ANSI X12N 835 VERSION 4010 & 4010A1
MEDICARE HIPAA COMPANION DOCUMENT
Fiscal Intermediaries
(As of 8/1/2004)

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/ Data Elements	835 and Medicare Requirements/Notes
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 ***13***.

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 ***25***.
BPR14 Situational, but required for Medicare if ACH in BPR04. Mapped to ff record 1, field ***26***.

BPR15 Situational, but required if ACH in BPR04. Mapped to ff record 1, field ***27***.

BPR16 Required. Mapped to ff record 1, field ***28***.

BPR17-21 Not used.

TRN Required.
TRN01 Required. Mapped to ff record 1, field ***29***.

TRN02 Required. If no payment is issued, insert the remittance advice number. Mapped to ff record 1, field ***30*** and ***31***.

TRN03 Required. TRN03 must =BPR10. Mapped to ff record 1, field ***23***.

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 ***32***.

DTM02 Required. Mapped to ff record 1, field ***33***.

DTM03-06 Not used.

N1 (080.A) Required for payer identification.
N101 Required. Mapped to ff record 10, field ***13***.

N102	Situational, but required for Medicare. Mapped to ff record 10, field ***14***.
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 ***15***.
N104	Situational, but required once the PlanID is effective. Mapped to ff record 10, field ***16***.
N105-106	Not used.
N3 (100)	Required for payer identification.
N301	Required. Mapped to ff record 10, field ***17***.
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 ***18***.
N4 (110)	Required for payer identification.
N401	Required. Mapped to ff record 10, field ***19***.
N402	Required. Mapped to ff record 10, field ***20***.
N403	Required. Mapped to ff record 10, field ***21***.
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 ***22***.
REF02	Required. Mapped to ff record 10, field ***23***.
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 ***13***.
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 ***14***.
N103	Required. Always enter "FI" until the NPI is effective. After that date, always enter "XX." Mapped to ff record 15, field ***15***.

N104 Required. Payee's TIN for qualifier FI mapped to ff record 15, field ***24***. NPI, when effective, mapped to ff record 15, field ***16***.

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 ***17***.

N302 Situational, but required if this segment is used and there is a second payee address line. Mapped to ff record 15, field ***18***.

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 ***19***.

N402 Required. Mapped to ff record 15, field ***20***.

N403 Required. Mapped to ff record 15, field ***21***.

N404 Situational. Only required if the address is other than the U. S. Mapped to ff record 15, field ***22***.

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 ***23***. PQ mapped to ff record 15, field ***25***.

REF02 Required. TJ (TIN) mapped to ff record 15, field ***24***. PQ mapped to ff record 15, field ***26***.

REF03-04 Not used.

Table 2, Detail Data

LX Situational, but required for Medicare.

LX01 Required. Mapped to ff record 20, field ***13***.

TS3 Situational, but required for intermediaries when applicable.

TS301 Required. Mapped to ff record ***20***, 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 ***28***.

TS217 Situational, but required for Medicare if any PPS Capital FSP DRG payment made. Mapped to ff record 21, field ***29***.

TS218 Situational, but required for Medicare if any PPS capital HSP DRG payment made. Mapped to ff record 21, field ***30***.

TS219 Situational, but required for Medicare if any PPS DSH DRG payment made. Mapped to ff record 21, field ***31***.

CLP Required.
CLP01 Required. Mapped to ff record 30, field ***13***.

CLP02 Required. Mapped to ff record 30, field ***14***. (Codes 5-17, 25 and 27 do not apply to Medicare.)

CLP03 Required. Mapped to ff record 30, field ***15***.

CLP04 Required. Mapped to ff record 30, field ***16***.

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 ***17***.

CLP07 Situational, but required for Medicare. Mapped to ff record ***30***, field 7.

CLP08 Situational, but required for Medicare. Mapped to ff record 30, field ***18***.

