

**ANSI X12N 835 VERSION 4010 & 4010A1
MEDICARE HIPAA COMPANION DOCUMENT
Fiscal Intermediaries
(As of 6/1/2006)**

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 4010A1 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 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/ 835 and Medicare Requirements/Notes
Data Elements

Envelope

ISA	Required
ISA01	Required. Enter 00 pending establishment of HIPAA security requirements for transmissions. Translator Generated (TG)
ISA02	Required. Enter 10 blank spaces pending establishment of HIPAA security requirements. TG
ISA03	Required. Enter 00 pending establishment of HIPAA security requirements. TG
ISA04	Required. Enter 10 blank spaces pending establishment of HIPAA security requirements. TG
ISA05	Required. Enter ZZ as Medicare trading partners will always mutually decide on the interchange sender ID to be used. TG
ISA06	Required. Mapped to flat file (ff) record 1, field 1.

ISA07	Required. The type of number used for receiver identification is individually negotiated between trading partners. Enter 29 if using the NPI number, when effective, as the qualifier. Enter ZZ, mutually defined, if using an alternate locally defined qualifier. Alternately, one of the other qualifiers permitted in the IG can be used if trading partners choose one of those means of identification. TG
ISA08	Required. The number must be locally determined. TG
ISA09	Required. Enter the transmission date. TG
ISA10	Required. Enter the transmission time. TG
ISA11	Required. TG
ISA12	Required. TG
ISA13	Required. TG
ISA14	Required. Enter 0. TG
ISA15	Required. Mapped to ff record 1, field <u>13</u> .
ISA16	Required. Locally determined, but “>” is recommended as the delimiter symbol. TG
IEA	Required.
IEA01	Required. TG
IEA02	Required. TG
GS	Required
GS01	Required. TG
GS02	Required. Mapped to ff record 1, field 1.
GS03	Required. The receiver’s code is established in the trading partner agreement. It may be the provider # (mapped to ff record 1, field 3), the provider chain ID # (mapped to ff record 1, field 2), the VAN ID # (in local records, TG), or the EDI submitter # (in local records, TG).
GS04	Required. TG
GS05	Required. TG
GS06	Required. TG

GS07 Required. TG
GS08 Required. TG

Table 1, Header Data

ST Required.
ST01 Required. Always enter “835.” TG

ST02 Required. TG

BPR Required.
BPR01 Required. Codes U and X do not apply to Medicare. Mapped to ff record 1, field 14.

BPR02 Required. Mapped to ff record 1, field 15.

BPR03 Required. Code D does not apply to Medicare. Mapped to ff record 1, field 16.

BPR04 Required. Codes BOP and FWT do not apply to Medicare. Mapped to ff record 1, field 17.

BPR05 Situational, but required for Medicare if ACH is entered in BPR04. Mapped to ff record 1, field 18.

BPR06 Situational, but required for Medicare if ACH in BPR04. Code 04 does not apply to Medicare. Mapped to ff record 1, field 19.

BPR07 Situational, but required for Medicare if ACH in BPR04. Mapped to ff record 1, field 20.

BPR08 Situational, but required for Medicare if ACH in BPR04. Mapped to ff record 1, field 21.

BPR09 Situational, but required for Medicare if ACH in BPR04. Mapped to ff record 1, field 22.

BPR10 Situational, but required for Medicare if ACH in BPR04. Mapped to ff record 1, field 23.

BPR11 Situational, but required for Medicare when BPR10 is used. Mapped to ff record 1, field 34. BPR11 and TRN04 must be identical.

BPR12 Situational, but required for Medicare if ACH in BPR04. Code 04 does not apply to Medicare. Mapped to ff record 1, field 24.

BPR13	Situational, but required for Medicare if ACH in BPR04. Mapped to ff record 1, field <u>25</u> .
BPR14	Situational, but required for Medicare if ACH in BPR04. Mapped to ff record 1, field <u>26</u> .
BPR15	Situational, but required if ACH in BPR04. Mapped to ff record 1, field <u>27</u> .
BPR16	Required. Mapped to ff record 1, field <u>28</u> .
BPR17-21	Not used.
TRN	Required.
TRN01	Required. Mapped to ff record 1, field <u>29</u> .
TRN02	Required. If no payment is issued, insert the remittance advice number. Mapped to ff record 1, field <u>30</u> and <u>31</u> .
TRN03	Required. TRN03 must =BPR10. Mapped to ff record 1, field <u>23</u> .
TRN04	Situational, but required for Medicare when BPR10 is used. Mapped to ff record 1, field 34. BPR11 and TRN04 must be identical.
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 payee.
REF01	Required. Always enter "EV." TG
REF02	Required. Must correspond to entry in ISA08. Mapped to ff record 1, field 2.
REF03-04	Not used.
REF (060.B)	Situational, but does not apply to Medicare intermediaries.
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. Mapped to ff record 1, field <u>32</u> .
DTM02	Required. Mapped to ff record 1, field <u>33</u> .
DTM03-06	Not used.
N1 (080.A)	Required for payer identification.
N101	Required. Mapped to ff record 10, field <u>13</u> .

