorandum (PM) contains the requirements for implementation of the electronic remittance advice (ERA) standard by the standard system maintainers, carriers, and DMERCs.

Version 4010 of the 835 includes some significant changes from earlier versions of Medicare-supported ERA formats. Changes include requirements to electronically void and correct claim history when adjusting a claim, rather than simply posting differences in payment; to identify the primary payer if denying a claim because Medicare is not primary; and to identify any secondary payer with whom benefits are coordinated. The void/adjustment process will probably impact contractor workflow for establishment of many account receivables, and may very well involve contractor staff from areas other than electronic data interchange.

Remittance Advice Standard Requirements

Medicare carriers and DMERCs will continue to use flat files for their internal system programming. The updated X12N 835 version 4010-supportive remittance advice flat file developed in conjunction with the Electronic Data Interchange Functional Work Group (EDIFWG) is posted at *www.hcfa.gov/medicare/edi/edi.htm* under the document name "B835v4010." Various carriers, DMERC, standard systems, and HCFA representatives have participated in EDIFWG activities. Subsequent adjustments may be issued if necessary to resolve problems detected during programming or testing. The flat file maps each flat file field to the corresponding 835 version 4010 data element, and notes if/where each data element was reported in the last of the National Standard Format (NSF)-based remittance advice flat file (NSF 2.01U).

Attachment 1 is the "Medicare X12N 835 Version 4010 HIPAA Companion Document." This itemizes the Medicare requirements for use of specific segments, data elements, and codes in the 835. Version 4010 of the 835 implementation guide may be downloaded without charge from *www.wpc-edi.com/HIPAA*, or you may phone 1-800-972-4334 to purchase hard copies.

Remittance Advice Remark Codes

As the initial user of 835 remark codes, HCFA became the defacto maintainer of this code set with ASC X12N approval. Since HIPAA applies to virtually all U.S. health care payers, and will result in much more extensive use of the 835 format, many payers other than Medicare will also begin to use remark codes. Remark code wording must be generic. Language referring to Medicare as the source of decisions in many remark code messages has been replaced by references to "we" Since the remittance advice identifies the issuer (Medicare for a claim processed by a carrier or DMERC), the meaning is the same. Existing message numbers have also stayed the same.

HCFA-Pub. 60B

Attachment 2 contains the currently approved, generically worded remark code messages. You may begin to use these messages in both your pre-HIPAA and HIPAA format ERAs and standard paper remittances as soon as programming changes are complete. None of these messages should be new to you, but if you do begin to use any of these messages for the first time, furnish providers advance notice of the new messages and their meanings prior to initial use. Any remark code may now be reported at either the claim or the line level, i.e., an "MA" code may now be reported in the LQ segment of the 835, and an "M" code in an MOA segment--if the wording of the message fits the situation being described at that level. "N" codes could always be reported at either the claim or the service level. All new remark codes will now begin with "N ."

Neither a Medicare carrier, DMERC, nor a non-Medicare payer may use a remark code in a version 4010 835 transaction that does not appear in attachment 2 or a subsequent HCFA-produced update to this list. This listing will be updated as needed, and is nationally accessible at *www.wpc-edi.com* by selecting the Guides, Health Care Code Lists, and Remittance Advice Remark Codes menu listings. Download the remark code message set from this website every quarter to keep abreast of the full list of messages approved for use. Attachment 2 and the website also include instructions to request modifications or additional remark codes. New remark codes introduced to meet Medicare-specific needs will continue to be included in the implementation instruction for the Medicare change that necessitated the new message. Remark codes will not otherwise be published in Medicare manuals. Nor will they be maintained on a HCFA website.

Standard Paper Remittance (SPR) and SPR/ERA Patient Account Number Reporting

Only one change is being made to the SPR format. Standard systems, carriers and DMERCs must complete system changes by following HCFA's normal October quarterly release process to enable reporting of a 20-character patient account number in an X12N 835 version 4010 when a number that large is submitted on a version 4010 claim (Attachment 3). The Medicare core system will continue to record a maximum of 17 characters for patient account numbers. Patient account numbers in excess of 17 characters will be populated from the repository established for coordination of benefits for both SPRs and ERAs. If a provider requests a SPR or ERA after a 20-character patient account number has been purged from the repository, the SPR/ERA will report the first 17-characters only. A similar limitation applies to reporting of provider line item control numbers in ERAs (see the note in REF segment repeat 100.A in Attachment 1).

All other data elements included in SPRs and ERAs will be populated from the Medicare core system. By as early as October 1, 2001, but no later than October 2002 standard systems must assure that all data elements that appear in both the SPR and the ERA for the same claim contain identical data. Fields shared by both formats for the same claim may not contain different data. As in the past, data not available in an ERA may not be reported in a SPR. SPRs will also be limited to reporting of one secondary payer, even when payment information for a claim is shared with more than one secondary payer under COB trading partners agreements (see NM1 segment repeat 030.E in Attachment 1).

Standard systems will also need to modify SPR programming if notified to begin using 11-digit National Drug Codes (NDC) in lieu of drug HCPCS. HCFA does not plan to replace the drug HCPCS with NDCs before FY 2002. If notified to begin using NDCs in lieu of drug HCPCS, the first 5 characters of the NDC must be printed in the 5 space SPR procedure code field and the remaining 6 characters printed in the 6 adjoining spaces normally reserved for HCPCS modifiers. This strategy avoids the need for expansion of the procedure code column and the related increase in the size and cost of most SPRs. Do not take action to replace drug HCPCS with NDCs, however, unless issued a separate HCFA instruction to that effect.

PC-Print

Carriers and DMERCs are no longer required to issue PC-Print software to providers. A survey of carriers indicated limited use of the NSF versions of PC-Print previously developed. Providers realize the most significant benefits of the 835, such as automatic posting of patient records and maintenance of accounts receivables, when they process the data electronically. When providers use the 835 as intended by the designers, they should rarely need hard copies of 835 data. Since providers still receive, or can request, SPRs, most carriers and DMERCs do not consider it cost effective, to continue to support PC-Print.

Carriers and DMERCs who consider there to be a local need for PC-Print software as an 835 marketing tool, to retain current 835 customers, or to respond to other demonstrated provider needs have the option to continue to generate PC-Print software. However, carriers and DMERCs who elect to continue to support PC-Print software, must be able to demonstrate that the benefits generated from the software exceed their costs to support the software.   If they elect to continue to support PC-Print software, the software must operate on Windows 95, 98, 2000, and NT platforms, be distributed to providers free or at cost, comply with the SPR format for reporting of remittance advice data, and be available for distribution to providers by January 2, 2002.

Manualization of this Information

The Medicare Carriers Manual sections dealing with the 835 transaction will be updated to include changes detailed in this and other HIPAA PMs.   HCFA plans to combine and manualize all of the HIPAA transactions information at the same time, following release of individual PMs for the various transactions. The DMERC contracts are also being updated to correspond to these changes.

Testing and Implementation

Standard system programming must be completed and the system changes and related documentation distributed to the processing centers according to the normal October release process, i.e., the release must be sent to the carrier/DMERC beta testers in August, and carriers and DMERCs must begin their testing of this change request by September. As per normal practice, HCFA will not issue test files to the carriers or DMERCs.   Each carrier and DMERC is responsible for the development of appropriate test files, either alone or in conjunction with other carriers and/or DMERCs.

Carriers and DMERCs must complete translator mapping for the 835 by September 30, 2001. Carriers and DMERCs must complete local system programming and internal testing to enable successful interface with their standard system for accurate generation of version 4010 of the 835 and the SPR from the 4010 flat file by November 30, 2001. Carriers and DMERCs must conduct limited provider beta testing of the 835 version 4010 with a small number of providers and/or outside clearinghouses involving a small number of claim batches during December 2001.

By January 2, 2002, carriers and DMERCs must be able to conduct system compatibility testing on version 4010 of the 835 with any Medicare provider or clearinghouse that applies for testing, and to issue 835 version 4010 transactions in production mode. Carriers and DMERCs may not discourage any provider, billing agent or clearinghouse from requesting 835 version 4010 testing. If either a provider, billing agent, clearinghouse, or a carrier or DMERC has any doubt about a receiver's acceptance and ability to use 835 version 4010 transmissions, the carrier or DMERC must encourage that receiver to test use of version 4010 of the 835 prior to full use in production.

Standard systems must support testing of providers and clearinghouses in 835 version 4010 at the same time production data is issued to the same providers and clearinghouses in a pre-4010 835 or an NSF version. Standard systems that do not already possess such parallel testing and production capability must be modified by December 1, 2001, to enable carriers and DMERCs to test version 4010 of the 835. More detail on specific testing requirements for providers, billing services, and clearinghouses will be issued in a separate PM.

Standard systems must also include program logic to enable carriers and DMERCs to identify situations where the flat file financial data may not have created a balanced 835 as specified in section 2.2.1 of the 835 version 4010 implementation guide. The logic must operate at the data center to generate an "out of balance" report that carriers and DMERCs can use to diagnose standard system errors for preparation of standard system correction requests. "Out-of-Balance" 835s should be rare exceptions, and not something to be expected, but this report would enable identification of balancing errors prior to transmission of data to providers. Carriers and DMERCs should not suspend transmission of 835 transactions pending correction of any identified balancing problems by their standard system, but depending on the nature of any identified problems, should alert providers regarding temporary problems they could experience pending necessary system correction.

Carriers and DMERCs must educate their providers on the differences between their current ERAs and the 835 version 4010 to avoid provider misinterpretation of reporting variations between the versions/formats. The version 4010 correction/reversal process may be particularly confusing to some providers, and in cases where different balancing logic is used, as in version 3030 versus version 4010, providers will need to be made aware of the changes they will encounter.

Provider and Clearinghouse Outreach

By November 30, 2001, carriers and DMERCs must notify their providers, third party provider billing services, provider clearinghouses, and vendors of/that:

? Each provider that has elected to receive an ERA must accept version 4010 of the 835, or contract with a clearinghouse to translate data from the 835 version 4010 standard on their behalf;

? A provider, provider billing service, trading partner, vendor or clearinghouse that elects to use a clearinghouse for translation services is liable for those costs;

? Whether PC-Print software will be issued for use with 835 version 4010, and if issued, when it will be available (no later than January 2, 2002) and how it may be obtained;

? The version 4010 835 implementation guide can be downloaded without charge from www.wpc-edi.com/HIPAA.

