

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1802	Date: August 28, 2009
	Change Request 6577

SUBJECT: Expansion of the Number of Services Fields in Medicare Summary Notices (MSNs)

I. SUMMARY OF CHANGES: This change request updates the MSN to expand the services provided field from three bytes to six bytes.

NEW/REVISED MATERIAL

EFFECTIVE DATE: JANUARY 1, 2010

IMPLEMENTATION DATE: JANUARY 4, 2010

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

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)

R=REVISED, N=NEW, D=DELETED

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	21/10.3.6/Claims Information Section

III. FUNDING:

SECTION A: For Fiscal Intermediaries and Carriers:

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

SECTION B: For Medicare Administrative Contractors (MACs):

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

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 1802	Date: August 28, 2009	Change Request: 6577
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SUBJECT: Expansion of the Number of Services Fields in Medicare Summary Notices (MSNs)

Effective Date: January 1, 2010

Implementation Date: January 4, 2010

I. GENERAL INFORMATION

A. Background: The Administrative Simplification provisions of Health Insurance Portability and Accountability Act (HIPAA) require the Secretary of Health and Human Services (HHS) to adopt standard electronic transactions and code sets for administrative healthcare transactions. The Secretary may also modify these standards periodically.

Under Transmittal 350, Change Request (CR) 6059, dated June 6, 2008, (CIP Expansion) in the January 09 Release, ViPS expanded the number of services field within VMS from 3 whole digits (e.g. 999) to 4 whole digits and 1 decimal place (e.g. 9999.9). This only expanded the size of the field on the file; it did not include changes to process with this expanded field. The system cannot actually be modified to process values greater than 3 whole digits until all downstream/outbound transactions are modified to accommodate the larger values. Otherwise the number of services values would be truncated on those transactions.

Those downstream/outbound transactions include CWF, the SPR, CERT, and the MSN. The changes to CWF to accommodate the larger number of services values, as well as other changes related to the new transaction versions were made under Transmittal 422, CR 6225, dated December 24, 2008. The changes to the SPR to accommodate the larger number of services values, as well as other changes related to the new transaction versions were made under Transmittal 511, CR 6376, dated July 1, 2009. This CR increases the number of services field in the MSN from three to six bytes.

B. Policy: The Administrative Simplification provisions of HIPAA require the Secretary of HHS to adopt standard electronic transactions and code sets for administrative health care transactions. The Secretary may also modify these standards periodically.

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)								
		A / B M A C	D M A C	F I	C A R I E R	R H H I	Shared-System Maintainers			
						F I S S	M C S	V M S	C W F	
6577.1	Shared system maintainers shall expand the number of services field from 3 bytes (e.g. 999) to 6 bytes (e.g., 9999.9).						X	X		

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B M A C	D M E M A C	F I	C A R R I E R	R H H I	Shared-System Maintainers				OTHER
							F I S S	M C S	V M S	C W F	
	None										

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements:

X-Ref Requirement Number	Recommendations or other supporting information:
6577.1	CR 6059, CR 6225, CR 6376

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s):

MSNs: Scott Schiller at scott.schiller@cms.hhs.gov or (410) 786-4514
 Systems: Sumita Sen at sumita.sen@cms.hhs.gov or (410) 786-5755

Post-Implementation Contact(s):

MSNs: Scott Schiller at scott.schiller@cms.hhs.gov or (410) 786-4514
 Systems: Sumita Sen at sumita.sen@cms.hhs.gov or (410) 786-5755

VI. FUNDING

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

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

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

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

10.3.6 - Claims Information Section

(Rev.1802, Issued: 08-28-09, Effective: 01-01-10, Implementation: 01-04-10)

A. General Information About the “Claims Information” Section

The claims information section contains the following elements:

- For Intermediaries:
 - Program Status Line ("Part A Hospital Insurance - Inpatient Claims" or "Part B Medical Insurance - Outpatient Facility Claims" or "Home Health Facility Claims" or "Hospice Facility Claims")
 - Column Heading
 - Claim Number
 - Provider's Name and Address
 - Attending/referring Physician's Name
 - Service Line Details
 - Claims Totals
 - Alphabetic Codes for "Notes"
 - The name and address of the billing provider includes the provider's name and complete address. Below the billing provider's name and address, if applicable, show "referred by the full name of the attending physician."
 - Claims should be displayed by billing provider in alphabetic order.
 - For multiple claims from one billing provider, sort claims chronologically by service.
 - Use standard abbreviation of Revenue Codes provided by the National Uniform Billing Committee and do not change wording.
 - If HCPCS are shown, use short description of services provided by CMS. If the descriptor is used, do not show the revenue code descriptor.

For Carriers - Part B Medical Insurance:

Except for the header and the provider name(s) and address(es), which are fixed, the data in Area II can vary in length. Area II contains the following elements:

- o Control number(s),
- o Provider name(s) and address(es),
- o Service or line item detail, and
- o Alphabetic note codes.

B. Technical Specifications for “Claims Information” Section For Intermediaries:

Program Status Line

- For inpatient claims print “PART A HOSPITAL INSURANCE - INPATIENT CLAIMS” in uppercase equivalent to 12-point bold type;
- For outpatient claims, print “PART B MEDICAL INSURANCE – OUTPATIENT FACILITY CLAIMS” in uppercase equivalent to 12-point bold type;
- For home health Part A claims, print “PART A - HOME HEALTH FACILITY CLAIMS”;
- For hospice claims, print “Part A - HOSPICE FACILITY CLAIMS.”

Allow equivalent to 10-point blank line.

Print a box equivalent to a 1-point line around the following claims information. The box will be variable in length depending on the number of claims displayed. There is a 1-byte margin between the claims information box line and the beginning and ending of printed information. There is a 1-byte space between columns. Print the column headings in mixed case type, equivalent to 10-point bold type, using 3 lines as in the exhibits.

Dates of Service - The “Dates of Service” column is 17 bytes wide. Center the column heading within the first 7 bytes.

Services Provided - Use for outpatient claims only. The “Services Provided” column is 45 bytes wide. Print the column heading flush left in the column.

Number of Services Provided - Use for Home Health claims. The “Number of Services Provided” column is 45 bytes wide. Print the column heading flush left in the column.

Benefit Days Used - Use for inpatient claims only. The “Benefit Days Used” column is 11 bytes wide. Print the column flush right.

Amount Charged - Used for Outpatient and Home Health Claims Only - The “Amount Charged” column is 11 bytes wide. Print the column heading flush right in the column.

Noncovered Charges - The “Noncovered Charges” column is 11 bytes wide. Print the column heading flush right in the column.

Deductible and Coinsurance - Used for Inpatient and Outpatient Claims - The “Deductible and Coinsurance” column is 10 bytes wide. Center the column heading. (For Home Health claims, the title is “Coinsurance”).

You May Be Billed - The “You May Be Billed” column is 10 bytes wide. Center the column heading.

See Notes Section - The “See Notes Section” is 7 bytes wide. Center the column heading.

Print a horizontal equivalent to 1-point line extending from left to right margin between the column headings and the claim(s) information.

Allow equivalent to 10-point blank line.

Print claim information within the box as follows:

- The claim number spans the “Dates of Service” and “Services Provided” columns. Do not extend information into the “Amount Charged” column.
 - Print “Claim number” in mixed case equivalent to 10-point mixed case followed by the actual claim number on the line directly above the provider name and address.
- The provider information spans the “Dates of Service” and “Services Provided” columns. Do not extend information into the “Amount Charged” column.
 - Print the billing provider name and mailing address in mixed case equivalent to 10-point bold type. Billing provider name and address should be separated by commas. Use the physical address of the billing provider if it is different from the mailing address. If possible, print this information on one line. Additional lines, if necessary, should be indented five bytes. For carriers, when using degree (e.g. M.D.) with provider name, place a period after the “M” and after the “D.”
 - Print “Referred by:” followed by the attending physician’s name and degree (if applicable) in mixed case equivalent to 10-point type. When printing degree (e.g., M.D.) with provider name, place a period after the “M” and after the “D.” Referring physician name and degree should be separated by a comma. If the UPIN submitted on the claim is not on file, use the name as shown on the claim. Suppress the “Referred by:” line if not able to identify the doctor. For carriers, if the referring physician is the same as any performing physician on the claim, suppress the referring physician line. If the UPIN submitted on the claim is not on the contractor’s file, suppress the “Referred by:” line. For clinic or group practice billing, print the performing physician’s name in mixed case equivalent to 10-point type immediately before the services the physician performed.

- Dates of Service - Print service line dates in mm/dd/yyyy format in “Dates of Service” column in mixed case equivalent to 10-point type, left justified. If services extend over several days, use a hyphen or dash to show the extension (mm/dd/yyyy - mm/dd/yyyy).
- The “Services Provided” column contains the HCPCS short descriptor in mixed case equivalent to 10-point type followed by code in parenthesis or revenue code descriptor. If no HCPCS code is present, show the revenue code standard abbreviation as defined by the National Uniform Billing Committee, left justified (bytes 1-47 are reserved for these descriptions). Print each service description on no more than 1 line, on the same line horizontally as the date of service.
- Number of Services Provided - The “Number of Services Provided” column is the revenue code standard abbreviation as defined by the National Uniform Billing Committee, preceded by the number of units, both of which are in mixed case to 10 point type. If a HCPCS code is present, the HCPCS short descriptor will be used. Left justify (bytes 1-45 are reserved for this element). Print each “Number of Services Provided” in no more than one line, on the same line horizontally as the “Date of Service.”
- Benefit Days Used - This column will show the number of days used during the hospital or skilled nursing facility admission (i.e., 12 days) Use case equivalent to 10 point type. Left justify (bytes 1-11 are reserved for this). Print each “Benefit days Used” in no more than one line on the same line horizontally as “Date of Service.”
- Align all dollar amounts appearing in the “Claim Information Box” by decimal. For zero dollar amounts, show “0.00.” Print all dollar amounts in mixed case equivalent type.
- Amount Charged - Show the submitted charge for each service line. Print a dollar sign on the first service line. Right justify all charges. This detail is not shown on Part A inpatient (hospital or SNF) claims. Print in mixed case equivalent to 10-point type.
- Noncovered Charges - Show the noncovered amount for each service line. Print a dollar sign on the first service line. Right justify all charges. Noncovered services will include beneficiary liable as well as provider liable charges.
- Deductible and Coinsurance - Show the “Deductible and Coinsurance” applicable for each service line. Print a dollar sign on the first service line. Right justify all amounts. Carriers show deductible and coinsurance with a message in the “Notes” section.
- You May Be Billed - Show the beneficiary liability for each service line. Print a dollar sign on the first service line. Right justify all amounts. Print in mixed case equivalent to 10-point type.
- See Notes Section - Enter lowercase “a” for the first item that requires an explanation. Place “a” and the appropriate message from §50 in the “See Notes Section” box. If the same message is needed for more than one claim or service line, print the same alphabetic code each

time the message is required on the MSN. Print alphabetic codes in mixed case equivalent to 10-point type.

- o If the contractor's system provides a second message for the same item, print the letter "b" in lowercase equivalent to 10-point type preceded by a comma. Show no more than three alphabetic codes per line.

- o For all remaining claims on the MSN, if a claim or service line requires a message, use the next available lowercase alphabetic code.

- o Print alphabetic codes for claim level notes in bold in the "See Notes Section" column on the same line as the billing provider's name. The next 3 codes will be directly below the first 3, which places them on the same line as the billing provider's street address. Print alphabetic codes for service lines in the "See Notes Section" column on the same line as the service. If more than 3 codes for line level, print on the next line below. Print alphabetic codes flush left. If more than 26 lower case alphabetic codes are used, begin using uppercase alphabetic codes.