CLP09 Situational, but required for Medicare intermediaries. Mapped to ff record 30, field ***19***.

CLP10 Not used.

CLP11 Situational, but required for intermediaries if DRG payments made. Mapped to ff record 30, field ***20***.

CLP12 Situational, but required for Medicare if DRG payment made. Mapped to ff record 30, field ***21***.

CLP13 Situational, but required for Medicare if discharge fraction was a factor in payment to an institution. Mapped to ff record 30, field ***22***.

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 does not apply to Medicare intermediaries.

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 2d 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 ***15***.

MIA04 Situational, but required for Medicare if DRG payment made. Mapped to ff record 42, field ***16***.

MIA05 Situational, but required for Medicare if at least one claim level remark code applies. Mapped to ff record 42, field ***17***.

MIA06 Situational, but required for Medicare if a disproportionate share amount is paid. Mapped to ff record 42, field ***18***.

MIA07 Situational, but required for Medicare if an MSP pass-through amount paid. Mapped to ff record 42, field ***19***.

MIA08 Situational. But required for Medicare if PP capital amount paid. Mapped to ff record 42, field ***20***.

MIA09 Situational, but required for Medicare if PPS capital FSP DRG amount paid. Mapped to ff record 42, field ***21***.

MIA10 Situational, but required for Medicare if PPS capital HSP DRG amount paid. Mapped to ff record 42, field ***22***.

MIA11	Situational, but required for Medicare if PPS capital DSH DRG amount paid. Mapped to ff record 42, field ***23***.
MIA12	Situational, but required for Medicare if old capital amount paid. Mapped to ff record 42, field ***24***.
MIA13	Situational, but required for Medicare if PPS capital IME amount paid. Mapped to ff record 42, field ***25***.
MIA14	Situational, but required for Medicare if PPS operating HSP DRG amount paid. Mapped to ff record 42, field ***26***.
MIA15	Situational, but required for Medicare if cost report days apply. Mapped to ff record 42, field ***27***.
MIA16	Situational, but required for Medicare if PPS operating FSP DRG amount paid. Mapped to ff record 42, field ***28***.
MIA17	Situational, but required for Medicare if PPS outlier amount paid. Mapped to ff record 42, field ***29***.
MIA18	Situational, but required for Medicare if indirect teaching amount paid. Mapped to ff record 42, field ***30***.
MIA19	Situational, but required for Medicare if professional component amount billed but not payable by this provider. Mapped to ff record 42, field ***31***.
MIA20	Situational but required for Medicare if a second claim level remark code applies. Mapped to ff record 42, field ***32***.
MIA21	Situational but required for Medicare if a third claim level remark code applies. Mapped to ff record 42, field ***33***.
MIA22	Situational but required for Medicare if a fourth claim level remark code applies. Mapped to ff record 42, field ***34***.
MIA23	Situational but required for Medicare if a fifth claim level remark code applies. Mapped to ff record 42, field ***35***.
MIA24	Situational but required for Medicare if a PPS capital exception amount paid. Mapped to ff record 42, field ***36***.
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 ***13***.

MOA02 Situational, but required for Medicare if any line items paid on a fee schedule basis. Mapped to ff record 43, field ***14***.

MOA03 Situational, but required for Medicare if at least one claim level remark code applies. Mapped to ff record 43, field ***15***.

MOA04 Situational, but required for Medicare if a second claim level remark code applies. Mapped to ff record 43, field ***16***.

MOA05 Situational, but required for Medicare if a third claim level remark code applies. Mapped to ff record 43, field ***17***.

MOA06 Situational, but required for Medicare if a fourth claim level remark code applies. Mapped to ff record 43, field ***18***.

MOA07 Situational, but required for Medicare if a fifth claim level remark code applies. Mapped to ff record 43, field ***19***.

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 (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 ***24***.