? Providers, agents, and clearinghouses who prefer advance testing to assure system compatibility of version 4010 of the 835 must schedule testing with their carrier or DMERC as soon as possible to obtain a testing appointment prior to October 2002. Appointment slots will be assigned on a first come basis. Each carrier and DMERC should come up with it's own testing schedule, and inform the providers, agents and clearinghouses about the specific deadline to request testing with that specific carrier or DMERC. Carriers and DMERCs will not be able to guarantee completion of testing by the end of September 2002 for any entities that delay requesting a testing appointment until late in the transition period. Unless a provider requests discontinuation of receipt of ERAs, current 835 and NSF remittance recipients will automatically be sent production 835 version 4010 transactions in October 2002;

? As result of the large number of providers, agents, clearinghouses, and trading partners that could request to be tested and the number of HIPAA standard transactions, it may not be feasible to test each entity during the last quarter of the transition process;

• Providers who request a copy of a previously issued ERA after: 1) a patient account number in excess of 17-characters has been purged from Medicare records will be sent only the first 17-characters of that patient account number; and 2) provider line item control numbers have been purged from Medicare records will not receive those control numbers in the ERA copy. The patient account number limitation applies to SPRs also. Line item control numbers are never reported in SPRs;

? There is no Medicare charge for this system testing; and

? Although Medicare will furnish providers with basic information on the HIPAA standard transaction requirements to enable providers to make educated and timely decisions to plan for their transition to the HIPAA standards, Medicare will not furnish in-depth training on the use and interpretation of the standards implementation guides. Providers who feel they have a need to obtain such in-depth training for their staff are expected to obtain training of that nature from commercial vendors, their clearinghouse, or through standards development organizations.

Carriers and DMERCs must be pro-active to assure that:

? Providers, agents, and clearinghouses are furnished adequate information for them to understand the impact of the HIPAA Administrative Simplification requirements, as implemented by Medicare, on their operations. Carriers and DMERCs must furnish appropriate

information in regularly scheduled provider bulletins/newsletters, in other provider educational publications, and during their regularly scheduled provider educational seminars to enable

those individuals and entities to make educated and timely decisions to plan their reaction to the HIPAA standards as implemented by Medicare; and

? A reasonable number of tests are conducted monthly throughout the transition period to enable Medicare providers, agents, and clearinghouses who request testing to complete testing before HCFA must discontinue support of non-HIPAA compliant electronic transactions.

Cost Issues

The Budget and Performance Requirements specify that carriers include one 835 upgrade per year in their line 1 routine maintenance costs. However, carriers are entitled to non-routine cost incurred for: translator upgrade if required to accommodate a higher volume of X12N transactions under HIPAA, translator mapping to the new X12N-based flat files, provider education on 835 version 4010 requirements, testing of SPR accuracy when generated with the 835 version 4010 flat file, provider beta testing of the 835 version 4010 with selected partners, optional PC-Print software design when cost effective, and system compatibility testing of providers, their agents, and clearinghouses at their request prior to issuance of the 835 version 4010 in production mode. Carriers should submit Supplemental Budget Requests for reasonable supplemental costs incurred to comply with these non-routine 835 requirements in FY 2001 and FY 2002.

DMERCs were not previously required to implement any ASC X12N standards. DMERCs are entitled to reasonable costs for implementation, testing, and transition to these ASC X12N standards, and should submit SBRs in FY 2001 and FY 2002 for the reasonable and allowable costs they incur to use version 4010 of the 835 transaction as described in this PM.

HIPAA established requirements binding on all health care payers, not only on Medicare. HIPAA did not fund national implementation of its Administrative Simplification standards requirements by all health payers. As with other system and program changes that impact a Medicare contractor=s parent company's private/commercial lines of business as well as their Medicare processing activities, direct and indirect costs related to such changes must be proportionately shared by the impacted lines and cost centers, and not charged to Medicare in total. Programming, transition, and operational costs related to a corporate clearinghouse operated by a Medicare contractor's parent company, or any other profit or non-profit line of business of the parent company not required to support Medicare processing under the terms of their Medicare contract, may not be charged in total or in part to the Medicare program.

The effective date and implementation date for this PM is October 1, 2001.

See the section of the instruction labeled "Cost Issues" for implementation cost information. For DMERCs only: HCFA is preparing a contract modification. Do not begin work on this PM until the modification is executed.

This PM may be discarded after January 1, 2003.

Contact person for the remittance advice information is Kathleen Simmons, (410) 786-6157.

3 Attachments

MEDICARE X12N 835 VERSION 4010

HIPAA COMPANION DOCUMENT

INTRODUCTION

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires that Medicare, and all other health insurance payers in the United States, comply with the electronic data interchange standards for health care as established by the Secretary of Health and Human Services. The X12N 835 version 4010 implementation guide has been established as the standard for compliance for remittance advice transactions. The implementation guide for that format is available electronically at www.wpc-edi.com/HIPAA.

Although that implementation guide contains requirements for use of specific segments and data elements within the segments, the guide was written for use by all health benefit payers, and not specifically for Medicare. This document has been prepared as a Medicare-specific companion document to that implementation guide and the flat file to clarify when conditional data elements and segments must be used for Medicare reporting, and identify those codes and data elements that never apply to Medicare and which may not be used in Medicare remittance advice transactions. This companion document supplements, but does not contradict any requirements in the 835 version 4010 implementation guide.

Table 1 - Header Data

Segment/ Data Elements	835 and Medicare Requirements/Notes
ST	Required.
ST01	Required. Always enter "835."
ST02	Required.
BPR	Required.
BPR01	Required. Codes U and X do not apply to Medicare.
BPR02	Required.
BPR03	Required. Code D does not apply to Medicare.
BPR04	Required. Codes BOP and FWT do not apply to Medicare.
BPR05	Situational, but required for Medicare if ACH is entered in BPR04.
BPR06	Situational, but required for Medicare if ACH in BPR04. Code 04 does not apply to Medicare.
BPR07	Situational, but required for Medicare if ACH in BPR04.
BPR08	Situational, but required for Medicare if ACH in BPR04.
BPR09	Situational, but required for Medicare if ACH in BPR04.
BPR10	Situational, but required for Medicare if ACH in BPR04.
BPR11	Situational, but does not apply to Medicare and should not be reported.
BPR12	Situational, but required for Medicare if ACH in BPR04. Code 04 does not apply to Medicare.
BPR13	Situational, but required for Medicare if ACH in BPR04.
BPR14	Situational, but required for Medicare if ACH in BPR04.
BPR15	Situational, but required if ACH in BPR04.
BPR16	Required.
BPR17-21	Not used.
TRN	Required.
TRN01	Required.
TRN02	Required.
TRN03	Required.
TRN04	Situational, but does not apply to Medicare.

CUR   Situational, but does not apply to Medicare.

REF (060.A) Situational, but required for Medicare if the 835 is being sent to any entity other than the provider.
REF01 Required.
REF02 Required.
REF03-04 Not used.

REF (060.B) Situational, but required for Medicare to identify a local version number for the implementation. Sometimes a local version number is needed to identify a post-implementation modification in programming, such as to correct a programming error. The local version number could be needed to answer a provider inquiry related to the programming modification.
REF01 Required.
REF02 Required. The version number is assigned locally.
REF03-04 Not used.

DTM (070) Situational, but required for Medicare if the date of the 835 is different than the cutoff date for the adjudication action that generated the 835.
DTM01 Required.
DTM02 Required.
DTM03-06 Not used.

N1 (080.A) Required for payer identification.
N101   Required.
N102   Situational, but required for Medicare.
N103   Situational. Always enter "XV" in this loop when the PlanID is effective, but not used prior to that date.
N104   Situational, but required once the PlanID is effective.
N105-106 Not used.

N3 (100) Required for payer identification.
N301   Required.
N302   Situational, but required by Medicare if there is more than 1 address line for the payer, such as for a suite number.

N4 (110) Required for payer identification.
N401   Required.
N402   Required.
N403   Required.
N404-406 Not used.

REF (120.A) Situational. Required for Medicare prior to the effective date of the Plan ID. After that date, a Medicare payer may use at its option in addition to the Plan ID in the 060 REF.
REF01 Required. Only 2U applies to Medicare.
REF02 Required.
REF03-04 Not used.

PER (130) Situational. Recommended for use for Medicare, but reporting of contact information in an 835 is at the option of individual Medicare contractors.
PER01 Required.
PER02 Situational. Optional for Medicare but recommended if this segment is used.
PER03 Situational, but required for Medicare if this segment is used.
PER04 Situational, but required for Medicare if there is an entry in PER03.
PER05 Situational. May be used at the option of a Medicare contractor to report a second contact.

PER06   Situational, but required if there is an entry in PER05.
PER07   Situational, but required for Medicare if segment is used and it is necessary
       to report a telephone extension number.
PER08-09 Not used.

N1 (080.B) Required to identify the payee.
N101   Required.
N102   Situational, but required for Medicare prior to the effective date of the NPI.
N103   Required. Always enter "FI" until the NPI is effective. After that date, always
       enter "XX."
N104   Required.
N105-106 Not used.

N3 (080)   Situational, but required for Medicare.
N301   Required.
N302   Situational, but required if there is a second payee address line.

N4 (100.B) Situational, but required for Medicare.
N401   Required.
N402   Required
N403   Required.
N404   Situational. Only required if the address is other than the U. S.
N405   Not used.
N406   Not used.

REF (120.B) Situational, but required for Medicare.
REF01   Required. Always enter "TJ" in this loop when the NPI is effective. Prior to that
       date, use 1C (Medicare provider number) or 1G (UPIN) for Medicare. 0B, 1A,
       1B,1D, 1E, 1F, 1H, D3, G2, N5 and PQ do not apply to Medicare.
REF02   Required.
REF03-04 Not used.

Table 2 - Detail Data

LX   Situational, but required for Medicare.
LX01   Required.

TS3   Situational. Not used by Medicare carriers, only by intermediaries.

