Program Memorandum Intermediaries

Department of Health and Human Services (DHHS)
HEALTH CARE FINANCING ADMINISTRATION (HCFA)

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CHANGE REQUEST 1522

SUBJECT: Health Insurance Portability Accountability Act of 1996 (HIPAA) Administrative Simplification - Implementation of Version 4010 of the Accredited Standards Committee X12N 835 (Payment/Remittance Advice) Transaction Standard Format

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

Version 4010 of the 835 includes some significant changes from earlier versions of the 835 supported by Medicare, including requirements to identify any secondary payer with whom benefits are coordinated, and to identify the primary payer if denying a claim because Medicare should be the secondary payer. See appendix D of the 835 version 4010 implementation guide for a summary of the changes. Version 4010 implementation guides may be downloaded without charge from *www.wpc-edi.com/HIPAA*, or you may phone 1-800-972-4334 to purchase hard copies.

Remittance Advice Standard Requirements

Intermediaries will continue to use flat files for their internal system programming. The updated X12N 835 version 4010-supportive remittance advice flat file is posted at *www.hcfa.gov/medicare/edi/edi.htm* under the document name "835A4010." Subsequent adjustments may be issued if necessary to resolve problems detected during programming or testing. The flat file maps each field to the corresponding 835 version 4010 data element. Attachment 1 is the "Medicare X12N 835 Version 4010 HIPAA Companion Document." This itemizes the Medicare requirements for use of specific segments, data elements, and codes in the 835, and maps the flat file to the corresponding 835 version 4010 segments and data elements.

Remittance Advice Remark Codes

As the initial user of 835 remark codes, HCFA became the defacto maintainer of this code set with ASC X12N approval. Since HIPAA applies to virtually all U.S. health care payers, and will result in much more extensive use of the 835 format, many payers other than Medicare will also begin to use remark codes. Remark code wording must be generic. Language referring to Medicare as the source of decisions in many remark code messages has been replaced by references to "we." Since the remittance advice identifies the issuer (Medicare for a claim processed by an intermediary), the meaning is the same. Existing message numbers have also stayed the same. Attachment 2 contains the currently approved, generically worded remark code messages.

You may begin to use these messages in both your pre-HIPAA and HIPAA format ERAs and standard paper remittances as soon as programming changes are complete. None of these messages should be new to you, but if you do begin to use any of these messages for the first time, furnish

providers advance notice of the new codes and their messages prior to initial use.

Any remark code may now be reported at either the claim or the line level, i.e., an "MA" code may now be reported in the LQ segment of the 835, and an "M" code in an MOA segment, if the wording of the message fits the situation being described at that level. "N" codes could always be reported at either the line or claim level. All new remark codes will now begin with "N".

Neither an intermediary nor any other Medicare or non-Medicare payer may use a remark code in a version 4010 835 transaction that does not appear in Attachment 2 or a subsequent HCFA-produced update to this list. This listing will be updated as needed, and is nationally accessible at *www.wpc-edi.com* by selecting HIPAA, Health Care Code Lists, and Remittance Advice Remark Codes menu listings. Review the remark code message set at this address every quarter to keep abreast of the full list of messages approved for use. Each update will include a list of the codes added within the past 3-6 months to facilitate identification of the changes.

Attachment 2 and the website also include instructions to request modifications or additional remark codes. New remark codes introduced to meet Medicare-specific needs will continue to be included in the implementation instruction for the Medicare change that necessitated the new message. Remark codes will not otherwise be published in Medicare manuals. Nor will they be maintained on a HCFA website.

Standard Paper Remittance (SPR) Advice

No changes are being made to the SPR format in conjunction with HIPAA implementation, but by October 2002, standard systems must use the version 4010 flat file, rather than any earlier flat file, to generate SPRs to avoid data variations between SPRs and ERAs in fields shared by both formats. Standard systems may change to use of the 4010 flat file for SPRs at any point after October 1, 2001, as long as completed by October 2002. Standard systems must furnish their intermediaries at least 90 days advance notice of their SPR changeover date. Intermediaries must in turn furnish their SPR users with advance notice of the effective date of the change and any differences they can expect to see in their SPRs as result of the flat file changeover.

PC-Print

The Fiscal Intermediary Standard System (FISS) maintainer will upgrade PC-Print for version 4010, and share the upgrade with both the FISS Data Centers and the Arkansas Part A Standard System Data Centers for distribution to their intermediaries, and through them, to provider users or providers that request the software. Individual intermediaries will not be funded to develop or procure alternate PC-Print software. The PC-Print software will operate on Windows-95, 98, 2000/Me, and NT platforms, and include self-explanatory loading and use information for providers. FISS will distribute this PC-Print software with the October 2001 release.

Manualization of this Information

The Medicare Intermediary Manual sections dealing with the 835 transaction will be updated to include changes detailed in this and any future HIPAA PMs that impact remittance advice reporting for HIPAA. HCFA plans to combine and manualize all of the HIPAA transactions information at the same time, following release of individual PMs for the various transactions.

Testing and Implementation

Standard system maintainers must distribute the system changes and related documentation to the processing centers according to their normal October release process. That release must be sent to the intermediary beta testers in August. Intermediaries must begin their testing of this change request in September, and must complete translator mapping and/or procurement for the 835 by September 30, 2001. Intermediaries must complete local system programming, and internal testing to enable successful interface with their standard system for accurate generation of version 4010 of

the 835 and the SPR from the 4010 flat file by November 30, 2001. HCFA will not issue test files to the

intermediaries for internal testing for this release. Each intermediary is responsible for the development of appropriate test files, either alone or in conjunction with other intermediaries.

The standard system maintainers must implement system changes as needed to enable intermediaries to conduct parallel automated tests with providers, clearinghouses and other trading partners of 835 version 4010 transaction. This will enable automated testing of a HIPAA 835 transaction, while continuing to issue 835s in a production mode in an earlier version. Standard systems that do not already possess such parallel testing and production capability must be modified by December 1, 2001, to enable intermediaries to test version 4010 of the 835 with partners.

By the end of December 2001, intermediaries must complete limited provider beta testing of the 835 version 4010 with a few providers and/or outside clearinghouses involving a small number of claim batches. By January 2, 2002, intermediaries must be able to issue 835 version 4010 transactions in production mode to any provider or clearinghouse that requests production data in that version. Intermediaries may not discourage providers, billing agents, and/or clearinghouses from requesting 835 testing. If either a provider, billing agent, clearinghouse, or an intermediary has any doubt about a receiver's acceptance and ability to use 835 version 4010 transmissions, the intermediary must encourage the receiver to test use of version 4010 of the 835 prior to full use in production.