N102	Situational, but required for Medicare. Mapped to ff record 10, field <u>14</u> .
N103	Situational. Always enter “XV” in this loop when the PlanID is effective, but not used prior to that date. Mapped to ff record 10, field <u>15</u> .
N104	Situational, but required once the PlanID is effective. Mapped to ff record 10, field <u>16</u> .
N105-106	Not used.
N3 (100)	Required for payer identification.
N301	Required. Mapped to ff record 10, field <u>17</u> .
N302	Situational in the 835, but required by Medicare if there is more than 1 address line for the payer, such as for a suite number. Mapped to ff record 10, field <u>18</u> .
N4 (110)	Required for payer identification.
N401	Required. Mapped to ff record 10, field <u>19</u> .
N402	Required. Mapped to ff record 10, field <u>20</u> .
N403	Required. Mapped to ff record 10, field <u>21</u> .
N404-406	Not used.
REF (120.A)	Situational. Required for Medicare prior to the effective date of the PlanID. After that date, a Medicare payer may use at its option in addition to the PlanID in the 060 REF.
REF01	Required. Enter 2U; EO, HI, and NF do not apply to Medicare. Mapped to ff record 10, field <u>22</u> .
REF02	Required. Mapped to ff record 10, field <u>23</u> .
REF03-04	Not used.
PER (130)	Situational, but will not be used by Medicare.
N1 (080.B)	Required to identify the payee.
N101	Required. Mapped to ff record 15, field <u>13</u> .
N102	Situational, but reporting of the payee’s name is required for Medicare prior to the effective date of the NPI. Mapped to ff record 15, field <u>14</u> .
N103	Required. Always enter “FI” until the NPI is effective. After that date, always enter “XX.” Mapped to ff record 15, field <u>15</u> .

N104	Required. Payee’s TIN for qualifier FI mapped to ff record 15, field <u>24</u> . NPI, when effective, mapped to ff record 15, field <u>16</u> .
N105-106	Not used.
N3 (100.B)	Situational, but required for Medicare if data reported in the N1 segment for this loop.
N301	Required. Mapped to ff record 15, field <u>17</u> .
N302	Situational, but required if this segment is used and there is a second payee address line. Mapped to ff record 15, field <u>18</u> .
N4 (110.B)	Situational, but required for Medicare if data reported in the N1 segment of this loop.
N401	Required. Mapped to ff record 15, field <u>19</u> .
N402	Required. Mapped to ff record 15, field <u>20</u> .
N403	Required. Mapped to ff record 15, field <u>21</u> .
N404	Situational. Only required if the address is other than the U. S. Mapped to ff record 15, field <u>22</u> .
N405-406	Not used.
REF (120.B)	Situational, but will be required for Medicare to report the Taxpayer Identification Number (TIN) when the National Payer Identifier (NPI) is effective. The TIN will be reported in N104 until that date.
REF01	Required. Always enter “TJ” in this loop when the NPI is effective. Prior to that date, use PQ (Payee Identification) for Medicare. 0B, 1A, 1B, 1C, 1D, 1E, 1F, 1G, 1H, D3, G2, and N5 do not apply to Medicare intermediaries. TJ mapped to ff record 15, field <u>23</u> . PQ mapped to ff record 15, field <u>25</u> .
REF02	Required. TJ (TIN) mapped to ff record 15, field <u>24</u> . PQ mapped to ff record 15, field <u>26</u> .
REF03-04	Not used.

Table 2, Detail Data

LX	Situational, but required for Medicare.
LX01	Required. Mapped to ff record 20, field <u>13</u> .
TS3	Situational, but required for intermediaries when applicable.
TS301	Required. Mapped to ff record <u>20</u> , field 3.

- TS302 Required. Mapped to ff record 20, field 5.
- TS303 Required. Mapped to ff record 20, field 4.
- TS304 Required. Mapped to ff record 20, field 14.
- TS305 Required. Mapped to ff record 20, field 15.
- TS306 Situational, but required for Medicare if there have been any covered charges for this provider for this fiscal period. The covered charge allowable by Medicare is the submitted charge minus the non-covered charges. Mapped to ff record 20, field 16.
- TS307 Situational, but required for Medicare if there have been any non-covered charges for this provider for this fiscal period. Mapped to ff record 20, field 17.
- TS308 Situational, but required for Medicare if there have been any denied charges for this provider for this fiscal period. Mapped to ff record 20, field 18.
- TS309 Situational, but required for Medicare if there have been any payments to this provider for this fiscal period. Includes total interest. The amount can be less than zero. Mapped to ff record 20, field 19.
- TS310 Situational, but required for Medicare if there have been any interest payments to this provider for this fiscal period. Mapped to ff record 20, field 20.
- TS311 Situational but required for Medicare if there have been any A2 contractual adjustments for this provider for this fiscal period. Mapped to ff record 20, field 21.
- TS312 Situational, but required for Medicare if there have been any Gramm-Rudman reductions for this provider for this fiscal period. Mapped to ff record 20, field 22.
- TS313 Situational, but required for Medicare if there have been any payments made by payer(s) primary to Medicare for claims processed by Medicare for this type of bill for this fiscal period. This includes any coinsurance and deductible amounts another payer paid for a beneficiary. Mapped to ff record 20, field 23.