SVC06-1 Situational, but required if the procedure or drug code has been changed during adjudication. ***Mapped to ff record 50, field 25 if HC, if N4 is field 27.***

SVC06-2 Required. HC mapped to ff record 50, field ***26***. N4 mapped to ff record 50, field ***28***. 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 ***29***.

SVC06-4 Situational, but required for Medicare if the second modifier was changed during adjudication. Mapped to ff record 50, field ***30***.

SVC06-5 Situational, but required for Medicare if the third modifier was changed during adjudication. Mapped to ff record 50, field ***31***.

SVC06-6 Situational, but required for Medicare if the fourth modifier was changed during adjudication. Mapped to ff record 50, field ***32***.

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 ***33***.

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 ***34***.

DTM02 Required. Mapped to ff record 50, field ***35***.

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 ***13***.

CAS02 Required. Mapped to ff record 51, field ***14***.

CAS03 Required. Mapped to ff record 51, field ***15***.

CAS04 Situational, but required for Medicare. Mapped to ff record 51, field ***16***.

CAS05 Situational, but required for Medicare if there is a second service level adjustment. Mapped to ff record 51, field ***17***.

CAS06 Situational, but required for Medicare if there is a second service level adjustment. Mapped to ff record 51, field ***18***.

CAS07 Situational, but required for Medicare if there is a second service level adjustment. Mapped to ff record 51, field ***19***.

CAS08 Situational, but required for Medicare if there is a third service level adjustment. Mapped to ff record 51, field ***20***.

CAS09 Situational, but required for Medicare if there is a third service level adjustment. Mapped to ff record 51, field ***21***.

CAS10 Situational, but required for Medicare if there is a third service level adjustment. Mapped to ff record 51, field ***22***.

CAS11 Situational, but required for Medicare if there is a fourth service level adjustment. Mapped to ff record 51, field ***23***.

CAS12 Situational, but required for Medicare if there is a fourth service level adjustment. Mapped to ff record 51, field ***24***.

CAS13 Situational, but required for Medicare if there is a fourth service level adjustment. Mapped to ff record 51, field ***25***.

CAS14 Situational, but required for Medicare if there is a fifth service level adjustment. Mapped to ff record 51, field ***26***.

CAS15 Situational, but required for Medicare if there is a fifth service level adjustment. Mapped to ff record 51, field ***27***.

CAS16 Situational, but required for Medicare if there is a fifth service level adjustment. Mapped to ff record 51, field ***28***.

CAS17 Situational, but required for Medicare if there is a sixth service level adjustment. Mapped to ff record 51, field ***29***.

CAS18 Situational, but required for Medicare if there is a sixth service level adjustment. Mapped to ff record 51, field ***30***.

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 ***20***.

PLB08 Situational, but required for Medicare if there is a third provider level adjustment. Mapped to ff record 60, field ***21***.

PLB09-1 Situational, but required if there is a fourth provider level adjustment. Mapped to ff record 60, field ***22***.

PLB09-2 Situational, but required for Medicare if there is a fourth provider level adjustment. Mapped to ff record 60, field ***23***.

PLB10 Situational, but required for Medicare if there is a fourth provider level adjustment. Mapped to ff record 60, field ***24***.

PLB11-1 Situational, but required for Medicare if there is a fifth provider level adjustment. Mapped to ff record 60, field ***25***.

PLB11-2 Situational, but required for Medicare if there is a fifth provider level adjustment. Mapped to ff record 60, field ***26***.

PLB12 Situational, but required for Medicare if there is a fifth provider level adjustment. Mapped to ff record 60, field ***27***.

PLB13-1 Situational, but required for Medicare if there is a sixth provider level adjustment. Mapped to ff record 60, field ***28***.

PLB13-2 Situational, but required for Medicare if there is a sixth provider level adjustment. Mapped to ff record 60, field ***29***.

PLB14 Situational, but required for Medicare if there is a sixth provider level adjustment. Mapped to ff record 60, field ***30***.

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