TS2   Situational. Not used by Medicare carriers, only by intermediaries.

CLP   Required.
CLP01   Required.
CLP02   Required. Codes 25 and 27 do not apply to Medicare and are not in the flat file.
CLP03   Required.
CLP04   Required.
CLP05   Situational, but required for Medicare if there is any patient financial
       responsibility for amounts not paid by Medicare.
CLP06   Required. Carriers always enter "MB." None of the other 835 codes apply to
       Medicare.
CLP07   Situational, but required for Medicare.
CLP08   Situational, but required for Medicare.
CLP09   Situational, but does not apply to Medicare carriers.
CLP10   Not used.
CLP11   Situational, but does not apply to carriers.
CLP12   Situational, but does not apply to carriers.
CLP13   Situational, but does not apply to carriers.

CAS (claim)   Situational, but does not apply to carriers. Adjustments for Medicare carriers should always be reported at the line level Unlike prior 835 versions, version 4010 does not require entry of an OA 93 message in a claim level CAS when there are no claim level adjustments.

NM1 (030.A)   Required to report patient-related information.
NM101   Required.
NM102   Required.
NM103   Required.
NM104   Required.
NM105   Situational, but required for Medicare when a middle name or initial is available for the patient.
NM106   Not used.
NM107   Situational, but will not be used for Medicare.
NM108   Situational, but required for Medicare. Always enter "HN" for Medicare, until notified that the HIPAA Individual Identifier is effective, at which point enter "II" in this data element. None of the other qualifiers apply to Medicare.
NM109   Situational, but required for Medicare if reported on the incoming claim.
NM110-111   Not used.

NM1 (030.B)   Situational, but the loop is intended for information on an insured when different than the patient. This situation does not apply in Medicare. Not used.

NM1 (030.C)   Situational, but is required for Medicare when the patient's name, as received on the claim, has been corrected.
NM101   Required. For Medicare purposes, the insured is the patient.
NM102   Required. Code 2 does not apply to Medicare.
NM103   Situational, but required for Medicare if the last name has been corrected.
NM104   Situational, but required for Medicare if the first name has been corrected.
NM105   Situational, and optional for Medicare carrier to report a corrected middle name or initial.
NM106   Not used.
NM107   Situational, but not used for Medicare.
NM108   Situational, but required for Medicare if the ID # has been corrected.
NM109   Situational, but required for Medicare if the ID # as been corrected.
NM110-111   Not used.

NM1 (030.D)   Situational, but required for Medicare if the rendering provider is other than the payee.
NM101   Required.
NM102   Required. Code 2 does not apply to Medicare.
NM103   Situational, but do not report for Medicare. (Medicare reports only the number, not the name of the rendering provider.)
NM104   Situational, but do not report for Medicare. (Medicare reports only the number, not the name of the rendering provider.)
NM105   Situational, but do not report for Medicare. (Medicare reports only the number, not the name of the rendering provider.)
NM106   Not used.
NM107   Situational, but do not report for Medicare. (Medicare reports only the number, not the name of the rendering provider.)
NM108   Required. Until the NPI is effective, always enter "UP" for Medicare. When the NPI is effective, always enter "XX." BD, BS, FI, MC, PC, and SL do not apply to Medicare.
NM109   Required.
NM110-111   Not used.

NM1 (030.E)   Situational, but required for Medicare if claim data is being transferred to another payer under a coordination of benefits (COB) agreement with that payer. Note: Although Medicare may send claim and payment information to multiple secondary payers, the 835 does not permit identification of more than one of those secondary payers. When COB transmissions are sent to more than one secondary payer for the same claim, enter remark code N89 (see Attachment 2) in a MOA segment remark code data element.

NM101   Required.
NM102   Required.
NM103   Required.
NM104-107   Not used.
NM108   Required. Until the PlanID is effective, always enter "PI" for Medicare; when effective, enter "XV." AD, FI, NI, and PP do not apply to Medicare.
NM109   Required.
NM110-111   Not used.

NM1 (030.F)   Situational. Required for Medicare when a claim is denied or rejected due to the need for processing by a primary payer. That primary payer should be identified in the remittance advice.

NM101   Required.
NM102   Required.
NM103   Required.
NM104-107   Not used.
NM108   Required. Until the PlanID is effective, always enter "PI" for Medicare in this loop. When effective, always enter "XV" for Medicare. AD, FI, NI, and PP do not apply to Medicare.
NM109   Required. Enter the PlanID when effective. Prior to that date, zero-fill.
NM110-111   Not used.

MIA   Situational, but does not apply to Medicare carriers.

MOA   Situational, but required for Medicare whenever any claim level remark code applies, such as an appeal rights remark code or when there is more than one COB payer.

MOA01   Situational, but does not apply to Medicare carriers.
MOA02   Situational, but does not apply to Medicare carriers.
MOA03   Situational, but required for Medicare whenever at least one claim level remark code applies, such as for an appeal remark code.
MOA04   Situational , but required for Medicare if more than one claim level remark code applies.
MOA05   Situational, but required for Medicare if a third claim level remark code applies.
MOA06   Situational, but required for Medicare if a fourth claim level remark code applies.
MOA07   Situational, but required for Medicare if a fifth claim level remark code applies.
MOA08   Situational, but does not apply to Medicare carriers.
MOA09   Situational, but does not apply to Medicare carriers.

REF (040.A)   Situational, but does not apply to Medicare carriers.

REF (040.B)   Situational, but does not apply to Medicare. Carriers identify rendering providers, if different than billing providers, at the service level.

DTM (050)   Situational, but required for Medicare.
DTM01   Required. Always enter "050" for Medicare. This data element would only be used to report the date of receipt of the claim. Medicare carriers must report the start and end dates of care at the service level, and expiration of coverage information (036) does not apply to Medicare.
DTM02   Required.
DTM03-06   Not used.

PER	Situational, Medicare contractors may report contact information at their option, either in table 1, or table 2, but it should not be necessary to report contact information in both tables.
PER01	Required.
PER02	Situational, and optional for use by a Medicare carrier. If furnished, contact data must be supplied by the carrier rather than the standard system.
PER03	Situational, but required for Medicare if the segment is used. Contact data must be furnished by the carrier.
PER04	Situational, but required for Medicare if this segment is used. Carrier must furnish the data.
PER05	Situational, and optional for use by a Medicare carrier if the carrier would like to report additional contact information. If used, the data must be furnished by the carrier.
PER06	Situational, but required for Medicare if an entry in PER05. Data must be furnished by the carrier.
PER07	Situational, and optional for a carrier to use to report the extension number of any phone number reported in PER04 or 06. Data must be furnished by the carrier.
PER08	Situational, and optional for a carrier to use to report the extension number of any phone number reported in PER04 or 06. Data must be furnished by the carrier.
PER09	Not used.
AMT (062)	Situational, but required for Medicare if the claim reported the patient made any payment for the claim.
AMT01	Required. Only F5 and I apply to Medicare carriers. No other codes for this data element apply to Medicare.
AMT02	Required.
AMT03	Not used.
QTY	Situational, but does not apply to Medicare carriers.
SVC	Situational, but required for Medicare carriers. Note: The HCPCS, modifiers, and when applicable, NDC code reported on a claim for a service must be reported on the 835 for that service, including in situations where a service is being adjusted for submission of an invalid procedure code or modifier. This situation is considered an exception to the HIPAA requirement that standard transactions be limited to reporting of valid medical codes.
SVC01-1	Required. Only codes HC and N4 apply to Medicare carriers. A separate loop need for each service reported.
SVC01-2	Required.
SVC01-3	Situational, but required for Medicare if HC applies and at least one modifier was reported on the claim for the service.
SVC01-4	Situational, but required for Medicare if HC applies and a second modifier was reported on the claim for the service.
SVC01-5	Situational, but required for Medicare if HC applies and a third modifier was reported on the claim for the service.
SVC01-6	Situational, but required for Medicare if HC applies and a fourth modifier was reported on the claim for the service.
SVC01-7	Situational, but text language may not be reported for Medicare on a remittance advice.
SVC02	Required.
SVC03	Required.
SVC04	Situational, but does not apply to carriers.
SVC05	Situational, but required for carriers.
SVC06-1	Situational, but required if the procedure or drug code has been changed during adjudication. Only HC and N4 apply to Medicare carriers.
SVC06-2	Required.
SVC06-3--7	Situational, but required for Medicare if modifiers are changed.

SVC07	Situational, but required for Medicare if the paid units of service is different than the billed units of service.
DTM (080)	Situational, but required for Medicare.
DTM01	Required.
DTM02	Required.
DTM03-06	Not used.
CAS (svc)	Situational , but required for Medicare whenever the amount paid for a service does not equal the amount billed. Medicare carriers are required to separately report every adjustment made to a service.
CAS01	Required. PI does not apply to Medicare. Necessary to use separate loops if more than 1 group code applies, or if there are more than 6 procedure codes per group.
CAS02	Required.
CAS03	Required.
CAS04	Situational, but not used for Medicare.
CAS05	Situational, but required for Medicare if there is a second service level adjustment.
CAS06	Situational, but required for Medicare if there is a second service level adjustment.
CAS07	Situational, but not used for Medicare.
CAS08	Situational, but required for Medicare if there is a third service level adjustment.
CAS09	Situational, but required for Medicare if there is a third service level adjustment.
CAS10	Situational, but not used for Medicare.
CAS11	Situational, but required for Medicare if there is a fourth service level adjustment.
CAS12	Situational, but required for Medicare if there is a fourth service level adjustment.
CAS13	Situational, but not used for Medicare.
CAS14	Situational, but required for Medicare if there is a fifth service level adjustment.
CAS15	Situational, but required for Medicare if there is a fifth service level adjustment.
CAS16	Situational, but not used for Medicare.
CAS17	Situational, but required for Medicare if there is a sixth service level adjustment.
CAS18	Situational, but required for Medicare if there is a sixth service level adjustment.
CAS19	Situational, but not used for Medicare.
REF (100.A)	Situational, but required for Medicare.
REF01	Required. Only LU and 6R apply to Medicare. Two loops must be used if both LU and 6R apply.
REF02	Required. Note: The provider line item control number (6R) is not used by and will not be retained by the Medicare core system. As with a 20-digit patient account number, use the COB data repository to populate REF02 for 6R. Do not report 6R in REF01 of a reissued ERA if there is no line item control number in the repository.
REF03-04	Not used.
REF (100.B)	Situational, but required for Medicare if the rendering provider for the service is other than the payee.
REF01	Required. Prior to the NPI effective date, always enter "1C" (the flat file does not differentiate between a UPIN and any other Medicare provider number) in this loop. After the NPI is effective, enter "HPI." The other codes do not apply to Medicare.
REF02	Required.
REF03-04	Not used.
AMT (110)	Situational, but required for Medicare carriers if any of the qualifiers apply.
AMT01	Required. Only KH and B6 apply to Medicare. Two loops must be used for Medicare if both apply.
AMT02	Required.