Standard systems must also include program logic with the October release to enable intermediaries to identify situations where the flat file financial data may not have created a balanced 835 as specified in section 2.2.1 of the 835 version 4010 implementation guide. The logic must operate with the standard system flat file at the data center to generate an "out of balance" report per provider to identify the existence of a balancing error. The error report must identify each out-of-balance claim, each out-of-balance line, and each out-of-balance PLB segment in an 835 per provider, but the report will not be able to diagnose the source of the error. The report will be a tool for intermediaries to diagnose standard system balancing errors for preparation of standard system correction requests.

"Out-of-Balance" 835s should be rare exceptions, and not something to be expected, but this report would enable identification of balancing errors prior to transmission of data to providers. Intermediaries should not suspend transmission of 835 transactions pending correction of any identified balancing problems by their standard system, but depending on the nature of any identified problems, should alert providers regarding temporary problems they could experience pending necessary system correction.

Intermediaries must educate their providers on the differences between their current 835 and version 4010 of the 835 to avoid provider misinterpretation of reporting variations between the versions. For example, version 3030M 835 users will need to be informed of the differences in the balancing computation they will encounter in version 4010.

More detail on specific testing requirements for providers, billing services, and clearinghouses will be issued in a separate PM.

Provider and Clearinghouse Outreach

By November 30, 2001, intermediaries must notify their providers, third party provider billing services, provider clearinghouses, and vendors that:

- Each provider that has elected to receive an ERA must accept version 4010 of the 835, or contract with a clearinghouse to translate data from the 835 version 4010 standard on their behalf;
- A provider, provider billing service, trading partner, vendor or clearinghouse that elects to use a clearinghouse for translation services is responsible for those costs;
- When PC-Print software for version 4010 will be available (no later than January 2, 2002) and how it may be obtained;

- The version 4010 835 implementation guide can be downloaded without charge from Washington Publishing Company's website www.wpc-edi.com/HIPAA;
- Providers, agents and clearinghouses who prefer advance testing to assure system compatibility of version 4010 of the 835 must schedule testing with their intermediaries as soon as possible to obtain a testing appointment prior to October 2002. Appointment slots will be assigned on a first come basis. Intermediaries will not be able to guarantee completion of testing by the end of September 2002 for any entity that delays requesting a testing appointment until late in the transition period. Unless a provider has requested that Medicare revert to issuance of SPRs only (do not encourage discontinuation of ERAs), current 835 and UB-92 remittance recipients will automatically be sent production 835 version 4010 transactions in October 2002;
- It may not be feasible to accommodate all entities that may want to be tested during the last quarter of the transition process because of the large number of providers, agents, clearinghouses, and trading partners who could request testing on the multiple HIPAA standard transactions;
- There is no Medicare charge for this system testing;
- Differences exist between their current 835 and version 4010 of the 835, and how these differences may impact their use of version 4010; and
- Although Medicare will furnish providers with basic information on HIPAA transaction requirements to enable them to make educated and timely decisions to plan for their transition to HIPAA standards, Medicare will not furnish in-depth training on the use and interpretation of the standard implementation guides. Providers with a need for such in-depth training for their staff are expected to obtain training of that nature from commercial vendors, their clearinghouse, or through standards development organizations.

Intermediaries must be pro-active to assure that providers, provider billing services, and clearinghouses are furnished adequate information for them to understand the impact of the HIPAA Administrative Simplification requirements, as implemented by Medicare, on their operations. Intermediaries must furnish appropriate information in regularly scheduled provider bulletins/newsletters, in other provider educational publications, during their regularly scheduled provider educational seminars, and in correspondence to enable those individuals and entities to make educated and timely decisions to plan their course of action in order to comply with the HIPAA standards as implemented by Medicare.

Cost Issues

The Budget and Performance Requirements (BPRs) specify that intermediaries include one 835 version upgrade per year in their line 1 maintenance costs. However, intermediaries are entitled to non-routine cost reimbursement related to HIPAA for: 1) translator upgrade if required to accommodate a higher volume of X12N transactions under HIPAA; 2) translator mapping to the new X12N-based flat file; 3) provider education on HIPAA transaction requirements (to the extent it exceeds routine educational efforts funded under the "Provider Education and Training" section of BPRs); 4) testing of SPR accuracy when generated with the 835 version 4010 flat file; 5) provider beta testing of the 835 with selected partners; and 6) testing requested by providers, their agents, clearinghouses, and trading partners for the HIPAA 835. Intermediaries should submit Supplemental Budget Requests for reasonable supplemental costs incurred to comply with these non-routine 835 requirements in FY 2001 and FY 2002.

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

Medicare processing under the terms of their Medicare contract may not be charged in total or in part to the Medicare program.

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

See the section of the instruction labeled "Cost Issues" for implementation cost information.

This PM may be discarded after January 1, 2003.

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

Attachments (2)

Attachment 1

MEDICARE X12N 835 VERSION 4010 HIPAA COMPANION DOCUMENT

Introduction

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

Although that implementation guide contains requirements for use of specific segments and data elements within the segments, the guide was written for use by all health benefit payers, and not specifically for Medicare. This document has been prepared as a Medicare-specific companion document to that implementation guide and 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 12.
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 13.
BPR02 Required. Mapped to ff record 1, field 14.
BPR03 Required. Code D does not apply to Medicare. Mapped to ff record 1, field 15.
BPR04 Required. Codes BOP and FWT do not apply to Medicare. Mapped to ff record 1, field 16.
BPR05 Situational, but required for Medicare if ACH is entered in BPR04. Mapped to ff record 1, field 17.
BPR06 Situational, but required for Medicare if ACH in BPR04. Code 04 does not apply to Medicare. Mapped to ff record 1, field 18.
BPR07 Situational, but required for Medicare if ACH in BPR04. Mapped to ff record 1, field 19.
BPR08 Situational, but required for Medicare if ACH in BPR04. Mapped to ff record 1, field 20.
BPR09 Situational, but required for Medicare if ACH in BPR04. Mapped to ff record 1, field 21.
BPR10 Situational, but required for Medicare if ACH in BPR04. Mapped to ff record 1, field 22.
BPR11 Situational, but does not apply to Medicare.
BPR12 Situational, but required for Medicare if ACH in BPR04. Code 04 does not apply to Medicare. Mapped to ff record 1, field 23.
BPR13 Situational, but required for Medicare if ACH in BPR04. Mapped to ff record 1, field 24.
BPR14 Situational, but required for Medicare if ACH in BPR04. Mapped to ff record 1, field 25.
BPR15 Situational, but required if ACH in BPR04. Mapped to ff record 1, field 26.
BPR16 Required. Mapped to ff record 1, field 27.
BPR17-21 Not used.

TRN Required.
TRN01 Required. Mapped to ff record 1, field 28.
TRN02 Required. If no payment is issued, insert the remittance advice number. Mapped to ff record 1, field 29 and 30.
TRN03 Required. TRN03 must =BPR10. Mapped to ff record 1, field 22.
TRN04 Situational in the 835, but does not apply to Medicare.

CUR Situational, but does not apply to Medicare.