- Claim Total Line - Indent 12 bytes and print in mixed case type equivalent to 10-point bold "Claim Total." Print the "Claim Total" line only for claims with more than one service line.

- o Total the amounts in each column and print the sum right justified and equivalent to 10-point bold type. Print a dollar sign preceding the total in each column. The total amount in the "Medicare Paid You" column includes all interest paid to the beneficiary for that claim.

- Print a horizontal line 1/16-inch wide in 20 percent shading extending from left to right margin on the claim information box. Print this shaded line between each claim shown on the MSN. Do not print the shaded line under the last claim displayed in the "Claims Information Section." Do not print the shaded line if only one claim is displayed on the MSN.

For Carriers:

Carriers print in the following order:

1. Horizontal line (0.048" wide extending from left to right margin).
2. In 10 point bold type, show "Details about this notice. (See the back for more information.)" Print this text in 10% shading.
3. Horizontal line (0.008" wide extending from left to right margin).
4. Display the provider name(s) and address(es), control number(s) (break control numbers into segments (see sample)), headings, and service detail according to the rules described below. The length and appearance of the service display will vary according to whether the MSN is for an assigned or unassigned claim. Print all of this information in 10 point type and bold where indicated.

For assigned claims (one billing provider, possibility of multiple control numbers), print, under the horizontal line, the following information in this order:

- o “BILL SUBMITTED BY:”, in all uppercase letters in 10 point bold type;
- o On the same line starting one half inch beyond the end of “BILL SUBMITTED BY:”, print the name of the provider. When using “M.D.” with the provider name, place a period after the “M” and after the “D.”
- o Directly underneath the words “BILL SUBMITTED BY:” print the words “Mailing address:” Print the address directly underneath the name of the provider and on a single line, if possible.
- o If the service was provided at a clinic/group practice that bills for its physicians, show the clinic/group practice name; and
- o If a solo practicing physician performed the service(s), show his/her name and complete mailing address.

For clinic/group practice billing, show the performing physician’s name as follows:

- Blank line;
- Print the following headings in 10 point bold:
 - o Dates;
 - o Services and Service Codes;
 - o Charge;
 - o Medicare Approved; and
 - o See Notes Below.

Print the “Dates” heading aligned with the left margin. Print the “Services and Service Codes” heading aligned with the provider name and mailing address. Use appropriate spacing as shown in Exhibits 1, 2, and 3 to print the remaining headings on the same line.

The information printed under each heading is described later in this section.

- Control number in 10 point bold type;
- Performing physician’s full name in 10 point bold type;

- Service items for performing physician;
- Blank line;

- If there is only one control number and one provider: after all of the service items have been listed, sum the charged and approved amounts to derive a total. Print a “+” beside the “charge” and “approved” amounts of the last line item and underline. Print “Total” in 10 point bold type face aligned with the left edge of the summary box found in area I and print the totals for the “Charge” and “Medicare Approved” columns. A “\$” is printed before each dollar total.

Use the totals of the “Charge” and “Medicare Approved” columns in the summary block in Area I. Also, use the total “Medicare Approved” amount in Area IV.

Suppress “Total” if only one line item appears on the MSN. There is no need to total one line item.

NOTE: For multiple control numbers and providers, do not follow the directions in number 8. until all control numbers, providers, and service items have been listed. For multiple performing physicians under the same control number, repeat numbers 5., 6., and 7. until all performing physicians’ names and service items have been listed. For multiple control numbers, repeat numbers 4., 5., 6., and 7. until the performing physicians names and service items for all control numbers have been printed. After the last provider’s services have been listed for the last control number, sum the charged and approved amounts. Do not leave a blank line between the last service item and the “Total.”