AMT03 Not used.

QTY Situational, but does not currently apply to Medicare carriers.

LQ Situational, but required for Medicare whenever any service level remark codes apply.

LQ01 Required. Always enter "HE" for Medicare.

LQ02 Required.

Table 3 - Summary

PLB Situational, but required for Medicare whenever there have been any provider-level adjustments.

PLB01 Required.

PLB02 Required. Carriers must furnish this from their provider file, or use a default value of 12/31 of the current year.

PLB03-1 Required. Only codes CS, AP, FB, LE, L6, 50, SL, WO, B2, J1, and IR apply to Medicare carriers.

PLB03-2 Situational, but required for Medicare. Positions 1-2=00 Positions 3-19=the Financial Control Number, Positions 20-30=the HIC number. NOTE: The note in the implementation guide is misphrased. Medicare carriers and DMERCs must report this information in these positions in this data element.

PLB04 Required.

PLB05-1 Situational data element, but required if there is a second provider level adjustment.

PLB05-2 Situational, but required if there is a second provider level adjustment.

PLB06 Situational, but required if there is a second provider level adjustment.

PLB07-1 Situational, but required if there is a third provider level adjustment.

PLB07-2 Situational, but required if there is a third provider level adjustment.

PLB08 Situational, but required if there is a third provider level adjustment.

PLB09-1 Situational, but required if there is a fourth provider level adjustment.

PLB09-2 Situational, but required if there is a fourth provider level adjustment.

PLB10 Situational, but required if there is a fourth provider level adjustment.

PLB11-1 Situational, but required if there is a fifth provider level adjustment.

PLB11-2 Situational, but required if there is a fifth provider level adjustment.

PLB12 Situational, but required if there is a fifth provider level adjustment.

PLB13-1 Situational, but required if there is a sixth provider level adjustment. Two loops must be used for Medicare if both apply.

PLB13-2 Situational, but required if there is a sixth provider level adjustment.

PLB14 Situational, but required if there is a sixth provider level adjustment.

SE Required.

SE01 Required. The transaction segment count is computed by the carrier system.

SE02 Required.

REMITTANCE ADVICE REMARK CODES (Updated 4/12/2001){PRIVATE }

{PRIVATE }General{tc \l 1 "General"}

Remark codes are used in a remittance advice to relay informational messages that cannot be expressed with a claim adjustment reason code. Remark codes are maintained by HCFA, but may be used by any health care payer when they apply. Medicare contractors may use their discretion to determine when certain remark codes apply to a payment decision, but a Medicare contractor must report any remark codes that do apply, subject to capacity limits in the standard.

Most remark codes were initially separated into service level and claim level categories. Some of the same messages were included in both categories. To simplify remark code use, these categories have been eliminated. Any remark code may now be reported at the service or the claim level, as applicable, in any electronic or paper remittance advice version. To eliminate duplication, the following remark code messages have been made inactive and should no longer be used effective with implementation of version 4010 of the X12 835: M34 (duplicates MA120), M72 (duplicates MA52), MA05 (information included in MA30, or MA40 or MA43), N41 (duplicates reason code 39), and N44 (duplicates reason code 137).

Rather than renumber existing M (prior service level) and MA (prior claim level) codes, and possibly confuse providers, "old" code numbers have been retained. All new post-consolidation remark codes, however, will begin with an N. The "N" is used to quickly differentiate remark codes from claim adjustment reason codes. Remark codes that apply at the service level must be reported in the X12 835 LQ segment. Remark codes that apply to an entire claim must be reported in the X12 835 MIA (inpatient) or MOA (non-inpatient) segment, as applicable.

Due to the growing number of remark codes, the codes have been classified according to subject matter to make it easier to locate particular remark codes. Some codes are listed under multiple classes. Class does not have any bearing on remark code identifiers, however. No intelligence is built into the number issued a remark code.

{PRIVATE }Remark Code Changes/Additions{tc \l 1 "Remark Code Changes/Additions"}

The following M codes contain changes or are new since release of the October 1998 version of this list: M51, M109, M110, M116, M118, M120-M144. Codes M122-137 are substitutes for the D series reason codes, which will be inactive for use in X12 835 transactions effective with version 4010. Effective with version 4010, the information formerly in D1-15 will be conveyed with reason code 16 and the appropriate remark code. The information in D98 will be conveyed with reason code 96 and remark code M137.

The following MA codes have changed or been added since release of the October 1998 version of this list: MA06, MA44, MA52, MA118, MA119, MA125, MA130-MA134. Codes MA131 and 132 are substitutes for the D series reason codes D97 and D99 which will be inactive for use in X12 835 transactions effective with version 4010. Effective with version 4010, the information formerly in D97 and D99 will be conveyed with reason code 96 and the applicable remark code.

The following N codes have been changed or added since October 1998: N3,N10, N16 ff.

{PRIVATE }Remark Code Classifications{tc \l 1 "Remark Code Classifications"}
Appeal Remarks: M25, M26, M27, M60, MA01, MA02, MA03, MA28, MA44, MA46, MA62, MA91, MA113, MA130, N1, N11, N83

Assignment Remarks: M40, MA09, MA28, MA72, N71

Coverage Remarks: M13, M14, M28, M37, M41, M55, M61, M63, M65, M71, M73, M74, M80, M82, M83, M86, M89, M90, M100, M101, M107, M111, M115, M116, M121, M134, M138, M139, M140, MA14, MA20, MA84, MA103, MA109, MA123, N30, N43, N86, N87

Enrollment Remarks: M138, MA25, MA47, MA54, MA55, MA56, MA57, MA73, MA96, MA97, MA98, N6, N12, N30, N52

Equipment/Orthotic/Prosthetic Remarks: M3, M4, M5, M6, M7, M9, M10, M11, M36, M93, M94, M98, M102, M103, M104, M105, M106, M112, M113, M114, M115, M116, M124, M125, MA50, MA128

Home Care Remarks: M18, M21, M92, M95, M135, M141, MA49, MA76, MA116, N69, N70, N88

Justification for Services Remarks: M25, M26, M42, M62, M69,MA20, MA54,N41,N72

Liability Remarks: M17, M25, M26, M27, M38, M39, M41, M48, MA11, MA13, MA47, MA56, MA59, MA72, MA74, MA77, MA78, MA101, N12, N23, N44, N58, N71

Medical Test Remarks: M1, M8, M12, M19, M30, M31, M66, M71, M73, M75, M88, M91, M96, M108, M111, M126, M129, M133, M142, MA51, MA110, MA111, MA116, MA120, MA121, MA129, N40,N86

Missing/Invalid Information Remarks: M12, M19, M20, M21, M22, M23, M24, M29, M30, M31, M33, M34, M35, M42, M44, M45, M46, M47, M49, M50, M51, M52, M53, M54, M56, M57, M58, M59, M60, M62, M64, M65, M67, M68, M69, M72, M73, M76, M77, M78, M79, M81, M84, M96, M98, M99, M101, M108, M110, M119, M120, M122, M123, M124, M125, M126, M127, M128, M129, M130, M131, M132, M133, M135, M136, M141, M142, M143, MA04, MA05, MA06, MA19, MA21, MA27, MA29, MA30, MA31, MA32, MA33, MA34, MA35, MA36, MA37, MA38, MA39, MA40, MA41, MA42, MA43, MA48, MA49, MA50, MA51, MA52, MA53, MA54, MA58, MA60, MA61, MA63, MA64, MA65, MA66, MA68, MA69, MA70, MA71, MA75, MA76, MA81, MA82, MA83, MA85, MA86, MA87, MA88, MA89, MA90, MA92, MA94, MA95, MA96, MA97,MA98, MA99, MA100, MA102, MA104, MA105, MA107, MA108, MA110, MA111, MA112, MA113, MA114, MA115, MA116, MA120, MA121, MA122, MA128, MA129, MA130, MA134, N3, N4, N5, N8, N21, N24, N26,N27, N28, N29, N31, N33, N34, N37, N38, N39, N40, N42, N46, N49, N50, N51, N53,N54, N56, N57, N60, N64, N65, N66,N75,N76,N77,N78,N80,N81

Overpayment Remarks: MA10, MA11, MA59, MA72, MA77, MA78

Payment Basis: M32, M69, M71, M74, M75, M109, M114, MA93, MA101, MA103, MA106, MA109, N2, N6, N9, N12, N13, N14, N16, N18, N45,N67, N68,N69,N84,N85.