- TS314 Situational but required for Medicare if any blood deductible amounts have applied to this provider for this type of bill for this fiscal period. Mapped to ff record 20, field 24.
- TS315 Situational, but required for Medicare if there have been payments made using the clinical lab or orthotics and prosthetics fee schedules. Equals the total covered charges minus sum of charges for line items paid on either the clinical lab or orthotics and prosthetics fee schedules. Mapped to ff record 20, field 25.
- TS316 Situational, but required for Medicare if any coinsurance was due to this provider for this type of bill summary for this fiscal period. Mapped to ff record 20, field 26.
- TS317 **Situational, but required for Medicare. The sum of reported charge amount when the qualifier is HC, should equal the amount shown in TS317. Mapped to ff record 20, field 27.**
- TS318 Situational, but required for Medicare if benefits allowed for HCPCS line items covered by the clinical lab or orthotics and prosthetics fee schedules for this provider for this fiscal period. Mapped to ff record 20, field 28.
- TS319 Situational, but required for Medicare if any cash deductible applied for this provider for this type of bill for this fiscal period. Mapped to ff record 20, field 29.
- TS320 Situational, but required for Medicare if any professional component amounts were paid to this provider for this type of bill for this fiscal period. Mapped to ff record 20, field 30.
- TS321 Situational, but required for Medicare if other payers satisfied the patient liability amounts (reason codes in the PR group) for this provider for this type of bill for this fiscal period. Mapped to ff record 20, field 31.
- TS322 Situational, but required if any refund made to patients by Medicare on behalf of this provider for this type of bill for this fiscal period. Mapped to ff record 20, field 32.
- TS323 Situational, but required for Medicare if this provider was on PIP for any portion of this fiscal period. Mapped to ff record 20, field 33.
- TS324 Situational, but required for Medicare if this provider was on PIP for any portion of this fiscal period. Mapped to ff record 20, field 34.
- TS2** Situational, but required for Medicare if there have been inpatient PPS payments to this provider for this type of bill for this fiscal period.

- TS201 Required. Mapped to ff record 21, field 13.
- TS202 Situational, but required for Medicare if any federal-specific operating DRG amounts have been paid. Mapped to ff record 21, field 14.
- TS203 Situational, but required for Medicare if any hospital-specific operating DRG amounts have been paid. Mapped to ff record 21, field 15.
- TS204 Situational, but required for Medicare if any disproportionate share payments have been paid. Mapped to ff record 21, field 16.
- TS205 Situational, but required for Medicare if capital payments, other than capital outliers, have been paid. Mapped to ff record 21, field 17.
- TS206 Situational, but required for Medicare if any indirect medical education payments made. Mapped to ff record 21, field 18.
- TS207 Situational, but required for Medicare if any day outlier payments made. Mapped to ff record 21, field 19.
- TS208 Situational, but required for Medicare if any day outlier payments made. Mapped to ff record 21, field 20.
- TS209 Situational, but required for Medicare if any cost outlier payments made. Mapped to ff record 21, field 21.
- TS210 Situational, but required for Medicare if DRG payments made. This is the *arithmetic* average length of stay for DRGs for this interchange transmission. Mapped to ff record 21 field 22.
- TS211 Situational, but required for Medicare when there have been discharges. Mapped to ff record 21, field 23.
- TS212 Situational, but required for Medicare if there have been cost report days. Mapped to ff record 21, field 24.
- TS213 Situational, but required for Medicare if there have been covered days. Mapped to ff record 21, field 25.
- TS214 Situational, but required for Medicare if there have been any non-covered days. Mapped to ff record 21, field 26.
- TS215 Situational, but required for Medicare if MSP pass-through amounts applied. Mapped to ff record 21, field 27.

TS216	Situational, but required for Medicare if DRG payments made. Mapped to ff record 21, field <u>28</u> .
TS217	Situational, but required for Medicare if any PPS Capital FSP DRG payment made. Mapped to ff record 21, field <u>29</u> .
TS218	Situational, but required for Medicare if any PPS capital HSP DRG payment made. Mapped to ff record 21, field <u>30</u> .
TS219	Situational, but required for Medicare if any PPS DSH DRG payment made. Mapped to ff record 21, field <u>31</u> .
CLP	Required.
CLP01	Required. Mapped to ff record 30, field <u>13</u> .
CLP02	Required. Mapped to ff record 30, field <u>14</u> . (Codes 5-17, 25 and 27 do not apply to Medicare.)
CLP03	Required. Mapped to ff record 30, field <u>15</u> .
CLP04	Required. Mapped to ff record 30, field <u>16</u> .
CLP05	Situational, but does not apply to intermediaries.
CLP06	Required. Intermediaries must always enter "MA." None of the other 835 codes apply to Medicare intermediaries. Mapped to ff record 30, field <u>17</u> .
CLP07	Situational, but required for Medicare. Mapped to ff record <u>30</u> , field 7.
CLP08	Situational, but required for Medicare. Mapped to ff record 30, field <u>18</u> .
CLP09	Situational, but required for Medicare intermediaries. Mapped to ff record 30, field <u>19</u> .
CLP10	Not used.
CLP11	Situational, but required for intermediaries if DRG payments made. Mapped to ff record 30, field <u>20</u> .
CLP12	Situational, but required for Medicare if DRG payment made. Mapped to ff record 30, field <u>21</u> .
CLP13	Situational, but required for Medicare if discharge fraction was a factor in payment to an institution. Mapped to ff record 30, field <u>22</u> .