REF (060.A) Situational, but required for Medicare if the 835 is being sent to any entity other than the 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 31.
DTM02 Required. Mapped to ff record 1, field 32.
DTM03-06 Not used.

N1 (080.A) Required for payer identification.
N101 Required. Mapped to ff record 10, field 12.
N102 Situational, but required for Medicare. Mapped to ff record 10, field 13.
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 14.
N104 Situational, but required once the PlanID is effective. Mapped to ff record 10, field 15.
N105-106 Not used.

N3 (100) Required for payer identification.
N301 Required. Mapped to ff record 10, field 16.
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 17.

N4 (110) Required for payer identification.
N401 Required. Mapped to ff record 10, field 18.
N402 Required. Mapped to ff record 10, field 19.
N403 Required. Mapped to ff record 10, field 20.
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 21.
REF02 Required. Mapped to ff record 10, field 22.
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 12.
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 13.
N103 Required. Always enter "FI" until the NPI is effective. After that date, always enter "XX." Mapped to ff record 15, field 14.
N104 Required. Payee's TIN for qualifier FI mapped to ff record 15, field 23. NPI, when effective, mapped to ff record 15, field 15.
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 16.
N302 Situational, but required if this segment is used and there is a second payee address line. Mapped to ff record 15, field 17.

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 18.
N402 Required. Mapped to ff record 15, field 19.
N403 Required. Mapped to ff record 15, field 20.
N404 Situational. Only required if the address is other than the U. S. Mapped to ff record 15, field 21.
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 22. PQ mapped to ff record 15, field 24.
REF02 Required. TJ (TIN) mapped to ff record 15, field 23. PQ mapped to ff record 15, field 25.
REF03-04 Not used.

Table 2, Detail Data

LX Situational, but required for Medicare.
LX01 Required. Mapped to ff record 20, field 12.

TS3 Situational, but required for intermediaries when applicable.
TS301 Required. Mapped to ff record 1, field 3.
TS302 Required. Mapped to ff record 1, field 5
TS303 Required. Mapped to ff record 1, field 4.
TS304 Required. Mapped to ff record 20, field 13.
TS305 Required. Mapped to ff record 20, field 14.
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 15.
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 16.
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 17.
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 18.
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 19.
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 20.
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 21.
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 22.

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 23.

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 24.

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 25.

TS317 Situational, but required for Medicare if provider billed for HCPCS line items payable on either clinical lab or orthotics and prosthetics fee schedules for this type of bill for this fiscal period. Mapped to ff record 20, field 26.

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 27.

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 28.

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 29.

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 30.

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 31.

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 32.

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 33.

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 12.

TS202 Situational, but required for Medicare if any federal-specific operating DRG amounts have been paid. Mapped to ff record 21, field 13.

TS203 Situational, but required for Medicare if any hospital-specific operating DRG amounts have been paid. Mapped to ff record 21, field 14.

TS204 Situational, but required for Medicare if any disproportionate share payments have been paid. Mapped to ff record 21, field 15.

TS205 Situational, but required for Medicare if capital payments, other than capital outliers, have been paid. Mapped to ff record 21, field 16.

TS206 Situational, but required for Medicare if any indirect medical education payments made. Mapped to ff record 21, field 17.

TS207 Situational, but required for Medicare if any day outlier payments made. Mapped to ff record 21, field 18.

TS208 Situational, but required for Medicare if any day outlier payments made. Mapped to ff record 21, field 19.

TS209 Situational, but required for Medicare if any cost outlier payments made. Mapped to ff record 21, field 20.

TS210 Situational, but required for Medicare if DRG payments made. This is the geometric average length of stay for DRGs for this interchange transmission. Mapped to ff record 21 field 21.

TS211 Situational, but required for Medicare when there have been discharges. Mapped to ff record 21, field 22.

TS212	Situational, but required for Medicare if there have been cost report days. Mapped to ff record 21, field 23.
TS213	Situational, but required for Medicare if there have been covered days. Mapped to ff record 21, field 24.
TS214	Situational, but required for Medicare if there have been any non-covered days. Mapped to ff record 21, field 25.
TS215	Situational, but required for Medicare if MSP pass-through amounts applied. Mapped to ff record 21, field 26.
TS216	Situational, but required for Medicare if DRG payments made. Mapped to ff record 21, field 27.
TS217	Situational, but required for Medicare if any PPS capital FSP DRG payment made. Mapped to ff record 21, field 28.
TS218	Situational, but required for Medicare if any PPS capital HSP DRG payment made. Mapped to ff record 21, field 29.
TS219	Situational, but required for Medicare if any PPS DSH DRG payment made. Mapped to ff record 21, field 30.
CLP	Required.
CLP01	Required. Mapped to ff record 30, field 12.
CLP02	Required. Mapped to ff record 30, field 13. Codes 5-17, 25 and 27 do not apply to Medicare.
CLP03	Required. Mapped to ff record 30, field 14.
CLP04	Required. Mapped to ff record 30, field 15.
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 16.
CLP07	Situational, but required for Medicare. Mapped to ff record 1, field 7.
CLP08	Situational, but required for Medicare. Mapped to ff record 30, field 17.
CLP09	Situational, but required for Medicare intermediaries. Mapped to ff record 30, field 18.
CLP10	Not used.
CLP11	Situational, but required for intermediaries if DRG payments made. Mapped to ff record 30, field 19.
CLP12	Situational, but required for Medicare if DRG payment made. Mapped to ff record 30, field 20.
CLP13	Situational, but required for Medicare if discharge fraction was a factor in payment to an institution. Mapped to ff record 30, field 21.
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 12. (If 2nd loop, mapped to ff record 31, field 31.)
CAS02	Required. Mapped to ff record 31, field 13. (If 2nd loop, mapped to field 32.)
CAS03	Required. Mapped to ff record 31, field 14. (If 2nd loop, mapped to field 33.)
CAS04	Situational. Mapped to ff record 31, field 15. (If 2nd loop, mapped to field 34.)
CAS05	Situational, but required for Medicare if a second claim level adjustment applies to this group code. Mapped to ff record 31, field 16. (If 2nd loop, mapped to field 35.)

CAS06 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.)
CAS07 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.)
CAS08 Situational, but required for Medicare if a third claim level adjustment applies to this group code. Mapped to ff record 31, field 19. (If 2nd loop mapped to field 38.)
CAS09 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.)
CAS10 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.)
CAS11 Situational, but required for Medicare if a fourth claim level adjustment applies to this group code. Mapped to ff record 31, field 22. (If 2nd loop, mapped to field 41.)
CAS12 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.)
CAS13 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.)
CAS14 Situational, but required for Medicare if a fifth claim level adjustment applies to this group code. Mapped to ff record 31, field 25. (If 2nd loop, mapped to field 44.)
CAS15 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.)
CAS16 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.)
CAS17 Situational, but required for Medicare if a sixth claim level adjustment applies to this group code. Mapped to ff record 31, field 28. (If 2nd loop, mapped to field 47.)
CAS18 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.)
CAS19 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.)