For unassigned claims (one control number, possibility of multiple providers), print, under the horizontal line, the following information in this order:

- Control number in 10 point bold type;
- Blank line;
- "BILL SUBMITTED BY:", in all uppercase letters in 10 point bold type;
- On the same line, one half inch beyond the end of “BILL SUBMITTED BY:”, print the name of the physician/supplier providing the medical service or supplies. Directly beneath the words “BILL SUBMITTED BY:” print the heading: “Mailing address:". Print the mailing address directly underneath the name of the physician/supplier. Print this information in no more than two lines.
- If the service was provided at a clinic/group practice that bills for its physicians, show the clinic/group practice name; and
- If a solo practicing physician performed the services, show his/her name and complete mailing address.

For clinic/group practice billing, show the performing physician's name immediately before the services he/she performed in 10 point bold type as directed below. If the system does not carry the clinic/group name for unassigned claims, show the performing provider's name in place of the clinic/group name followed by the clinic/group address.

- Blank line.
- Print the following headings in 10 point bold underlined:
 - Services and Service Codes,
 - Dates,
 - Charge,
 - Medicare Approved, and
 - See Notes Below.

Print the "Dates" heading aligned with the left margin. Print the "Services and Service Codes" heading aligned with the provider/supplier name and address. Use appropriate spacing as shown in Exhibits 1, 2 and 3 to print the remaining headings on the same line.

The information printed under each heading is described later in this section.

- Print the performing physician's name in 10 point bold type if the provider is a clinic. List all service items in chronological order for that physician. For each performing physician billed by a clinic, list his/her name in 10 point bold type followed on the next line by the service item(s). Generally there is only one provider. If so, after all of the service items have been listed, sum the charged and approved amounts to derive a total. Print a "+" beside the "charge" and "approved" amounts of the last line item and underline. Print "Total" in 10 point bold type face aligned with the left edge of the area I summary box and print the totals for the "Charge" and "Medicare Approved" columns. Print a "\$" before each dollar total.

Use the totals of the "Charge" and "Medicare Approved" columns in the summary block in Area I. Also, use the total "Medicare Approved" amount in Area IV.

Suppress "Total" if only one line item appears on the MSN. There is no need to total one line item.

NOTE 1: For multiple providers (when beneficiaries submit claims, see Note 2), do not print the totals until all providers and service items have been listed. For each provider, print the information shown above for unassigned claims. After the last provider's services have been listed, sum the charge and approved amounts. Do not leave a blank line between the last service item and "Total".

NOTE 2: Unassigned claims are submitted by providers and should, therefore, be one claim to one MSN. However, produce an MSN showing multiple providers when beneficiaries have submitted claims. Generate these when:

- o Services were provided before September 1, 1990;
- o Services were not covered by Medicare and beneficiaries want a formal coverage determination;
- o Physicians or suppliers refuse to submit claims for services on or after September 1, 1990;
- o Services were provided outside the United States;
- o Used DME is purchased from a private source; or
- o Medicare is secondary payer.

- Aligned with the left margin, print the following statement in 10 point bold type: “Your provider(s) did not accept assignment. We are paying you the amount that we owe you. See #4 on the back.” (NOTE: print this statement on a single line preceded by a blank line). Do not print the “We are paying you the amount that we owe you” portion of the message when no payment is made.

The data printed under each of the headings mentioned above are described here. Print each service, code, date, charge, approved amount and notes on one line.

The “Services Provided” column contains the number of services, HCPCS code short descriptor, procedure code, and modifiers. Print in mixed case equivalent to 10-point type. The first 6 bytes are fixed and reserved for the number of services. Right justify the number of services within these 6 bytes. Byte 7 is a space. Bytes 8 through 47 are reserved for the HCPCS short descriptors, procedure codes and modifiers. Print each service description in no more than 1 line in mixed case equivalent to 10-point type. Follow the descriptor by procedure code, and modifier(s) if necessary, in parentheses. The carrier separates procedure codes and modifiers with a dash.