- CAS (020)** Situational. May only be used if there are claim level adjustments. Adjustments reported at the service level may not be reported again, individually or in total, at the claim 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. Payers, including Medicare, are prohibited from use of any reason code that is not listed for use with version 4010 in the official reason code compendium maintained at www.wpc-edi.com under 835 codes. This list is generally updated in late February, July and October. See the service level CAS segment for more information on Medicare use of the CAS.
- CAS01** Required. Medicare contractors are limited to use of the CO, CR, OA, and PR group codes. PI may not be used for Medicare. Mapped to ff record 31, field 13. (If 2nd loop, mapped to ff record 31, field 32.)
- CAS02** Required. Mapped to ff record 31, field 14. (If 2nd loop, mapped to field 33.)
- CAS03** Required. Mapped to ff record 31, field 15. (If 2nd loop, mapped to field 34.)
- CAS04** Situational. Mapped to ff record 31, field 16. (If 2nd loop, mapped to field 35.)
- CAS05** Situational, but required for Medicare if a second claim level adjustment applies to this group code. Mapped to ff record 31, field 17. (If 2nd loop, mapped to field 36.)
- CAS06** Situational, but required for Medicare if a second claim level adjustment applies to this group code. Mapped to ff record 31, field 18. (If 2nd loop, mapped to field 37.)
- CAS07** Situational, but required for Medicare if a second claim level adjustment applies to this group code. Mapped to ff record 31, field 19. (If 2nd loop, mapped to field 38.)
- CAS08** Situational, but required for Medicare if a third claim level adjustment applies to this group code. Mapped to ff record 31, field 20. (If 2nd loop mapped to field 39.)
- CAS09** Situational, but required for Medicare if a third claim level adjustment applies to this group code. Mapped to ff record 31, field 21. (If 2nd loop, mapped to field 40.)

- CAS10 Situational, but required for Medicare if a third claim level adjustment applies to this group code. Mapped to ff record 31, field 22. (If 2nd loop, mapped to field 41.)
- CAS11 Situational, but required for Medicare if a fourth claim level adjustment applies to this group code. Mapped to ff record 31, field 23. (If 2nd loop, mapped to field 42.)
- CAS12 Situational, but required for Medicare if a fourth claim level adjustment applies to this group code. Mapped to ff record 31, field 24. (If 2nd loop, mapped to field 43.)
- CAS13 Situational, but required for Medicare if a fourth claim level adjustment applies to this group code. Mapped to ff record 31, field 25. (If 2nd loop, mapped to field 44.)
- CAS14 Situational, but required for Medicare if a fifth claim level adjustment applies to this group code. Mapped to ff record 31, field 26. (If 2nd loop, mapped to field 45.)
- CAS15 Situational, but required for Medicare if a fifth claim level adjustment applies to this group code. Mapped to ff record 31, field 27. (If 2nd loop, mapped to field 46.)
- CAS16 Situational, but required for Medicare if a fifth claim level adjustment applies to this group code. Mapped to ff record 31, field 28. (If 2nd loop, mapped to field 47.)
- CAS17 Situational, but required for Medicare if a sixth claim level adjustment applies to this group code. Mapped to ff record 31, field 29. (If 2nd loop, mapped to field 48.)
- CAS18 Situational, but required for Medicare if a sixth claim level adjustment applies to this group code. Mapped to ff record 31, field 30. (If 2nd loop, mapped to field 49.)
- CAS19 Situational, but required for Medicare if a sixth claim level adjustment applies to this group code. Mapped to ff record 31, field 31. (If 2nd loop, mapped to field 50.)
- NM1 (030.A)** Required to report patient-related information.
- NM101 Required. Mapped to ff record 40, field 13.
- NM102 Required. Mapped to ff record 40, field 14.
- NM103 Required. Mapped to ff record 40, field 15.

- NM104 Required. Mapped to ff record 40, field 16.
- NM105 Situational, but required for Medicare when a middle name or initial is available for the patient. Mapped to ff record 40, field 17.
- NM106 Not used.
- NM107 Situational, but will not be used by 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. Mapped to ff record 40, field 18.
- NM109 Situational, but required for Medicare if reported on the incoming claim. Mapped to ff record 40, field 19.
- 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.
- NM1 (030.C)** Situational, but required for Medicare when the HIC number has been corrected.
- NM101 Required. For Medicare purposes, the insured is the patient. Mapped to ff record 40, field 20.
- NM102 Required. Code 2 does not apply to Medicare. Mapped to ff record 40, field 21.
- NM103 Situational, but not used by Medicare.
- NM104 Situational, but not used by Medicare.
- NM105 Situational, but not used by Medicare.
- NM106 Not used.
- NM107 Situational, but not used for Medicare.
- NM108 Situational, but required for Medicare if the patient’s ID # has been corrected. Mapped to ff record 40, field 22.
- NM109 Situational, but required for Medicare if the patient’s ID # as been corrected. Mapped to ff record 40, field 23.

- NM110-111 Not used.
- NM1 (030.D)** *Situational, but required for Medicare if the NPI is reported on the incoming claim and validated.*
- NM101 *Required. Mapped to ff record 40 (2), field 13.*
- NM102 *Required. Code 1 does not apply to Medicare. Mapped to ff record 40 (2), field 14.*
- NM103 *Situational. Mapped to ff record 40 (2), field 15.*
- NM104 Situational, but will not be used by Medicare.
- NM105 Situational, but will not be used by Medicare.
- NM106 Not used.
- NM107 Situational, but will not be used by Medicare.
- NM108 *Situational, but required for Medicare if the NPI is reported on the incoming claim. Always enter "XX" for Medicare. Mapped to ff record 40 (2), field 18.*
- NM109 *Situational, but required for Medicare if NPI is reported on the incoming claim. Mapped to ff record 40 (2), field 19.*
- 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, report remark code N89 (see attachment 2) in a claim level remark code data element.
- NM101 Required. Mapped to ff record 41, field 13.
- NM102 Required. Mapped to ff record 41, field 14.
- NM103 Required. Mapped to ff record 41, field 15.