Place of Service Remarks: M77, M97, M134, MA24, MA25, MA105, MA114, MA115, MA123, MA134, N38, N47,N79

Responsible Provider: M40, M43, M48, M88, M96, M97, M109, M115, M116, M120, M134, M136, M142, M143, MA12, MA24, MA47, MA80, MA101, MA109, MA123, MA129, MA131, N32, N40, N47, N55, N73

Secondary Payment Remarks: M32, M43, M56, MA04, MA07, MA08, MA11, MA14, MA16, MA17, MA18, MA19, MA64, MA68, MA73, MA83, MA85, MA86, MA87, MA88, MA89, MA90, MA92, MA99, MA118, N4, N5, N6, N8, N9, N12, N23, N36, N48,N82,N89

Separate Payment Remarks: M2, M14, M15, M80, M86, M109, M121, M144, MA15, N15, N19, N20, N44, N61, N62, N63

Miscellaneous Remarks: M16, M70, M85, M87, M109, M114, M117, M118, M137, M144, MA22, MA23, MA26, MA45, MA67, MA74, MA79, MA93, MA103, MA106, MA117, MA118, MA19, MA124, MA125, MA132, MA133, N2, N7, N10, N13, N14, N16, N17, N18, N21, N22, N25, N35, N41, N44, N59,N74

Remark Codes

Code   Description
Value

Code Value	Description
M1	X-ray not taken within the past 12 months or near enough to the start of treatment.
M2	Not paid separately when the patient is an inpatient.
M3	Equipment is the same or similar to equipment already being used.
M4	This is the last monthly installment payment for this durable medical equipment.
M5	Monthly rental payments can continue until the earlier of the 15th month from the first rental month, or the month when the equipment is no longer needed.
M6	You must furnish and service this item for as long as the patient continues to need it. We can pay for maintenance and/or servicing for every 6 month period after the end of the 15th paid rental month or the end of the warranty period.
M7	No rental payments after the item is purchased, or after the total of issued rental payments equals the purchase price.
M8	We do not accept blood gas tests results when the test was conducted by a medical supplier or taken while the patient is on oxygen.
M9	This is the tenth rental month. You must offer the patient the choice of changing the rental to a purchase agreement.

M10   Equipment purchases are limited to the first or the tenth month of medical necessity.

M11   DME, orthotics and prosthetics must be billed to the DME carrier who services the patient's zip code.

M12   Diagnostic tests performed by a physician must indicate whether purchased services are included on the claim.

M13   No more than one initial visit may be covered per specialty per medical group. Visit may be rebilled with an established visit code.

M14   No separate payment for an injection administered during an office visit, and no payment for a full office visit if the patient only received an injection.

M15   Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.

M16   See the letter or bulletin of (date) for further information. [Note: Payer must supply the date of the letter/bulletin.]

M17   Payment approved as you did not know, and could not reasonably have been expected to know, that this would not normally have been covered for this patient. In the future, you will be liable for charges for the same service(s) under the same or similar conditions.

M18   Certain services may be approved for home use. Neither a hospital nor a SNF is considered to be a patient's home.

M19   Oxygen certification/recertification (HCFA-484) is incomplete or is required.

M20   HCPCS needed.

M21   Claim for services/items provided in a home must indicate the place of residence.

M22   Claim lacks the number of miles traveled.

M23   Invoice needed for the cost of the material or contrast agent.

M24   Claim must indicate the number of doses per vial.

M25   Payment has been (denied for the/made only for a less extensive) service because the information furnished does not substantiate the need for the (more extensive) service. If you believe the service should have been fully covered as billed, or if you did not know and could not reasonably have been expected to know that we would not pay for this (more extensive) service, or if you notified the patient in writing in advance that we would not pay for this (more extensive) service and he/she agreed in writing to pay, ask us to review your claim within six months of receiving this notice. If you do not request a review, we will, upon application from the patient, reimburse him/her for the amount you have collected from him/her (for the/in excess of any deductible and coinsurance amounts applicable to the less extensive) service. We will recover the reimbursement from you as an overpayment.

M26   Payment has been (denied for the/made only for a less extensive) service because the information furnished does not substantiate the need for the (more extensive) service. If you have collected (any amount from the patient/any amount that exceeds the limiting charge for the less extensive service), the law requires you to refund that amount to the patient within 30 days of receiving this notice.

The law permits exceptions to the refund requirement in two cases:

      o   If you did not know, and could not have reasonably been expected to know, that we would not pay for this service: or

      o   If you notified the patient in writing before providing the service that you believed that we were likely to deny the service, and the patient signed a statement agreeing to pay for the service.

If you come within either exception, or if you believe the carrier was wrong in its determination that we do not pay for this service, you should request review of this determination within 30 days of receiving this notice. Your request for review should include any additional information necessary to support your position.

If you request review within the 30-day period, you may delay refunding the amount to the patient until you receive the results of the review. If the review decisions favorable to you, you do not need to make any refund. If, however, the review is unfavorable, the law specifies that you must make the refund within 15 days of receiving the unfavorable review decision.

The law also permits you to request review at any time within six months of receiving this notice. A review requested after the 30-day period does not permit you to delay making the refund. Regardless of when a review is requested, the patient will be notified that you have requested one, and will receive a copy of the determination.

The patient has received a separate notice of this denial decision. The notice advises that he/she may be entitled to a refund of any amounts paid, if you should have known that we would not pay and did not tell him/her. It also instructs the patient to contact your office if he/she does not hear anything about a refund within 30 days.

The requirements for refund are in §1842(l) of the Social Security Act and 42CFR411.408. The section specifies that physicians who knowingly and willfully fail to make appropriate refunds may be subject to civil monetary penalties and/or exclusion from the program.

   Contact this office if you have any questions about this notice.

M27   The patient has been relieved of liability of payment of these items and services under the limitation of liability provision of the law. You, the provider, are ultimately liable for the patient's waived charges, including any charges for coinsurance, since the items or services were not reasonable and necessary or constituted custodial care, and you knew or could reasonably have been expected to know, that they were not covered.

You may appeal this determination provided that the patient does not exercise his/her appeal rights. If the beneficiary appeals the initial determination, you are automatically made a party to the appeals determination. If, however, the patient or his/her representative has stated in writing that he/she does not intend to request

a reconsideration, or the patient's liability was entirely waived in the initial determination, you may initiate an appeal.

You may ask for a reconsideration for hospital insurance (or a review for medical insurance) regarding both the coverage determination and the issue of whether you exercised due care. The request for reconsideration must be filed within 60 days (or 6 months for a medical insurance review) from the date of this notice. You may make the request through any Social Security office or through this office.

M28   This does not qualify for payment under Part B when Part A coverage is exhausted or not otherwise available.
M29   Claim lacks the operative report.
M30   Claim lacks the pathology report.
M31   Claim lacks the radiology report.
M3   This is a conditional payment made pending a decision on this service by the patient's primary payer. This payment may be subject to refund upon your receipt of any additional payment for this service from another payer. You must contact this office immediately upon receipt of an additional payment for this service.
M33   Claim lacks the UPIN of the ordering/referring or performing physician or practitioner, or the UPIN is invalid. (Substitute NPI for UPIN when effective)
M34   Claim lacks the CLIA certification number.

       (Note: M34 duplicates remark code message MA120. Message M34 is inactive effective with implementation of version 4010 of the X12 835. M34may not be used after that date.)
M35   Claim lacks pre-operative photos or visual field results.
M36   This is the 11th rental month. We cannot pay for this until   you indicate that the patient has been given the option of changing the rental to a purchase.
M37   Service not covered when the patient is under age 35.
M38   The patient is liable for the charges for this service as you informed the patient in writing before the service was furnished that we would not pay for it, and the patient agreed to pay.
M39   The patient is not liable for payment for this service as the advance notice of noncoverage you provided the patient did not comply with program requirements.
M40   Claim must be assigned and must be filed by the practitioner's employer.
M41   We do not pay for this as the patient has no legal obligation to pay for this.
M42   The medical necessity form must be personally signed by the attending physician.
M43   Payment for this service previously issued to you or another provider by another carrier/intermediary.
M44   Incomplete/invalid condition code.
M45   Incomplete/invalid occurrence codes and dates.
M46   Incomplete/invalid occurrence span code and dates.
M47   Incomplete/invalid internal or document control number.
M48   Payment for services furnished to hospital inpatients (other than professional services of physicians)can only be made to the hospital. You must request payment from the hospital rather than the patient for this service.
M49   Incomplete/invalid value code(s) and/or amount(s).
M50   Incomplete/invalid revenue code(s).

M51   Incomplete/invalid, procedure code(s) and/or rates, including "not otherwise
        classified" or "unlisted" procedure codes submitted without a narrative
        description or the description is insufficient.
         (Add to message by Medicare carriers only: "Refer to the HCPCS Directory. If
         an appropriate procedure code(s) does not exist, refer to Item 19 on the HCFA-
         1500 instructions.")
M52   Incomplete/invalid "from" date(s) of service.
M53   Did not complete or enter the appropriate number (one or more) of days or
        units(s) of service.
M54   Did not complete or enter the correct total charges for services rendered.
M55   We do not pay for self-administered anti-emetic drugs that are not administered
        with a covered oral anti-cancer drug.
M56   Incomplete/invalid payer identification.
M57   Incomplete/invalid provider number. (Substitute NPI for provider number when
        effective.)
M58   Resubmit the claim with the missing/correct information so that it may be
        processed.
M59   Incomplete/invalid "to" date(s) of service.
M60   Rejected without appeal rights due to invalid CMN form or format. Resubmit
         with completed, OMB-approved form or in an approved format.
M61   We cannot pay for this as the approval period for the FDA clinical trial has
        expired.
M62   Incomplete/invalid treatment authorization code.
M63   We do not pay for more than one of these on the same day.
M64   Incomplete/invalid other diagnosis code.
M65   One interpreting physician charge can be submitted per claim when a purchased
        diagnostic test is indicated. Submit a separate claim for each interpreting physician.
M66   Our records indicate that you billed diagnostic tests subject to price limitations
        and the procedure code submitted includes a professional component. Only the
        technical component is subject to price limitations. Submit the technical and
professional components of this service as separate line items.
M67   Incomplete/invalid other procedure code(s) and/or date(s).
M68   Incomplete/invalid attending or referring physician identification.
M69   Paid at the regular rate as you did not submit documentation to justify modifier 22.
M70   NDC code submitted for this service was translated to a HCPCS code for
     processing, but continue to submit the NDC on future claims for this item.
M71   Total payment reduced due to overlap of tests billed.
M72   Did not enter full 8-digit date (MM/DD/CCYY).

        (Note: M72 duplicates remark code message MA52. Message M72 is inactive
        effective with implementation of version 4010 of the X12 835. M72 may not be
        used after that date.)
M73   The HPSA bonus can only be paid on the professional component of this service.
        Rebill as separate professional and technical components. Use the HPSA
        modifier on the professional component only.