Print the following modifier descriptors on the next line when applicable. When printing a modifier descriptor, drop the procedure code and its modifier(s) to the line with the modifier descriptor. Begin printing the procedure code directly under the short descriptor. The modifier descriptor should follow immediately after the procedure code.

Services and applicable modification codes and descriptions are shown in the following table.

Service	Modifier Code	Modifier Description on MSN(s)
Assistant surgery	80, 81, and 82	Assistant surgeon
Professional component	26	Professional charge
Technical component	TC	Technical charge
DME rental	RR	Rental
DME purchase	NR	Purchase
DME maintenance/service	MS	Maintenance/service
DME replacement/repair	RP	Replacement/repair
Post-op care	55	Care after operation
Pre-op care	56	Care before operation
Ambulatory surgical center fees	SG	Surgery center fee

NOTE FOR DME MACs: If there are three or more modifiers, drop the procedure code and its modifiers to the next line. Begin printing the procedure directly under the short descriptor. The modifier descriptor should follow immediately after the procedure code.

Dates - Use the first three letters of the month name as a three letter abbreviation for the month. If the services extended over several days or into the following month, use a “-” to show the extension.

Charges - Show submitted charge(s). Print the dollar sign on the first line. After of the service items have been listed, sum the charges to derive a total. Print a “+” beside the charge for the last line item and underline.

Medicare Approved - Show the fee schedule amount or approved charge. For claims involving psychiatric outpatient services, print the approved amount before the psychiatric reduction. Print the dollar sign on the first line. After all of the service items are printed, sum the charges to derive a total. Print a “+” beside the charge for the last line item and underline.

See Notes Below - Print the heading if there are any explanatory notes. Suppress the heading if the MSN does not require notes.

Enter “a” for the first line item which requires explanation. See [§30.2](#) for a list of the notes to be used on the MSN. Place “a” and the appropriate explanation from §30.2 under “Notes.” If another line item is reduced or disallowed for the same reason, also print “a” beside this line item. If the system provides a second explanation for this line item, print the letter “b”, preceded by a comma. Enter the explanation from §30.2 in the “Notes” section. Show no more than 5 alphabetic codes and notes per line.

Print notes pertaining to a single line by entering the alphabetic code in the “Notes” column to the right of the line. When there is more than one claim on the MSN, print notes pertaining to a single claim to the right of the claim control number. Print notes pertaining to all claims to the right of the “Total” amount.

- Horizontal line (0.018” wide extending from left to right margin). If Area III starts on a subsequent page, do not print this horizontal line.

Align all dollar amounts appearing in Area II by decimal. For zero dollar amounts, show “0.00”.

Additional Claims Information Specifications

- The contractor may split a claim between pages if the claim is more than 10 lines long. If there is insufficient space to print at least 5 lines, do not split the claim. Put the claim on the next page.

- If there is a need to continue the “Claims Information Box” past the first page, print the program status line on the top of continuing pages in the upper left corner below the header, followed by “(continued)” equivalent to 12-point bold lower case type.

- Repeat column headings and line specifications according to the preceding instructions.
- Allow 1 equivalent to 12-point blank line between claims information and beginning of notes section.

- (CARRIERS ONLY): If no “Notes” section is printed, the blank line should precede the section that follows. When a single MSN contains both assigned and unassigned claims, each claim type should be displayed in its appropriate box. The boxes should follow directly after each other. Allow one 12-point blank line between the bottom line of the first box and the assignment status line of the second box. Each box should be created following the specifications in this section. When assigning alphabetic codes for the “See Notes Section” column, if the same message is needed in both the assigned and unassigned claims information boxes, print the same alphabetic code each time the message is required. When a claim in the second claims information box requires a new message, use the next available alphabetic code after the last code used in the preceding box.

- The MSN may be split if more than 99 claims are processed in one 30-day period or if more than 99 no-pay claims are processed in one 90 day period.

Do not print claims denied as duplicates.