- NM104-107 Not used.
- NM108 Required. Until the PlanID is effective, enter “PI” for Medicare if another or no ID number is available for the payer. When PlanID is effective, enter “XV.” AD, FI, NI, and PP do not apply to Medicare. Mapped to ff record 41, field 16.
- NM109 Required. Enter the PlanID when effective. Prior to that date, enter the other number if available with PI, or if no ID number is available, enter 00 with PI. Mapped to ff record 41, field 17.
- NM110-111 Not used.
- NM1 (030.F)** Situational, but required for Medicare when a claim is denied or rejected due to the need for processing by a primary payer. That primary payer must be identified in the remittance advice. This segment notifies the provider whom to bill first. Do not use when NM1 segment 030.E applies.
- NM101 Required. Mapped to ff record 41, field 18. (If 2nd loop, mapped to field 23.)
- NM102 Required. Mapped to ff record 41, field 19. (If 2^d loop, mapped to field 24.)
- NM103 Required. Mapped to ff record 41, field 20. (If 2nd loop, mapped to field 25.)
- 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. Mapped to ff record 41, field 21. (If 2nd loop, mapped to field 26.)
- NM109 Required. Enter the PlanID when effective. Prior to that date, enter 00. Mapped to ff record 41, field 22. (If 2nd loop, mapped to field 27.)
- NM110-111 Not used.
- MIA** Situational, but required for Medicare when there has been inpatient care.
- MIA01 Required. Always enter zero. Mapped to ff record 42, field 13.
- MIA02 Situational, but required for Medicare if there has been an operating outlier payment. Mapped to ff record 42, field 14.

MIA03	Situational, but required for Medicare if lifetime psychiatric days used. Mapped to ff record 42, field <u>15</u> .
MIA04	Situational, but required for Medicare if DRG payment made. Mapped to ff record 42, field <u>16</u> .
MIA05	Situational, but required for Medicare if at least one claim level remark code applies. Mapped to ff record 42, field <u>17</u> .
MIA06	Situational, but required for Medicare if a disproportionate share amount is paid. Mapped to ff record 42, field <u>18</u> .
MIA07	Situational, but required for Medicare if an MSP pass-through amount paid. Mapped to ff record 42, field <u>19</u> .
MIA08	Situational. But required for Medicare if PP capital amount paid. Mapped to ff record 42, field <u>20</u> .
MIA09	Situational, but required for Medicare if PPS capital FSP DRG amount paid. Mapped to ff record 42, field <u>21</u> .
MIA10	Situational, but required for Medicare if PPS capital HSP DRG amount paid. Mapped to ff record 42, field <u>22</u> .
MIA11	Situational, but required for Medicare if PPS capital DSH DRG amount paid. Mapped to ff record 42, field <u>23</u> .
MIA12	Situational, but required for Medicare if old capital amount paid. Mapped to ff record 42, field <u>24</u> .
MIA13	Situational, but required for Medicare if PPS capital IME amount paid. Mapped to ff record 42, field <u>25</u> .
MIA14	Situational, but required for Medicare if PPS operating HSP DRG amount paid. Mapped to ff record 42, field <u>26</u> .
MIA15	Situational, but required for Medicare if cost report days apply. Mapped to ff record 42, field <u>27</u> .
MIA16	Situational, but required for Medicare if PPS operating FSP DRG amount paid. Mapped to ff record 42, field <u>28</u> .
MIA17	Situational, but required for Medicare if PPS outlier amount paid. Mapped to ff record 42, field <u>29</u> .

MIA18	Situational, but required for Medicare if indirect teaching amount paid. Mapped to ff record 42, field <u>30</u> .
MIA19	Situational, but required for Medicare if professional component amount billed but not payable by this provider. Mapped to ff record 42, field <u>31</u> .
MIA20	Situational but required for Medicare if a second claim level remark code applies. Mapped to ff record 42, field <u>32</u> .
MIA21	Situational but required for Medicare if a third claim level remark code applies. Mapped to ff record 42, field <u>33</u> .
MIA22	Situational but required for Medicare if a fourth claim level remark code applies. Mapped to ff record 42, field <u>34</u> .
MIA23	Situational but required for Medicare if a fifth claim level remark code applies. Mapped to ff record 42, field <u>35</u> .
MIA24	Situational but required for Medicare if a PPS capital exception amount paid. Mapped to ff record 42, field <u>36</u> .
MOA	Situational, but required for Medicare intermediaries if there has been other than inpatient care and at least one claim level remark code applies for that non-inpatient care.
MOA01	Situational, but required for Medicare if reimbursement rate reporting applies. Mapped to ff record 43, field <u>13</u> .
MOA02	Situational, but required for Medicare if any line items paid on a fee schedule basis. Mapped to ff record 43, field <u>14</u> .
MOA03	Situational, but required for Medicare if at least one claim level remark code applies. Mapped to ff record 43, field <u>15</u> .
MOA04	Situational, but required for Medicare if a second claim level remark code applies. Mapped to ff record 43, field <u>16</u> .
MOA05	Situational, but required for Medicare if a third claim level remark code applies. Mapped to ff record 43, field <u>17</u> .
MOA06	Situational, but required for Medicare if a fourth claim level remark code applies. Mapped to ff record 43, field <u>18</u> .
MOA07	Situational, but required for Medicare if a fifth claim level remark code applies. Mapped to ff record 43, field <u>19</u> .