M74	This service does not qualify for a HPSA bonus payment.
M75	Allowed amount adjusted. Multiple automated multichannel tests performed on the same day combined for payment.
M76	Incomplete/invalid patient's diagnosis(es) and condition(s).
M77	Incomplete/invalid place of service(s).
M78	Did not complete or enter accurately an appropriate HCPCS modifier(s).
M79	Did not complete or enter the appropriate charge for each listed service.
M80	We cannot pay for this when performed during the same session as a previously processed service for the patient.
M81	Patient's diagnosis code(s) is truncated, incorrect or missing; you are required to code to the highest level of specificity.
M82	Service is not covered when patient is under age 50.
M83	Service is not covered unless the patient is classified as at high risk.
M84	Old and new HCPCS cannot be billed for the same date of service.
M85	Subjected to review of physician evaluation and management services.
M86	Service denied because payment already made for similar procedure within set time frame.
M87	Claim/service(s) subjected to CFO-CAP prepayment review.
M88	We cannot pay for laboratory tests unless billed by the laboratory that did the work.
M89	Not covered more than once under age 40.
M90	Not covered more than once in a 12 month period.
M91	Lab procedures with different CLIA certification numbers must be billed on separate claims.
M92	Services subjected to review under the Home Health Medical Review Initiative.
M93	Information supplied supports a break in therapy. A new capped rental period began with delivery of this equipment.
M94	Information supplied does not support a break in therapy. A new capped rental period will not begin.
M95	Services subjected to Home Health Initiative medical review/cost report audit.
M96	The technical component of a service furnished to an inpatient may only be billed by that inpatient facility. You must contact the inpatient facility for technical component reimbursement. If not already billed, you should bill us for the professional component only.
M97	Not paid to practitioner when provided to patient in this place of service. Payment included in the reimbursement issued the facility.
M98	Begin to report the Universal Product Number on claims for items of this type. We will soon begin to deny payment for items of this type if billed without the correct UPN.
M99	Incomplete/invalid/missing Universal Product Number.
M100	We do not pay for an oral anti-emetic drug that is not administered for use immediately before, at, or within 48 hours of administration of a covered chemotherapy drug.
M101	Begin to report a G1-G5 modifier with this HCPCS. We will soon begin to deny payment for this service if billed without a G1-G5 modifier.
M102	Service not performed on equipment approved by the FDA for this purpose.

M103   Information supplied supports a break in therapy. However, the medical information we have for this patient does not support the need for this item as billed. We have approved payment for this item at a reduced level, and a new capped rental period will begin with the delivery of this equipment.

M104   Information supplied supports a break in therapy. A new capped rental period will begin with delivery of the equipment. This is the maximum approved under the fee schedule for this item or service.

M105   Information supplied does not support a break in therapy.   The medical information we have for this patient does not support the need for this item as billed. We have approved payment for this item at a reduced level, and a new capped rental period will not begin.

M106   Information supplied does not support a break in therapy. A new capped rental period will not begin. This is the maximum approved under the fee schedule for this item or service.

M107   Payment reduced as 90-day rolling average hematocrit for ESRD patient exceeded 36.5%.

M108   Must report the PIN of the physician who interpreted the diagnostic test. (Substitute NPI for PIN when effective.)

M109   We have provided you with a bundled payment for a teleconsultation. You must send 25 percent of the teleconsultation payment to the referring practitioner.

M110   Missing/invalid provider number for the provider from whom you purchased interpretation services.(Substitute NPI for provider number when effective.)

M111   We do not pay for chiropractic manipulative treatment when the patient refuses to have an x-ray taken.

M112   The approved amount is based on the maximum allowance for this item under the DMEPOS Competitive Bidding Demonstration.

M113   Our records indicate that this patient began using this service(s) prior to the current round of the DMEPOS Competitive Bidding Demonstration. Therefore, the approved amount is based on the allowance in effect prior to this round of bidding for this item.

M114   This service was processed in accordance with rules and guidelines under the Competitive Bidding Demonstration Project. If you would like more information regarding this project, you may phone 1-888-289-0710.

M115   This item is denied when provided to this patient by a nondemonstration supplier.

M116   Even though this service is being paid in accordance with the rules and guidelines under the Competitive Bidding Demonstration, future claims may be denied when this item is provided this patient by a nondemonstration supplier. If you would like more information regarding this project, you may phone 1-888-289-0710.

M117   Not covered unless supplier files an electronic media claim (EMC).

M118   Letter to follow containing further information.

M119   National Drug Code (NDC) needed.

M120   Lacks UPIN of the substituting physician who furnished the service(s) under a reciprocal billing or locum tenens arrangement. (Substitute NPI for UPIN when effective.)

M121   We pay for this service only when performed with a covered cryosurgical ablation.

M122   Level of subluxation is missing or inadequate.
M123   Failed to submit the name, strength, or dosage of the drug furnished.
M124   Information to indicate if the patient owns the equipment that requires the part or supply was missing.
M125   Information about the period of time for which this will be needed was missing.
M126   The individual lab codes included in the test were not submitted.
M127   The patient's medical record for this service was not submitted with the claim as required.
M128   The date of the patient's most recent physician visit must be submitted.
M129   Indicator lacking that "X-ray is available for review."
M130   Invoice or statement certifying the actual cost of the lens, less discounts, or the type of intraocular lens used was missing.
M131   Completed physician financial relationship form not on file.
M132   Completed pacemaker registration form required.
M133   Claim did not identify who performed the purchased diagnostic test or the amount you were charged for the test.
M134   Performed by a facility/supplier in which the ordering/referring physician has a financial interest.
M135   Claim lacked indication that the plan of treatment is on file.
M136   Claim lacked indication that the service was supervised or evaluated by a physician.
M137   Part B coinsurance under a demonstration project.
M138   Patient identified as a demonstration participant but the patient was not enrolled in the demonstration at the time services were rendered. Coverage is limited to demonstration participants.
M139   Denied services exceed the coverage limit for the demonstration.
M140   Service not covered until after the patient's 50th birthday, i.e., no coverage prior to the day after the 50th birthday.
M141   Missing/incomplete/invalid physician certified plan of care.
M142   Missing/incomplete/invalid American Diabetes Association Certificate of Recognition to establish qualification.
M143   We have no record that you are licensed to dispensed drugs in the State where located.
M144   Pre-/post-operative care payment is included in the allowance for the surgery/procedure.

MA01   (Initial Part B determination, Medicare carrier or intermediary)--If you do not agree with what we approved for these services, you may appeal our decision. To make sure that we are fair to you, we require another individual that did not process your initial claim to conduct the review. However, in order to be eligible for a review, you must write to us within 6 months of the date of this notice, unless you have a good reason for being late.

        (Note: An intermediary must add: An institutional provider, e.g., hospital, SNF, HHA may appeal only if the claim involves a medical necessity denial, a SNF

recertified bed denial, or a home health denial because the patient was not homebound or was not in need of intermittent skilled nursing services, and either the patient or the provider is liable under §1879 of the Social Security Act, and the patient chooses not to appeal.)

(Note: Carriers who issue telephone review decisions should add: If you meet the criteria for a telephone review, you should phone this office if you wish to request a telephone review.)

MA02   (Initial Medicare Part A determination)--If you do not agree with this determination, you have the right to appeal. You must file a written request for a reconsideration within 60 days of receipt of this notification. Decisions made by a PRO must be appealed to that PRO. (An institutional provider, e.g., hospital, SNF, HHA, may appeal only if the claim involves a medical necessity denial, a SNF noncertified bed denial, or a home health denial because the patient was not homebound or was not in need of intermittent skilled nursing services, and either the patient or the provider is liable under §1879 of the Social Security Act, and the patient chooses not to appeal.)

MA03   (Medicare Hearing)--If you do not agree with the approved amounts and $100 or more is in dispute (less deductible and coinsurance), you may ask for a hearing. You must request a hearing within 6 months of the date of this notice. To meet the $100, you may combine amounts on other claims that have been denied. This includes reopened reviews if you received a revised decision. You must appeal each claim on time. At the hearing, you may present any new evidence which could affect our decision.

(Note: An Intermediary must add: An institutional provider, e.g., hospital, SNF, home health care, may appeal only if the claim involves a medical necessity denial, a SNF noncertified bed denial, or a home health denial because the patient was not homebound or was not in need of intermittent skilled nursing services, and either the patient or the provider is liable under §1879 of the Social Security Act, and the patient chooses not to appeal.)

MA04   Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible.

MA05   Incorrect admission date, patient status or type of bill entry on claim.

(Note: MA05 duplicates information in remark codes MA30, MA40 and MA43. Message MA05 is inactive effective with implementation of version 4010 of the X12 835. MA05 may not be used after that date.)

MA06   Incorrect/incomplete/missing beginning and/or ending date(s) on claim.

MA07   The claim information has also been forwarded to Medicaid for review.

MA08   You should also submit this claim to the patient's other insurer for potential payment of supplemental benefits. We did not forward the claim information as the supplemental coverage is not with a Medigap plan, or you do not participate in Medicare.

MA09   Claim submitted as unassigned but processed as assigned. You agreed to accept assignment for all claims.

MA10   The patient's payment was in excess of the amount owed. You must refund the overpayment to the patient.

MA11   Payment is being issued on a conditional basis. If no-fault   insurance, liability insurance, workers' compensation, Department of Veterans Affairs, or a group health plan for employees and dependents also covers this claim, a refund may be due us. Contact us if the patient is covered by any of these sources.

MA12   You have not established that you have the right under the law to bill for services furnished by the person(s) that furnished this (these) service(s).

MA13   You may be subject to penalties if you bill the patient for amounts not reported with the PR (patient responsibility) group code.

MA14   Patient is a member of an employer-sponsored prepaid health plan. Services from outside that health plan are not covered. However, as you were not previously notified of this, we are paying this time. In the future, we will not pay you for non-plan services.

MA15   Your claim has been separated to expedite handling. You will receive a separate notice for the other services reported.

MA16   The patient is covered by the Black Lung Program. Send this claim to the Department of Labor, Federal Black Lung Program, P.O. Box 828, Lanham-Seabrook MD 20703.

MA17   We are the primary payer and have paid at the primary rate. You must contact the patient's other insurer to refund any excess it may have paid due to its erroneous primary payment.

MA18   The claim information is also being forwarded to the patient's supplemental insurer. Send any questions regarding supplemental benefits to them.