NM1 (030.A) Required to report patient-related information.
NM101 Required. Mapped to ff record 40, field 12.
NM102 Required. Mapped to ff record 40, field 13.
NM103 Required. Mapped to ff record 40, field 14.
NM104 Required. Mapped to ff record 40, field 15.
NM105 Situational, but required for Medicare when a middle name or initial is available for the patient. Mapped to ff record 40, field 16.
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 17.
NM109 Situational, but required for Medicare if reported on the incoming claim. Mapped to ff record 40, field 18.
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 19.
NM102 Required. Code 2 does not apply to Medicare. Mapped to ff record 40, field 20.
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 21.
NM109 Situational, but required for Medicare if the patient's ID # as been corrected. Mapped to ff record 40, field 22.
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 12.
NM102 Required. Mapped to ff record 41, field 13.
NM103 Required. Mapped to ff record 41, field 14
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 15.
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 16.
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 17. (If 2nd loop, mapped to field 22.)
NM102 Required. Mapped to ff record 41, field 18. (If 2d loop, mapped to field 23.)
NM103 Required. Mapped to ff record 41, field 19. (If 2nd loop, mapped to field 24.)
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 20. (If 2nd loop, mapped to field 25.)
NM109 Required. Enter the PlanID when effective. Prior to that date, enter 00. Mapped to ff record 41, field 21. (If 2nd loop, mapped to field 26.)
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, field12.

MIA02	Situational, but required for Medicare if there has been an operating outlier payment. Mapped to ff record 42, field 13.
MIA03	Situational, but required for Medicare if lifetime psychiatric days used. Mapped to ff record 42, field 14.
MIA04	Situational, but required for Medicare if DRG payment made. Mapped to ff record 42, field 15.
MIA05	Situational, but required for Medicare if at least one claim level remark code applies. Mapped to ff record 42, field 16.
MIA06	Situational, but required for Medicare if a disproportionate share amount is paid. Mapped to ff record 42, field 17.
MIA07	Situational, but required for Medicare if an MSP pass-through amount paid. Mapped to ff record 42, field 18.
MIA08	Situational. But required for Medicare if PP capital amount paid. Mapped to ff record 42, field 19.
MIA09	Situational, but required for Medicare if PPS capital FSP DRG amount paid. Mapped to ff record 42, field 20.
MIA10	Situational, but required for Medicare if PPS capital HSP DRG amount paid. Mapped to ff record 42, field 21.
MIA11	Situational, but required for Medicare if PPS capital DSH DRG amount paid. Mapped to ff record 42, field 22.
MIA12	Situational, but required for Medicare if old capital amount paid. Mapped to ff record 42, field 23.
MIA13	Situational, but required for Medicare if PPS capital IME amount paid. Mapped to ff record 42, field 24.
MIA14	Situational, but required for Medicare if PPS operating HSP DRG amount paid. Mapped to ff record 42, field 25.
MIA15	Situational, but required for Medicare if cost report days apply. Mapped to ff record 42, field 26.
MIA16	Situational, but required for Medicare if PPS operating FSP DRG amount paid. Mapped to ff record 42, field 27.
MIA17	Situational, but required for Medicare if PPS outlier amount paid. Mapped to ff record 42, field 28.
MIA18	Situational, but required for Medicare if indirect teaching amount paid. Mapped to ff record 42, field 29.
MIA19	Situational, but required for Medicare if professional component amount billed but not payable by this provider. Mapped to ff record 42, field 30.
MIA20	Situational but required for Medicare if a second claim level remark code applies. Mapped to ff record 42, field 31.
MIA21	Situational but required for Medicare if a third claim level remark code applies. Mapped to ff record 42, field 32.
MIA22	Situational but required for Medicare if a fourth claim level remark code applies. Mapped to ff record 42, field 33.
MIA23	Situational but required for Medicare if a fifth claim level remark code applies. Mapped to ff record 42, field 34.
MIA24	Situational but required for Medicare if a PPS capital exception amount paid. Mapped to ff record 42, field 35.
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 12.
MOA02	Situational, but required for Medicare if any line items paid on a fee schedule basis. Mapped to ff record 43, field 13.
MOA03	Situational, but required for Medicare if at least one claim level remark code applies. Mapped to ff record 43, field 14.
MOA04	Situational, but required for Medicare if a second claim level remark code applies. Mapped to ff record 43, field 15.

MOA05 Situational, but required for Medicare if a third claim level remark code applies. Mapped to ff record 43, field 16.

MOA06 Situational, but required for Medicare if a fourth claim level remark code applies. Mapped to ff record 43, field 17.

MOA07 Situational, but required for Medicare if a fifth claim level remark code applies. Mapped to ff record 43, field 18.

MOA08 Situational, but required for Medicare if ESRD payment made. Mapped to ff record 43, field 19.

MOA09 Situational, but required for Medicare if professional component amount billed but not payable to this provider. Mapped to ff record 43, field 20.

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 12.

REF02 Required. Mapped to ff record 44, field 13.

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 14. "232" mapped to ff record 44, field 16. "233" mapped to ff record 44, field 18.

DTM02 Required. Mapped to ff record 44, field 15 for 050. Mapped to ff record 44, field 17 for 232. Mapped to ff record 44, field 19 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 20; NL mapped to ff record 44, field 22; ZK for hemophilia add on to ff record 44, field 24; F5 to ff record 44, field 26; I to ff record 44, field 28; ZZ for inpatient outlier payment to ff record 44, field 30; AU to ff record 44, field 32. 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 21. NL mapped to ff record 44, field 23. Hemophilia add on (ZK) mapped to ff record 44, field 25. F5 mapped to ff record 44, field 27. I mapped to ff record 44, field 29. Any inpatient outlier payment (ZZ) mapped to ff record 44, field 31. AU mapped to ff record 44, field 33. 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 34; NA mapped to ff record 44, field 36; LA to ff record 44, field 38; CD to ff record 44, field 40; ZK mapped to ff record 44, field 42; and OU mapped to ff record 44, field 44.

QTY02 Required. CA mapped to ff record 44, field 35. NA mapped to ff record 44, field 37. LA mapped to ff record 44, field 39. CD mapped to ff record 44, field 41. ZK is mapped to ff record 44, field 43. OU is mapped to ff record 44, field 45. 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.

SVC01-1 Required. Only HC, NU, N4 and ZZ apply to Medicare intermediaries. HC mapped to ff record 50, field 12; NU mapped to ff record 50, field 12; ZZ mapped to ff record 50, field 12; N4 mapped to ff record 50, field 14. HC and Z would not apply to the same line, but NU and HC or NU and ZZ could apply t 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. (Contrary to the implementation guide note which only mentions SNF billing.) N4 will not be used until Medicare begins usage of NDC codes for drugs.

SVC01-2 Required. 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.
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 16.

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 17.

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 18.

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 19.

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

SVC02 Required. Mapped to ff record 50, field 20.