- MOA08 Situational, but required for Medicare if ESRD payment made. Mapped to ff record 43, field 20.
- MOA09 Situational, but required for Medicare if professional component amount billed but not payable to this provider. Mapped to ff record 43, field 21.
- REF** (040.A) Situational, but required for Medicare if provider submitted a proprietary identification number on the claim.
- REF01 Required. Only “EA” applies to Medicare. Mapped to ff record 44, field 13.
- REF02 Required. Mapped to ff record 44, field 14.
- REF03-04 Not used.
- REF** (040.B) Situational, but does not apply to Medicare intermediaries.
- DTM** (050) Situational, but multiple loops required for Medicare.
- DTM01 Required. “050” mapped to ff record 44, field 15. “232” mapped to ff record 44, field 17. “233” mapped to ff record 44, field 19.
- DTM02 Required. Mapped to ff record 44, field 16 for 050. Mapped to ff record 44, field 18 for 232. Mapped to ff record 44, field 20 for 233.
- DTM03-06 Not used.
- PER** (060) Situational, but not used by Medicare.
- AMT** (062) Situational, but required for Medicare if any of the qualifiers in AMT01 apply to the claim.
- AMT01 Required. Use multiple loops if more than 1 qualifier applies. DY mapped to ff record 44, field 21; NL mapped to ff record 44, field 23; ZK for hemophilia add on to ff record 44, field 25; F5 to ff record 44, field 27; I to ff record 44, field 29; ZZ for inpatient outlier payment to ff record 44, field 31; AU to ff record 44, field 33. ZL, New Technology Add-on is mapped to ff record 44, field 35. The other qualifiers do not apply to Medicare at this time.

NOTE: Pre-4010, NJ was reported in the AMT segment to report the gross amount of payment made by the primary payer on the claim. NJ is not approved for use in 4010. In 4010, primary payment reporting will be limited to the use of claim adjustment reason code 23 to convey the amount of the primary payment that impacted the Medicare payment calculation. This may be less than the gross payment made by the primary payer. Since Medicare would be primary in this instance, the provider

would already have been notified of the gross amount of the primary's payment by that payer. This is not considered an essential data element for a secondary payer's remittance advice.

AMT02 Required. Inpatient or partial hospitalization per diem amount (DY) mapped to ff record 44, field 22. NL mapped to ff record 44, field 24. Hemophilia add on (ZK) mapped to ff record 44, field 26. F5 mapped to ff record 44, field 28. I mapped to ff record 44, field 30. Any inpatient outlier payment (ZZ) mapped to ff record 44, field 32. AU mapped to ff record 44, field 34. New Technology Add-on and Electroconvulsive Therapy (ZL) is mapped to ff record 44, field 36. The other qualifiers do not apply to Medicare at this time.

AMT03 Not used.

QTY (064) Situational, but required for Medicare if any of the QTY01 qualifiers apply. Use multiple loops if more than 1 qualifier applies.

QTY01 Required. CA mapped to ff record 44, field 37; NA mapped to ff record 44, field 39; LA to ff record 44, field 41; CD to ff record 44, field 43; ZK mapped to ff record 44, field 45; and OU mapped to ff record 44, field 47.

QTY02 Required. CA mapped to ff record 44, field 38. NA mapped to ff record 44, field 40. LA mapped to ff record 44, field 42. CD mapped to ff record 44, field 44. ZK is mapped to ff record 44, field 46. OU is mapped to ff record 44, field 48. The other qualifiers in the implementation guide do not apply to Medicare at this time.

NOTE 1: VS, visits, had been reported at the service level for covered and non-covered HHA visits prior to version 4010. With HH PPS, it will only be necessary to report HHA visits if there are 4 or fewer visits during an episode. In version 4010, the number of visits, when 4 or less, will be reported as the line adjustment quantity (SVC level CAS04, 07, 10, 13, 16, or 19) for the final HHA bill for the episode. The HHA will still be paid on a per visit basis in that situation.

NOTE 2: Pre-4010, FL was used to report the approved units for hemophilia add on. FL is not available for use in the 4010 implementation guide. Use ZK to report the hemophilia covered units in version 4010. SVC Situational, but required for Medicare when service level detail included on the incoming claim. A separate loop is required for each procedure.

SVC

SVC01-1 Required. Only HC, NU, N4 and ZZ apply to Medicare intermediaries. HC mapped to ff record 50, field 13; NU mapped to ff record 50, field 13; ZZ mapped to ff record 50, field 13; N4 mapped to ff record 50, field 15.

HC and ZZ would not apply to the same line, but NU and HC or NU and ZZ could apply to the same line. When more than one applies to the same line, enter the HC or ZZ in SVC01-1 and the NU in SVC04. ZZ will be used to report HIPPS codes if used in SNF or HHA billing. Subsequent to the approval of the qualifier for HIPPS codes, the HIPPS code set was expanded to include codes other than for SNFs, such as for home health. Data maintenance is underway with X12 to have the HIPPS code definition likewise expanded. Although the version 4010 implementation guide suggests the code set is limited to SNF codes, that is not the case. The HIPPS qualifier will be used for Medicare reporting of any applicable approved HIPPS codes. N4 will not be used until Medicare begins usage of NDC codes for drugs.

SVC01-2 Required. HC mapped to ff record 50, field 14. NU mapped to ff record 50, field 14. ZZ mapped to ff record 50, field 14. N4 mapped to ff record 50, field 16.