MA19   Information was not sent to the Medigap insurer due to incorrect/invalid information you submitted concerning that insurer. Verify yourinformation and submit your secondary claim directly to that insurer.

MA20   SNF stay not covered when care is primarily related to the use of an urethral catheter for convenience or the control of incontinence.

MA21   SSA records indicate mismatch with name and sex.

MA22   Payment of less than $1.00 suppressed.

MA23   Demand bill approved as result of medical review.

MA24   Christian Science Sanitorium/SNF bill in the same benefit period.

MA25   A patient may not elect to change a hospice provider more than once in a benefit period.

MA26   Our records indicate that you were previously informed of this rule.

MA27   Incorrect entitlement number or name shown on the claim. Use the entitlement number or name shown on this notice for future claims for this patient.

MA28   Receipt of this notice by a physician or supplier who did not accept assignment is for information only and does not make the physician or supplier a party to the determination. No additional rights to appeal this decision, above those rights already provided for by regulation/instruction, are conferred by receipt of this notice.

MA29   Incomplete/invalid provider name, city, State, and zip code.
MA30   Incomplete/invalid type of bill.
MA31   Incomplete/invalid beginning and ending dates of the period billed.
MA32   Incomplete/invalid number of covered days during the billing period.
MA33   Incomplete/invalid number of noncovered days during the billing period.
MA34   Incomplete/invalid number of coinsurance days during the billing period.
MA35   Incomplete/invalid number of lifetime reserve days.
MA36   Incomplete/invalid patient's name.
MA37   Incomplete/invalid patient's address.

        (Note: When used, a payer must verify that an address, with city, State, and zip code, and a phone number are present.)
MA38   Incomplete/invalid patient's birthdate.
MA39   Incomplete/invalid patient's sex.
MA40   Incomplete/invalid admission date.
MA41   Incomplete/invalid type of admission.
MA42   Incomplete/invalid source of admission.
MA43   Incomplete/invalid patient status.
MA44   No appeal rights. Adjudicative decision based on law.
MA45   As previously advised, a portion or all of your payment is being held in a special account.
MA46   The new information was considered, however, additional payment cannot be issued. Review the information listed for the explanation.
MA47   Our records show you have opted out of Medicare, agreeing with the patient not to bill Medicare for services/tests/supplies furnished. As result, we cannot pay this claim. The patient is responsible for payment
MA48   Incomplete/invalid name and/or address of responsible party or primary payer .
MA49   Incomplete/invalid six-digit provider number of home health agency or hospice for physician(s) performing care plan oversight services.
MA50   Incomplete/invalid investigational device exemption number for FDA-approved clinical trial services.
MA51   Incomplete/invalid CLIA certification number for laboratory services billed by physician office laboratory.
MA52   Did not enter full 8-digit date (MM/DD/CCYY for paper form or CCYY/MM/DD for electronic format).
MA53   Inconsistent demonstration project information. Correct and resubmit with information on no more than one demonstration project.
MA54   Physician certification or election consent for hospice care not received timely.
MA55   Not covered as patient received medical health care services, automatically revoking his/her election to receive religious non-medical health care services.
MA56   Our records show you have opted out of Medicare, agreeing with the patient not to bill Medicare for services/tests/supplies furnished. As result, we cannot pay this claim. The patient is responsible for payment, but under Federal law, you cannot charge the patient more than the limiting charge amount.
MA57   Patient submitted written request to revoke his/her election for religious non-medical health care services.
MA58   Incomplete release of information indicator.

MA59   The patient overpaid you for these services. You must issue the patient a refund within 30 days for the difference between his/her payment and the total amount shown as patient responsibility on this notice.

MA60   Incomplete/invalid patient's relationship to insured.

MA61   Did not complete or enter correctly the patient's social security number or health insurance claim number.

MA62   Telephone review decision

MA63   Incomplete/invalid principal diagnosis code.

MA64   Our records indicate that we should be the third payer for this claim. We cannot process this claim until we have received payment information from the primary and secondary payers.

MA65   Incomplete/invalid admitting diagnosis.

MA66   Incomplete/invalid principal procedure code and/or date.

MA67   Correction to a prior claim.

MA68   We did not crossover this claim because the secondary insurance information on the claim was incomplete. Supply complete information or use the PLANID of the insurer to assure correct and timely routing of the claim.

MA69   Incomplete/invalid remarks.

MA70   Incomplete provider representative signature.

MA71   Incomplete/invalid provider representative signature date.

MA72   The patient overpaid you for these assigned services. You must issue the patient a refund within 30 days for the difference between his/her payment to you and the total of the amount shown as patient responsibility and as paid to the patient on this notice.

MA73   Informational remittance associated with a Medicare demonstration. No payment issued under fee-for-service Medicare as patient has elected managed care.

MA74   This payment replaces an earlier payment for this claim that was either lost, damaged or returned.

MA75   Our records indicate neither a patient's or authorized representative's signature was submitted on the claim. Since this information is not on file, resubmit.

MA76   Incomplete/invalid provider number of HHA or hospice when physician is performing care plan oversight services.

MA77   The patient overpaid you. You must issue the patient a refund within 30 days for the difference between the patient's payment less the total of our and other payer payments and the amount shown as patient responsibility on this notice.

MA78   The patient overpaid you. You must issue the patient a refund within 30 days for the difference between our allowed amount total and the amount paid by the patient.

MA79   Billed in excess of interim rate.

MA80   Informational notice. No payment issued for this claim with this notice. Payment issued to the hospital by its intermediary for all services for this encounter under a demonstration project.

MA81   Our records indicate neither a physician or supplier signature is on the claim or on file.

MA82   Did not complete or enter the correct physician/supplier's billing number/NPI and/or billing name, address, city, State, zip code, and phone number.

MA83   Did not indicate whether we are the primary or secondary payer. Refer to Item 11 in the HCFA-1500 instructions for assistance.

MA84   Patient identified as participating in the National Emphysema Treatment Trial but our records indicate that this patient is either not a participant, or has not yet been approved for this phase of the study. Contact Johns Hopkins University, the study coordinator, to resolve if there was a discrepancy.

MA85   Our records indicate that a primary payer exists (other than ourselves); however, you did not complete or enter accurately the insurance plan/group/program name or identification number. Enter the PlanID when effective.

MA86   Our records indicate that there is insurance primary to ours; however, you either did not complete or enter accurately the group or policy number of the insured.

MA87   Our records indicate that a primary payer exists (other than ourselves); however, you did not complete or enter accurately the correct insured's name.

MA88   Our records indicate that a primary payer exists (other than ourselves); however, you did not complete or enter accurately the insured's address and/or telephone number.

MA89   Our records indicate that a primary payer exists (other than ourselves); however, you did not complete or enter the appropriate patient's relationship to the insured.

MA90   Our records indicate that there is insurance primary to ours; however, you either did not complete or enter accurately the employment status code of the primary insured.

MA91   This determination is the result of the appeal you filed.

MA92   Our records indicate that there is insurance primary to ours; however, you did not complete or enter accurately the required information.

    (NOTE: Carriers must also add: Refer to the HCFA-1500 instructions on how to complete MSP information.)

MA93   Non-PIP claim.

MA94   Did not enter the statement "Attending physician not hospice employee" on the claim to certify that the rendering physician is not an employee of the hospice. Refer to item 19 on the HCFA-1500.

MA95   A "not otherwise classified" or "unlisted" procedure code(s) was billed, but a narrative description of the procedure was not entered on the claim. Refer to item 19 on the HCFA-1500.

MA96   Claim rejected. Coded as a Medicare Managed Care Demonstration but patient is not enrolled in a Medicare managed care plan.

MA97   Claim rejected. Does not contain the Medicare Managed Care Demonstration contract number, however, the beneficiary is enrolled in a Medicare managed care plan.

MA98   Claim rejected. Does not contain the correct Medicare Managed Care Demonstration contract number for this beneficiary.

MA99   Our records indicate that a Medigap policy exists; however, you did not complete or enter accurately any of the required information. Refer to the HCFA-1500 instructions on how to complete a mandated Medigap transfer.

MA100   Did not complete or enter accurately the date of current illness, injury or pregnancy.

MA101 A SNF is responsible for payment of outside providers who furnish these services/supplies to residents.

MA102 Did not complete or enter accurately the referring/ordering/supervising physician's/physician's assistant's, nurse practitioner's, or clinical nurse specialist's name and/or UPIN. (Substitute "NPI" for "UPIN" when effective.)

MA103 Hemophilia add on

MA104 Did not complete or enter accurately the date the patient was last seen and/or the UPIN of the attending physician. (Substitute "NPI" for "UPIN" when effective.)

MA105 Missing/invalid provider number for this place of service. Place of service code shown as 21, 22, or 23 (hospital). (Substitute "NPI" for provider number when effective.)

MA106 PIP claim

MA107 Paper claim contains more than three separate data items in field 19.

MA108 Paper claim contains more than one data item in field 23.

MA109 Claim processed in accordance with ambulatory surgical guidelines.

MA110 Our records indicate that you billed diagnostic test(s) subject to price limitations; however, you did not indicate whether the test(s) were performed by an outside entity or if no purchased tests are included on the claim.

MA111 Our records indicate that you billed diagnostic test(s) subject to price limitations and indicated that the test(s) were performed by an outside entity; however, you did not indicate the purchase price of the test(s) and/or the performing laboratory's name and address.

MA112 Our records indicate that the performing physician/supplier/practitioner is a member of a group practice; however, you did not complete or enter accurately their carrier assigned individual and group PINs. (Substitute "NPI" for "PIN" when effective.)

MA113 Incomplete/invalid taxpayer identification number (TIN) submitted by you per the Internal Revenue Service. Your claims cannot be processed without your correct TIN, and you may not bill the patient pending correction of your TIN. There are no appeal rights for unprocessable claims, but you may resubmit this claim after you have notified this office of your correct TIN.

MA114 Did not complete or enter accurately the name and address, the carrier assigned PIN, or the regional office assigned OSCAR number of the entity where services were furnished. (Substitute "NPI" for "PIN" when effective.)

MA115 Our records indicate that you billed one or more services in a Health professional shortage area (HPSA); however, you did not enter the physical location (name and address, or PIN) where the service(s) were rendered. (Substitute "NPI" for "PIN" when effective.)