SVC03 Required. Mapped to ff record 50, field 21.

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 22.

SVC05 Situational, but required for Medicare. Mapped to ff record 50, field 23.

SVC06-1 Situational, but required if the procedure or drug code has been changed during adjudication.

SVC06-2 Required. HC mapped to ff record 50, field 24. N4 mapped to ff record 50, field 26. 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 28.

SVC06-4 Situational, but required for Medicare if the second modifier was changed during adjudication. Mapped to ff record 50, field 29.

SVC06-5	Situational, but required for Medicare if the third modifier was changed during adjudication. Mapped to ff record 50, field 30.
SVC06-6	Situational, but required for Medicare if the fourth modifier was changed during adjudication. Mapped to ff record 50, field 31.
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 32.
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 33.
DTM02	Required. Mapped to ff record 50, field 34.
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 12.
CAS02	Required. Mapped to ff record 51, field 13.
CAS03	Required. Mapped to ff record 51, field 14.
CAS04	Situational, but required for Medicare. Mapped to ff record 51, field 15.
CAS05	Situational, but required for Medicare if there is a second service level adjustment. Mapped to ff record 51, field 16.
CAS06	Situational, but required for Medicare if there is a second service level adjustment. Mapped to ff record 51, field 17.
CAS07	Situational, but required for Medicare if there is a second service level adjustment. Mapped to ff record 51, field 18.
CAS08	Situational, but required for Medicare if there is a third service level adjustment. Mapped to ff record 51, field 19.
CAS09	Situational, but required for Medicare if there is a third service level adjustment. Mapped to ff record 51, field 20.
CAS10	Situational, but required for Medicare if there is a third service level adjustment. Mapped to ff record 51, field 21.
CAS11	Situational, but required for Medicare if there is a fourth service level adjustment. Mapped to ff record 51, field 22.
CAS12	Situational, but required for Medicare if there is a fourth service level adjustment. Mapped to ff record 51, field 23.
CAS13	Situational, but required for Medicare if there is a fourth service level adjustment. Mapped to ff record 51, field 24.
CAS14	Situational, but required for Medicare if there is a fifth service level adjustment. Mapped to ff record 51, field 25.
CAS15	Situational, but required for Medicare if there is a fifth service level adjustment. Mapped to ff record 51, field 26.
CAS16	Situational, but required for Medicare if there is a fifth service level adjustment. Mapped to ff record 51, field 27.
CAS17	Situational, but required for Medicare if there is a sixth service level adjustment. Mapped to ff record 51, field 28.
CAS18	Situational, but required for Medicare if there is a sixth service level adjustment. Mapped to ff record 51, field 29
CAS19	Situational, but required for Medicare if there is a sixth service level adjustment. Mapped to ff record 51, field 30.
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 35; RB mapped to ff record 50, field 35. 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 reassociate lines for split claims. None of the other qualifiers currently apply to intermediaries.

REF02 Required. 1S mapped to ff record 50, field 36. RB mapped to ff record 50, field 37 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 38. B6 mapped to ff record 50, field 40.

AMT02 Required. DY mapped to ff record 50, field 39. B6 mapped to ff record 50, field 41.

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. 1 st HE mapped to ff record 50, field 42; 2nd to field 44; 3rd to field 46; 4th to field 48; 5th to field 50; 6th to field 52; 7th to field 54; 8th to field 56; and 9th to field 58..

LQ02 Required. 1st mapped to ff record 50, fields 43, and succeeding to fields 45, 47, 49, 51, 53, 55, 57, and 59 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 1, field 3.

PLB02 Required. Mapped to ff record 1, field 4.

PLB03-1 Required. The X12N provider adjustment code must be reported in 03-1, and the Medicare provider adjustment code in 03-2. The first X12N provider adjustment code is mapped to ff record 60, field 12.

NOTE: Outpatient PPS instructions had directed intermediaries to identify Transitional Outpatient Payments (TOPs) with BN 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 BN 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 13). Contrary to the misphrased note in the implementation guide, intermediaries should not report any additional data in positions 3-30 of this data element. Nor may intermediaries report

	anything other than the Medicare provider adjustment code in positions 1-2 of this data element.
PLB04	Required. Mapped to ff record 60, field 14.
PLB05	Situational, but required if there is a second provider level adjustment. Mapped to ff record 60, field 15.
PLB05-2	Situational, but required for Medicare if there is a second provider level adjustment. Mapped to ff record 60, field 16.
PLB06	Situational, but required for Medicare if there is a second provider level adjustment. Mapped to ff record 60, field 17.
PLB07-1	Situational, but required if there is a third provider level adjustment. Mapped to ff record 60, field 18.
PLB07-2	Situational, but required for Medicare if there is a third provider level adjustment. Mapped to ff record 60, field 19.
PLB08	Situational, but required for Medicare if there is a third provider level adjustment. Mapped to ff record 60, field 20.
PLB09-1	Situational, but required if there is a fourth provider level adjustment. Mapped to f record 60, field 21.
PLB09-2	Situational, but required for Medicare if there is a fourth provider level adjustment. Mapped to ff record 60, field 22.
PLB10	Situational, but required for Medicare if there is a fourth provider level adjustment. Mapped to ff record 60, field 23.
PLB11-1	Situational, but required for Medicare if there is a fifth provider level adjustment. Mapped to ff record 60, field 24.
PLB11-2	Situational, but required for Medicare if there is a fifth provider level adjustment. Mapped to ff record 60, field 25.
PLB12	Situational, but required for Medicare if there is a fifth provider level adjustment. Mapped to ff record 60, field 26.
PLB13-1	Situational, but required for Medicare if there is a sixth provider level adjustment. Mapped to ff record 60, field 27.
PLB13-2	Situational, but required for Medicare if there is a sixth provider level adjustment. Mapped to ff record 60, field 28.
PLB14	Situational, but required for Medicare if there is a sixth provider level adjustment. Mapped to ff record 60, field 29.
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

Attachment 2

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Remark Codes

Code Value	Description
M1	X-ray not taken within the past 12 months or near enough to the start of treatment.
M2	Not paid separately when the patient is an inpatient.
M3	Equipment is the same or similar to equipment already being used.
M4	This is the last monthly installment payment for this durable medical equipment.
M5	Monthly rental payments can continue until the earlier of the 15th month from the first rental month, or the month when the equipment is no longer needed.
M6	You must furnish and service this item for as long as the patient continues to need it. We can pay for maintenance and/or servicing for every 6-month period after the end of the 15th paid rental month or the end of the warranty period.
M7	No rental payments after the item is purchased, or after the total of issued rental payments equals the purchase price.
M8	We do not accept blood gas tests results when the test was conducted by a medical supplier or taken while the patient is on oxygen.
M9	This is the tenth rental month. You must offer the patient the choice of changing the rental to a purchase agreement.
M10	Equipment purchases are limited to the first or the tenth month of medical necessity.