NOTE: When a service is being denied due to submission of an invalid HCPCS, HIPPS, NDC or revenue code, the invalid submitted code must be entered in this data element. This is a necessary exception to the HIPAA requirement for use of valid medical codes.

SVC01-3 Situational, but required for Medicare if HC applies and at least one modifier was reported on the claim for the service. Modifiers do not apply to and may not be reported for other procedure code types. Mapped to ff record 50, field 17.

SVC01-4 Situational, but required for Medicare if HC applies and a second modifier was reported on the claim for the service. Mapped to ff record 50, field 18.

SVC01-5 Situational, but required for Medicare if HC applies and a third modifier was reported on the claim for the service. Mapped to ff record 50, field 19.

SVC01-6 Situational, but required for Medicare if HC applies and a fourth modifier was reported on the claim for the service. Mapped to ff record 50, field 20.

SVC01-7 Situational, but Medicare will not report text language in a remittance advice.

SVC02 Required. Mapped to ff record 50, field 21.

SVC03 Required. Mapped to ff record 50, field 22.

SVC04 Situational, but required for Medicare if both a HCPCS or NDC, and a revenue code, were reported on the claim for the same service. Mapped to ff record 50, field 23.

SVC05	Situational, but required for Medicare. Mapped to ff record 50, field <u>24</u> .
SVC06-1	Situational, but required if the procedure or drug code has been changed during adjudication. <u>Mapped to ff record 50, field 25 if HC, if N4 is field 27.</u>
SVC06-2	Required. HC mapped to ff record 50, field <u>26</u> . N4 mapped to ff record 50, field <u>28</u> . Medicare would not change a NU (revenue code) or ZZ (HIPPS code) during adjudication.
SVC06-3	Situational, but required for Medicare if the first modifier was changed during adjudication. Mapped to ff record 50, field <u>29</u> .
SVC06-4	Situational, but required for Medicare if the second modifier was changed during adjudication. Mapped to ff record 50, field <u>30</u> .
SVC06-5	Situational, but required for Medicare if the third modifier was changed during adjudication. Mapped to ff record 50, field <u>31</u> .
SVC06-6	Situational, but required for Medicare if the fourth modifier was changed during adjudication. Mapped to ff record 50, field <u>32</u> .
SVC06-7	Situational, but text will not be reported by Medicare.
SVC07	Situational, but required for Medicare if the paid units of service is different than the billed units of service. Mapped to ff record 50, field <u>33</u> .
DTM (080)	Situational, but required for Medicare when service level data is reported on the claim.
DTM01	Required. Only 472 applies to intermediaries. 472 mapped to ff record 50, field <u>34</u> .
DTM02	Required. Mapped to ff record 50, field <u>35</u> .
DTM03-06	Not used.
CAS (090)	Situational, but required for Medicare whenever the amount paid for a service does not equal the amount billed. Medicare intermediaries are required to separately report every adjustment made to a service. It is necessary to use separate loops if more than 1 group code applies, or if there are more than 6 adjustment codes per group.
CAS01	Required. PI does not apply to Medicare. Mapped to ff record 51, field <u>13</u> .
CAS02	Required. Mapped to ff record 51, field <u>14</u> .

CAS03	Required. Mapped to ff record 51, field <u>15</u> .
CAS04	Situational, but required for Medicare. Mapped to ff record 51, field <u>16</u> .
CAS05	Situational, but required for Medicare if there is a second service level adjustment. Mapped to ff record 51, field <u>17</u> .
CAS06	Situational, but required for Medicare if there is a second service level adjustment. Mapped to ff record 51, field <u>18</u> .
CAS07	Situational, but required for Medicare if there is a second service level adjustment. Mapped to ff record 51, field <u>19</u> .
CAS08	Situational, but required for Medicare if there is a third service level adjustment. Mapped to ff record 51, field <u>20</u> .
CAS09	Situational, but required for Medicare if there is a third service level adjustment. Mapped to ff record 51, field <u>21</u> .
CAS10	Situational, but required for Medicare if there is a third service level adjustment. Mapped to ff record 51, field <u>22</u> .
CAS11	Situational, but required for Medicare if there is a fourth service level adjustment. Mapped to ff record 51, field <u>23</u> .
CAS12	Situational, but required for Medicare if there is a fourth service level adjustment. Mapped to ff record 51, field <u>24</u> .
CAS13	Situational, but required for Medicare if there is a fourth service level adjustment. Mapped to ff record 51, field <u>25</u> .
CAS14	Situational, but required for Medicare if there is a fifth service level adjustment. Mapped to ff record 51, field <u>26</u> .
CAS15	Situational, but required for Medicare if there is a fifth service level adjustment. Mapped to ff record 51, field <u>27</u> .
CAS16	Situational, but required for Medicare if there is a fifth service level adjustment. Mapped to ff record 51, field <u>28</u> .
CAS17	Situational, but required for Medicare if there is a sixth service level adjustment. Mapped to ff record 51, field <u>29</u> .
CAS18	Situational, but required for Medicare if there is a sixth service level adjustment. Mapped to ff record 51, field <u>30</u> .