MA116 Did not complete the statement "Homebound" on the claim to validate whether laboratory services were performed at home or in an institution.

MA117 This claim has been assessed a $1 user fee.

MA118 Coinsurance and/or deductible amounts apply to a claim for services or supplies furnished to a Medicare-eligible veteran through a facility of the Department of Veterans Affairs. No Medicare payment issued.

MA119 Provider level adjustment for late claim filing applies to this claim.

MA120 Did not complete or enter accurately the CLIA number.
MA121 Did not complete or enter accurately the date the x-ray was performed.
MA122 Did not complete or enter accurately the initial date "actual" treatment occurred.
MA123 Your center was not selected to participate in this study, therefore, we cannot pay for these services.
MA124 Processed for IME only.
MA125 Per legislation governing this program, payment constitutes payment in full.
MA126-127 Reserved for future use
MA128 Did not complete or enter accurately the six digit FDA approved, identification number.
MA129 This provider was not certified for this procedure on this date of service. Effective 1/1/98, we will begin to deny payment for such procedures. Contact to correct or obtain CLIA certification. (Claim processor must provide the name and phone number of the State agency to be contacted.)
MA130 Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Submit a new claim with the complete/correct information.
MA131 Physician already paid for services in conjunction with this demonstration claim. You must have the physician withdraw that claim and refund the payment before we can process your claim.
MA132 Adjustment to the pre-demonstration rate.
MA133 Claim overlaps inpatient stay. Rebill only those services rendered outside the inpatient stay.
MA134 Missing/incomplete/invalid provider number of the facility where the patient resides.

N1 You may appeal this decision in writing within the required time limits following receipt of this notice.
N2 This allowance has been made in accordance with the most appropriate course of treatment provision of the plan.
N3 Required/consent form incomplete, incorrect, or not on file.
N4 Prior insurance carrier EOB received was insufficient.
N5 EOB received from previous payer. Claim not on file.
N6 Under FEHB law (U.S.C. 8904(b)), we cannot pay more for covered care than the amount Medicare would have allowed if the patient were enrolled in Medicare Part A.
N7 Processing of this claim/service has included consideration under major medical provisions.
N8 Crossover claim denied by previous payer and complete claim data not forwarded. Resubmit this claim to this payer to provide adequate data for adjudication.
N9 Adjustment represents the estimated amount the primary payer may have paid.
N10 Claim/service adjusted because of the finding of a review organization/professional consult/manual adjudication.
N11 Denial reversed because of medical review.

N12   Policy provides coverage supplemental to Medicare. As member does not appear to be enrolled in Medicare Part B, the member is responsible for payment of the portion of the charge that would have been covered by Medicare.

N13   Payment based on professional/technical component modifier(s).

N14   Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.

N15   Services for a newborn must be billed separately.

N16   Family/member out-of-pocket maximum has been met. Payment based on a higher percentage.

N17   Per admission deductible.

N18   Payment based on the Medicare allowed amount.

N19   Procedure code incidental to primary procedure.

N20   Service not payable with other service rendered on the same date.

N21   Range of dates separated onto single lines.

N22   This procedure was added because it more accurately describes the services rendered.

N23   Patient liability may be affected due to coordination of benefits with primary carrier and/or maximum benefit provisions.

N24   Electronic funds transfer (EFT) banking information incomplete/invalid.

N25   This company has been contracted by your benefit plan to provide administrative claims payment services only. This company does not assume financial risk or obligation with respect to claims processed on behalf of your benefit plan.

N26   Itemized bill required for claim adjudication.

N27   Treatment number not indicated on claim.

N28   Consent form requirements not fulfilled.

N29   Required documentation/orders/notes/summary/report/invoice needed to adjudicate.

N30   Recipient ineligible for this service.

N31   Prescribing/referring/attending   practitioner   license   number   is absent/incorrect/incomplete.

N32   Provider performing service must submit claim.

N33   No record of health check prior to initiation of treatment.

N34   Incorrect claim form for this service.

N35   Program integrity/utilization review decision.

N36   Claim must meet primary payer's processing requirements before we can consider payment.

N37   Tooth number/letter required.

N38   Place of service missing.

N39   Procedure code is not compatible with tooth number/letter.

N40   Procedure requires x-ray.

N41   Authorization request denied. (Note: N41 duplicates reason code message 39. Message N41 is inactive effective with implementation of version 4010 of the X12 835. N41 may not be used after that date.)

N42   No record of mental health assessment.

N43   Bed hold or leave days exceeded.

N44   Payor's share of regulatory surcharges, assessments, allowances or health care-related taxes paid directly to the regulatory authority. (Note: N44 duplicates remark code message 137. Message N44 is inactive effective with implementation of version 4010 of the X12 835. N44 may not be used after that date.)

N45   Payment based on authorized amount.

N46   Missing/incomplete/invalid admission hour.

N47   Claim conflicts with another inpatient stay.

N48   Claim information does not agree with information received from other insurance carrier.

N49   Court ordered coverage information needs validation.

N50   Discharge information missing/incomplete/incorrect/invalid.

N51   Electronic interchange agreement not on file for provider/submitter.

N52   Patient not enrolled in the billing provider=s managed care plan on the date of service.

N53   Incomplete/invalid street, city, state and/or zip code for the point of pickup.

N54   Claim information is inconsistent with pre-certified/authorized services.

N55   Procedures for billing with group/referring/performing providers were not followed.

N56   Procedure code billed is not correct for the service billed.

N57   Missing/incomplete/invalid prescribing/dispensed date.

N58   Patient liability amount missing, invalid, or not on file.

N59   Refer to your provider manual for additional program and provider information.

N60   A valid NDC is required for payment of drug claims effective October 2002.

N61   Rebill services on separate claims.

N62   Inpatient admission spans multiple rate periods. Resubmit separate claims.

N63   Rebill services   on separate claim lines.

N64   The "from" and "to" dates must be different.

N65   Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider. Contact the Health Plan prior to refiling the claim.

N66   Claim lacks necessary documentation.

N67   Professional provider services not paid separately. Included in facility payment under a demonstration project. Apply to that facility for payment, or resubmit your claim if: the facility notifies you the patient was excluded from this demonstration; or if you furnished these services in another location on the date of the patient's admission or discharge from a demonstration hospital. If services were furnished in a facility not involved in the demonstration on the same date the patient was discharged from or admitted to a demonstration facility, you must report the provider ID number for the non-demonstration facility on the new claim.

N68   Prior payment being cancelled as we were subsequently notified this patient was covered by a demonstration project in this site of service. Professional services were included in the payment made to the facility. You must contact the facility for your payment. Prior payment made to you by the patient or another insurer for this claim must be refunded to the payer within 30 days.

N69   PPS code changed by claims processing system. Insufficient visits or therapies.

N70   Home health consolidated billing and payment applies. Ancillary providers/suppliers must contact the HHA for reimbursement.

N71   Your unassigned claim for a drug or biological was processed as an assigned claim. The law requires you must take assignments on all claims for drugs and biologicals.

N72   PPS code changed by medical reviewers. Not supported by clinical records.

N73   A SNF is responsible for payment of outside providers who furnish these services/supplies to residents.

N74   Resubmit with multiple claims, each claim covering services provided in only one calendar month

N75   Missing or invalid tooth surface information

N76   Missing or invalid number of riders (for ambulance services)

N77   Missing or invalid designated provider number

N78   The necessary components of the child and teen checkup (EPSDT) were not completed.

N79   Service billed is not compatible with patient location information

N80   Missing or invalid prenatal screening information

N81   Procedure billed is not compatible with tooth surface code

N82   Provider must accept insurance payment as payment in full when a third party payer contract specifies full reimbursement.

N83   No appeal rights. Adjudicative decision based on the provisions of a demonstration project.

N84   Further installment payments forthcoming.

N85   Final installment payment.

N86   A failed trial of pelvic muscle exercise training is required in order for biofeedback training for the treatment of urinary incontinence to be covered.

N87   Home use of biofeedback therapy is not covered.

N88   This payment is being made conditionally. An HHA episode of care notice has been filed for this patient. When a patient is treated under a HHA episode of care, consolidated billing requires that certain therapy services and supplies, such as this, be included in the HHA's payment. This payment will need to be recouped from you if we establish that the patient is concurrently receiving treatment under a HHA episode of care.

N89   Payment information for this claim has been forwarded to more than one other payer, but format limitations permit only one of the secondary payers to be identified in this remittance advice.

REQUESTS FOR ADDITIONAL CODES

HCFA has national responsibility for maintenance of the remittance advice remark codes. Requests for new or changed remark codes should be submitted to HCFA via the Washington Publishing Company webpage remark code request function. Requests for codes must include the name, phone number, company name, and e-mail address of the requestor, the suggested wording for the new or revised message, and an explanation of how the message will be used and why it is needed.   A fax number or mail address is acceptable in the absence of an e-mail address. Requests may also be mailed to: Health Care Financing Administration, OIS/SSG/DHCISS, Mail Stop N2-14-26, 7500 Security Blvd., Baltimore MD 21244-1850. HCFA expects to issue a response to most remark message requests within 2 weeks of receipt.

CARRIER NAME
ADDRESS 1
ADDRESS 2
CITY, STATE ZIP
(9099) 111-2222

**MEDICARE
REMITTANCE
NOTICE**

PERF PROV	SERV DATE	POS	NOS	PROC	MODS	BILLED	ALLOWED	DEDUCT	COINS	PROV PD	RC-AMT

NAME LLLLLLLLLLLL, FFFFFFFF HIC 123456789012 ACNT *12345678901234567890* ICN 123456789012345 ASG X MOA 11111 22222
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PT RESP 12345.12   CLAIM TOTALS 1234567.12 1234567.12 1234.12 12345.12   1234567.12 1234567.12 NET
ADJS: PREV PD 1234567.12   PD TO BENE 1234567.12   INT 1234567.12   MSP 1234567.12   OTHER RRRRRR 1234567.12
CLAIM INFORMATION FORWARDED TO： XXXXXXXXXXXXXXXXXXXXXXXX   RRRRRR 1234567.12
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