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

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

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

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

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

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

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

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

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

M20 HCPCS needed.

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

M22 Claim lacks the number of miles traveled.

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

M24 Claim must indicate the number of doses per vial.

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

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

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

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

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

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

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

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

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

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

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

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

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

You may ask for a reconsideration for hospital insurance (or a review for medical insurance) regarding both the coverage determination and the issue of whether you

exercised due care. The request for reconsideration must be filed within 60 days (or 6 months for a medical insurance review) from the date of this notice. You may make the request through any Social Security office or through this office.

M28 This does not qualify for payment under Part B when Part A coverage is exhausted or not otherwise available.

M29 Claim lacks the operative report.

M30 Claim lacks the pathology report.

M31 Claim lacks the radiology report.

M3 This is a conditional payment made pending a decision on this service by the patient's primary payer. This payment may be subject to refund upon your receipt of any additional payment for this service from another payer. You must contact this office immediately upon receipt of an additional payment for this service.

M33 Claim lacks the UPIN of the ordering/referring or performing physician or practitioner, or the UPIN is invalid. (Substitute NPI for UPIN when effective)

M34 Claim lacks the CLIA certification number.
(**Note:** M34 duplicates remark code message MA120. Message M34 is inactive effective with implementation of version 4010 of the X12 835. M34may not be used after that date.)

M35 Claim lacks pre-operative photos or visual field results.

M36 This is the 11th rental month. We cannot pay for this until you indicate that the patient has been given the option of changing the rental to a purchase.

M37 Service not covered when the patient is under age 35.

M38 The patient is liable for the charges for this service as you informed the patient in writing before the service was furnished that we would not pay for it, and the patient agreed to pay.

M39 The patient is not liable for payment for this service as the advance notice of non-coverage you provided the patient did not comply with program requirements.

M40 Claim must be assigned and must be filed by the practitioner's employer.

M41 We do not pay for this as the patient has no legal obligation to pay for this.

M42 The medical necessity form must be personally signed by the attending physician.

M43 Payment for this service previously issued to you or another provider by another carrier/intermediary.

M44 Incomplete/invalid condition code.

M45 Incomplete/invalid occurrence codes and dates.

M46 Incomplete/invalid occurrence span code and dates.

M47 Incomplete/invalid internal or document control number.

M48 Payment for services furnished to hospital inpatients (other than professional services of physicians) can only be made to the hospital. You must request payment from the hospital rather than the patient for this service.

M49 Incomplete/invalid value code(s) and/or amount(s).

M50 Incomplete/invalid revenue code(s).

M51 Incomplete/invalid, procedure code(s) and/or rates, including "not otherwise classified" or "unlisted" procedure codes submitted without a narrative description or the description is insufficient.

(Add to message by Medicare carriers only: "Refer to the HCPCS Directory. If an appropriate procedure code(s) does not exist, refer to Item 19 on the Form HCFA-1500 instructions.")

M52 Incomplete/invalid "from" date(s) of service.

M53 Did not complete or enter the appropriate number (one or more) of days or units(s) of service.

M54 Did not complete or enter the correct total charges for services rendered.

M55 We do not pay for self-administered anti-emetic drugs that are not administered with a covered oral anti-cancer drug.

M56 Incomplete/invalid payer identification.

M57 Incomplete/invalid provider number. (Substitute NPI for provider number when effective.)

M58 Please resubmit the claim with the missing/correct information so that it may be processed.

M59 Incomplete/invalid "to" date(s) of service.

M60 Rejected without appeal rights due to invalid CMN form or format. Resubmit with completed, OMB-approved form or in an approved format.

M61 We cannot pay for this as the approval period for the FDA clinical trial has expired.

M62 Incomplete/invalid treatment authorization code.

M63 We do not pay for more than one of these on the same day.

M64 Incomplete/invalid other diagnosis code.

M65 One interpreting physician charge can be submitted per claim when a purchased diagnostic test is indicated. Submit a separate claim for each interpreting physician.

M66 Our records indicate that you billed diagnostic tests subject to price limitations and the procedure code submitted includes a professional component. Only the technical component is subject to price limitations. Submit the technical and professional components of this service as separate line items.

M67 Incomplete/invalid other procedure code(s) and/or date(s).

M68 Incomplete/invalid attending or referring physician identification.

M69 Paid at the regular rate as you did not submit documentation to justify modifier 22.

M70 NDC code submitted for this service was translated to a HCPCS code for processing, but continue to submit the NDC on future claims for this item.

M71 Total payment reduced due to overlap of tests billed.

M72 Did not enter full 8-digit date (MM/DD/CCYY).
(**Note:** M72 duplicates remark code message MA52. Message M72 is inactive effective with implementation of version 4010 of the X12 835. M72 may not be used after that date.)

M73 The HPSA bonus can only be paid on the professional component of this service. Rebill as separate professional and technical components. Use the HPSA modifier on the professional component only.

M74 This service does not qualify for a HPSA bonus payment.

M75 Allowed amount adjusted. Multiple automated multichannel tests performed on the same day combined for payment.

M76 Incomplete/invalid patient's diagnosis(es) and condition(s).

M77 Incomplete/invalid place of service(s).

M78 Did not complete or enter accurately an appropriate HCPCS modifier(s).
M79 Did not complete or enter the appropriate charge for each listed service.
M80 We cannot pay for this when performed during the same session as a previously processed service for the patient.
M81 Patient's diagnosis code(s) is truncated, incorrect or missing; you are required to code to the highest level of specificity.
M82 Service is not covered when patient is under age 50.
M83 Service is not covered unless the patient is classified as at high risk.
M84 Old and new HCPCS cannot be billed for the same date of service.
M85 Subjected to review of physician evaluation and management services.
M86 Service denied because payment already made for similar procedure within set time frame.
M87 Claim/service(s) subjected to CFO-CAP prepayment review..
M88 We cannot pay for laboratory tests unless billed by the laboratory that did the work.
M89 Not covered more than once under age 40.
M90 Not covered more than once in a 12 month period.
M91 Lab procedures with different CLIA certification numbers must be billed on separate claims.
M92 Services subjected to review under the Home Health Medical Review Initiative.
M93 Information supplied supports a break in therapy. A new capped rental period began with delivery of this equipment.
M94 Information supplied does not support a break in therapy. A new capped rental period will not begin.
M95 Services subjected to Home Health Initiative medical review/cost report audit.
M96 The technical component of a service furnished to an inpatient may only be billed by that inpatient facility. You must contact the inpatient facility for technical component reimbursement. If not already billed, you should bill us for the professional component only.
M97 Not paid to practitioner when provided to patient in this place of service. Payment included in the reimbursement issued the facility.
M98 Begin to report the Universal Product Number (UPN) on claims for items of this type. We will soon begin to deny payment for items of this type if billed without the correct UPN.
M99 Incomplete/invalid/missing UPN.
M100 We do not pay for an oral anti-emetic drug that is not administered for use immediately before, at, or within 48 hours of administration of a covered chemotherapy drug.
M101 Begin to report a G1-G5 modifier with this HCPCS. We will soon begin to deny payment for this service if billed without a G1-G5 modifier.
M102 Service not performed on equipment approved by the FDA for this purpose.
M103 Information supplied supports a break in therapy. However, the medical information we have for this patient does not support the need for this item as billed. We have approved payment for this item at a reduced level, and a new capped rental period will begin with the delivery of this equipment.