- CAS19 Situational, but required for Medicare if there is a sixth service level adjustment. Mapped to ff record 51, field 31.
- REF (100.A)** Situational, but required for Medicare if any of the qualifiers apply. Multiple loops required if more than 1 qualifier applies.
- REF01 Required. 1S mapped to ff record 50, field 36; RB mapped to ff record 50, field 36. 1S and RB would not apply to the same line simultaneously. 6R does not apply to Medicare intermediaries, as indicated in the implementation guide note for the standard, this situational segment “is used to provide additional information used in the process of adjudicating this service.” Since intermediary claims are not subject to splitting, provider control number is not used for Medicare adjudication and is not needed by providers to re-associate lines for split claims. None of the other qualifiers currently apply to intermediaries.
- REF02 Required. 1S mapped to ff record 50, field 37. RB mapped to ff record 50, field 38 when a rate code factored in the payment. The APC number will only be reported with the first HCPCS, and not for subsequent HCPCS, in that APC.
- REF03-04 Not used.
- REF (100.B)** Situational, but does not apply to Medicare intermediaries.
- AMT (110)** Situational, but required for Medicare intermediaries if any of the qualifiers apply. Multiple loops must be used if more than 1 qualifier applies.
- AMT01 Required. Only DY and B6 currently apply to Medicare intermediaries. DY mapped to ff record 50, field 39. B6 mapped to ff record 50, field 41.
- AMT02 Required. DY mapped to ff record 50, field 40. B6 mapped to ff record 50, field 42.
- AMT03 Not used.
- QTY** Situational, but does not apply to Medicare intermediaries in version 4010. Used to report covered and non-covered HHA visits in prior versions. Most HHA care will now be paid under HH PPS. In those cases where individual HHA visit payments are made, the number of covered visits will be reported in SVC05, the quantity data element for the HHA visits HCPCS ad with the VS qualifier in a claim level QTY segment. The number of non-covered visits will be shown as a quantity adjustment in the CAS segment for the HHA visits HCPCS.
- LQ** Situational, but required for Medicare whenever any service level remark codes apply. Multiple loops must be used if more than 1 service level

remark code applies. The flat file can record up to 19 remark codes per service.

LQ01 Required. Only “HE” applies to Medicare intermediaries. 1st HE mapped to ff record 50, field 43; 2nd to field 45; 3rd to field 47; 4th to field 49; 5th to field 51; 6th to field 53; 7th to field 55; 8th to field 57; and 9th to field 59.

LQ02 Required. 1st mapped to ff record 50, fields 44, and succeeding to fields 46, 48, 50, 52, 54, 56, 58, and 60 respectively.

Table 3, Summary Data

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

PLB01 Required. Mapped to ff record 60, field 3.

PLB02 Required. Mapped to ff record 60, field 4.

PLB03-1 Required. The X12N provider adjustment *reason* code must be reported in 03-1, and the Medicare provider adjustment *identifier* code in 03-2. The first X12N provider adjustment *reason* code is mapped to ff record 60, field 13.

NOTE: Outpatient PPS instructions had directed intermediaries to identify Transitional Outpatient Payments (TOPs) with **IR** in this data element, but some providers associate BN with managed care only and not with fee for service payments. For Medicare’s use of version 4010, report TOPs with IS, interim settlement, in PLB03-1 and IR in the first 2 positions of PLB03-2.

PLB03-2 Situational, but required for Medicare. Positions 1-2=the first Medicare provider adjustment code (mapped to ff record 60, field 14). Although the 4010 implementation version suggests differently, Medicare will use only these 2 positions as per subsequent change in the IG.

PLB04 Required. Mapped to ff record 60, field 15.

PLB05-1 Situational, but required if there is a second provider level adjustment. Mapped to ff record 60, field 16.

PLB05-2 Situational, but required for Medicare if there is a second provider level adjustment. Mapped to ff record 60, field 17.

PLB06 Situational, but required for Medicare if there is a second provider level adjustment. Mapped to ff record 60, field 18.

PLB07-1 Situational, but required if there is a third provider level adjustment. Mapped to ff record 60, field 19.

PLB07-2	Situational, but required for Medicare if there is a third provider level adjustment. Mapped to ff record 60, field <u>20</u> .
PLB08	Situational, but required for Medicare if there is a third provider level adjustment. Mapped to ff record 60, field <u>21</u> .
PLB09-1	Situational, but required if there is a fourth provider level adjustment. Mapped to ff record 60, field <u>22</u> .
PLB09-2	Situational, but required for Medicare if there is a fourth provider level adjustment. Mapped to ff record 60, field <u>23</u> .
PLB10	Situational, but required for Medicare if there is a fourth provider level adjustment. Mapped to ff record 60, field <u>24</u> .
PLB11-1	Situational, but required for Medicare if there is a fifth provider level adjustment. Mapped to ff record 60, field <u>25</u> .
PLB11-2	Situational, but required for Medicare if there is a fifth provider level adjustment. Mapped to ff record 60, field <u>26</u> .
PLB12	Situational, but required for Medicare if there is a fifth provider level adjustment. Mapped to ff record 60, field <u>27</u> .
PLB13-1	Situational, but required for Medicare if there is a sixth provider level adjustment. Mapped to ff record 60, field <u>28</u> .
PLB13-2	Situational, but required for Medicare if there is a sixth provider level adjustment. Mapped to ff record 60, field <u>29</u> .
PLB14	Situational, but required for Medicare if there is a sixth provider level adjustment. Mapped to ff record 60, field <u>30</u> .
GE	Required.
GE01	Required. TG
GE02	Required. Must equal GS06. TG
SE	Required.
SE01	Required. The transaction segment count is computed by the carrier system. TG
SE02	Required. Must equal ST02. TG