M104 Information supplied supports a break in therapy. A new capped rental period will begin with delivery of the equipment. This is the maximum approved under the fee schedule for this item or service.
M105 Information supplied does not support a break in therapy. The medical information we have for this patient does not support the need for this item as billed. We have approved payment for this item at a reduced level, and a new capped rental period will not begin.
M106 Information supplied does not support a break in therapy. A new capped rental period will not begin. This is the maximum approved under the fee schedule for this item or service.
M107 Payment reduced as 90-day rolling average hematocrit for ESRD patient exceeded 36.5%.
M108 Must report the PIN of the physician who interpreted the diagnostic test. (Substitute NPI for PIN when effective.)
M109 We have provided you with a bundled payment for a teleconsultation. You must send 25 percent of the teleconsultation payment to the referring practitioner.
M110 Missing/invalid provider number for the provider from whom you purchased interpretation services.(Substitute NPI for provider number when effective.)
M111 We do not pay for chiropractic manipulative treatment when the patient refuses to have an x-ray taken.
M112 The approved amount is based on the maximum allowance for this item under the DMEPOS Competitive Bidding Demonstration.
M113 Our records indicate that this patient began using this service(s) prior to the current round of the DMEPOS Competitive Bidding Demonstration. Therefore, the approved amount is based on the allowance in effect prior to this round of bidding for this item.
M114 This service was processed in accordance with rules and guidelines under the Competitive Bidding Demonstration Project. If you would like more information regarding this project, you may phone 1-888-289-0710.
M115 This item is denied when provided to this patient by a non-demonstration supplier.
M116 Even though this service is being paid in accordance with the rules and guidelines under the Competitive Bidding Demonstration, future claims may be denied when this item is provided this patient by a non-demonstration supplier. If you would like more information regarding this project, you may phone 1-888-289-0710.
M117 Not covered unless supplier files an electronic media claim (EMC).
M118 Letter to follow containing further information.
M119 National Drug Code (NDC) needed.
M120 Lacks UPIN of the substituting physician who furnished the service(s) under a reciprocal billing or locum tenens arrangement. (Substitute NPI for UPIN when effective.)
M121 We pay for this service only when performed with a covered cryosurgical ablation.
M122 Level of subluxation is missing or inadequate.
M123 Failed to submit the name, strength, or dosage of the drug furnished.
M124 Information to indicate if the patient owns the equipment that requires the part or supply was missing.
M125 Information about the period of time for which this will be needed was missing.

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

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

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

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

MA02 (Initial Medicare Part A determination)--If you do not agree with this determination, you have the right to appeal. You must file a written request for a reconsideration within 60 days of receipt of this notification. Decisions made by a PRO must be appealed to that PRO. (An institutional provider, e.g., hospital, SNF, HHA, may appeal only if the claim involves a medical necessity denial, a SNF noncertified bed denial, or a home health denial because the patient was not homebound or was not in need of intermittent skilled nursing services, and either the patient or the provider is liable under Section1879 of the Social Security Act, and the patient chooses not to appeal.)

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

(**Note:** An intermediary must add: An institutional provider, e.g., hospital, SNF, Home Health Care, may appeal only if the claim involves a medical necessity denial, a SNF noncertified bed denial, or a home health denial because the patient was not homebound or was not in need of intermittent skilled nursing services, and either the patient or the provider is liable under Section1879 of the Social Security Act, and the patient chooses not to appeal.)

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

MA05 Incorrect admission date, patient status or type of bill entry on claim.
(**Note:** MA05 duplicates information in remark codes MA30, MA40 and MA43. Message MA05 is inactive effective with implementation of version 4010 of the X12 835. MA05 may not be used after that date.)

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

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

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

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

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

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

MA12 You have not established that you have the right under the law to bill for services furnished by the person(s) that furnished this (these) service(s).
MA13 You may be subject to penalties if you bill the patient for amounts not reported with the PR (patient responsibility) group code.
MA14 Patient is a member of an employer-sponsored prepaid health plan. Services from outside that health plan are not covered. However, as you were not previously notified of this, we are paying this time. In the future, we will not pay you for non-plan services.
MA15 Your claim has been separated to expedite handling. You will receive a separate notice for the other services reported.
MA16 The patient is covered by the Black Lung Program. Send this claim to the Department of Labor, Federal Black Lung Program, P.O. Box 828, Lanham-Seabrook MD 20703.
MA17 We are the primary payer and have paid at the primary rate. You must contact the patient's other insurer to refund any excess it may have paid due to its erroneous primary payment.
MA18 The claim information is also being forwarded to the patient's supplemental insurer. Send any questions regarding supplemental benefits to them.
MA19 Information was not sent to the Medigap insurer due to incorrect/invalid information you submitted concerning that insurer. Please verify your information and submit your secondary claim directly to that insurer.
MA20 SNF stay not covered when care is primarily related to the use of an urethral catheter for convenience or the control of incontinence.
MA21 SSA records indicate mismatch with name and sex.
MA22 Payment of less than $1.00 suppressed.
MA23 Demand bill approved as result of medical review.
MA24 Christian Science Sanitorium/ SNF bill in the same benefit period.
MA25 A patient may not elect to change a hospice provider more than once in a benefit period.
MA26 Our records indicate that you were previously informed of this rule.
MA27 Incorrect entitlement number or name shown on the claim. Please use the entitlement number or name shown on this notice for future claims for this patient.
MA28 Receipt of this notice by a physician or supplier who did not accept assignment is for information only and does not make the physician or supplier a party to the determination. No additional rights to appeal this decision, above those rights already provided for by regulation/instruction, are conferred by receipt of this notice.
MA29 Incomplete/invalid provider name, city, state, and zip code.
MA30 Incomplete/invalid type of bill.
MA31 Incomplete/invalid beginning and ending dates of the period billed.
MA32 Incomplete/invalid number of covered days during the billing period.
MA33 Incomplete/invalid number of noncovered days during the billing period.
MA34 Incomplete/invalid number of coinsurance days during the billing period.
MA35 Incomplete/invalid number of lifetime reserve days.
MA36 Incomplete/invalid patient's name.

MA37 Incomplete/invalid patient's address.
(**Note:** When used, a payer must verify that an address, with city, State, and zip code, and a phone number are present.)
MA38 Incomplete/invalid patient's birthdate.
MA39 Incomplete/invalid patient's sex.
MA40 Incomplete/invalid admission date.
MA41 Incomplete/invalid type of admission.
MA42 Incomplete/invalid source of admission.
MA43 Incomplete/invalid patient status.
MA44 No appeal rights. Adjudicative decision based on law.
MA45 As previously advised, a portion or all of your payment is being held in a special account.
MA46 The new information was considered, however, additional payment cannot be issued. Review the information listed for the explanation.
MA47 Our records show you have opted out of Medicare, agreeing with the patient not to bill Medicare for services/tests/supplies furnished. As result, we cannot pay this claim. The patient is responsible for payment
MA48 Incomplete/invalid name and/or address of responsible party or primary payer .
MA49 Incomplete/invalid six-digit provider number of home health agency or hospice for physician(s) performing care plan oversight services.
MA50 Incomplete/invalid Investigational Device Exemption number for FDA-approved clinical trial services.
MA51 Incomplete/invalid CLIA certification number for laboratory services billed by physician office laboratory.
MA52 Did not enter full 8-digit date (MM/DD/CCYY for paper form or CCYY/MM/DD for electronic format).
MA53 Inconsistent demonstration project information. Correct and resubmit with information on no more than one demonstration project.
MA54 Physician certification or election consent for hospice care not received timely.
MA55 Not covered as patient received medical health care services, automatically revoking his/her election to receive religious non-medical health care services.
MA56 Our records show you have opted out of Medicare, agreeing with the patient not to bill Medicare for services/tests/supplies furnished. As result, we cannot pay this claim. The patient is responsible for payment, but under Federal law, you cannot charge the patient more than the limiting charge amount.
MA57 Patient submitted written request to revoke his/her election for religious non-medical health care services.
MA58 Incomplete release of information indicator.
MA59 The patient overpaid you for these services. You must issue the patient a refund within 30 days for the difference between his/her payment and the total amount shown as patient responsibility on this notice.
MA60 Incomplete/invalid patient's relationship to insured.
MA61 Did not complete or enter correctly the patient's social security number or health insurance claim number.
MA62 Telephone review decision
MA63 Incomplete/invalid principal diagnosis code.

MA64 Our records indicate that we should be the third payer for this claim. We cannot process this claim until we have received payment information from the primary and secondary payers.
MA65 Incomplete/invalid admitting diagnosis.
MA66 Incomplete/invalid principal procedure code and/or date.
MA67 Correction to a prior claim.
MA68 We did not crossover this claim because the secondary insurance information on the claim was incomplete. Supply complete information or use the PLANID of the insurer to assure correct and timely routing of the claim.
MA69 Incomplete/invalid remarks.
MA70 Incomplete provider representative signature.
MA71 Incomplete/invalid provider representative signature date.
MA72 The patient overpaid you for these assigned services. You must issue the patient a refund within 30 days for the difference between his/her payment to you and the total of the amount shown as patient responsibility and as paid to the patient on this notice.
MA73 Informational remittance associated with a Medicare demonstration. No payment issued under fee-for-service Medicare as patient has elected managed care.
MA74 This payment replaces an earlier payment for this claim that was either lost, damaged or returned.
MA75 Our records indicate neither a patient's or authorized representative's signature was submitted on the claim. Since this information is not on file, resubmit.
MA76 Incomplete/invalid provider number of HHA or hospice when physician is performing care plan oversight services.
MA77 The patient overpaid you. You must issue the patient a refund within 30 days for the difference between the patient's payment less the total of our and other payer payments and the amount shown as patient responsibility on this notice.
MA78 The patient overpaid you. You must issue the patient a refund within 30 days for the difference between our allowed amount total and the amount paid by the patient.
MA79 Billed in excess of interim rate.
MA80 Informational notice. No payment issued for this claim with this notice. Payment issued to the hospital by its intermediary for all services for this encounter under a demonstration project.
MA81 Our records indicate neither a physician or supplier signature is on the claim or on file.
MA82 Did not complete or enter the correct physician/supplier's billing number/NPI and/or billing name, address, city, state, zip code, and phone number.
MA83 Did not indicate whether we are the primary or secondary payer. Refer to Item 11 in the Form HCFA-1500 instructions for assistance.
MA84 Patient identified as participating in the National Emphysema Treatment Trial but our records indicate that this patient is either not a participant, or has not yet been approved for this phase of the study. Contact Johns Hopkins University, the study coordinator, to resolve if there was a discrepancy.

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

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

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

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

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

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

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

MA92 Our records indicate that there is insurance primary to ours; however, you did not complete or enter accurately the required information.
(**NOTE:** Medicare Carriers must also add: Refer to the Form HCFA-1500 instructions on how to complete MSP information.)

MA93 Non-PIP claim.

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

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

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

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

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

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

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

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

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

MA103 Hemophilia Add On

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

MA105 Missing/invalid provider number for this place of service. Place of service code shown as 21, 22, or 23 (hospital). (Substitute "NPI" for provider number when effective.)
MA106 PIP claim.
MA107 Paper claim contains more than three separate data items in field 19
MA108 Paper claim contains more than one data item in field 23.
MA109 Claim processed in accordance with ambulatory surgical guidelines.
MA110 Our records indicate that you billed diagnostic test(s) subject to price limitations; however, you did not indicate whether the test(s) were performed by an outside entity or if no purchased tests are included on the claim.
MA111 Our records indicate that you billed diagnostic test(s) subject to price limitations and indicated that the test(s) were performed by an outside entity; however, you did not indicate the purchase price of the test(s) and/or the performing laboratory's name and address.
MA112 Our records indicate that the performing physician/supplier/practitioner is a member of a group practice; however, you did not complete or enter accurately their carrier assigned individual and group PINs. (Substitute "NPI" for "PIN" when effective.)
MA113 Incomplete/invalid taxpayer identification number (TIN) submitted by you per the Internal Revenue Service. Your claims cannot be processed without your correct TIN, and you may not bill the patient pending correction of your TIN. There are no appeal rights for unprocessable claims, but you may resubmit this claim after you have notified this office of your correct TIN.
MA114 Did not complete or enter accurately the name and address, the carrier assigned PIN, or the regional office assigned OSCAR number of the entity where services were furnished. (Substitute"NPI" for "PIN" when effective.)
MA115 Our records indicate that you billed one or more services in a Health Professional Shortage Area (HPSA); however, you did not enter the physical location (name and address, or PIN) where the service(s) were rendered. (Substitute "NPI" for "PIN" when effective.)
MA116 Did not complete the statement "Homebound" on the claim to validate whether laboratory services were performed at home or in an institution.
MA117 This claim has been assessed a $1.00 user fee.
MA118 Coinsurance and/or deductible amounts apply to a claim for services or supplies furnished to a Medicare-eligible veteran through a facility of the Department of Veterans Affairs. No Medicare payment issued.
MA119 Provider level adjustment for late claim filing applies to this claim.
MA120 Did not complete or enter accurately the CLIA number.
MA121 Did not complete or enter accurately the date the X-Ray was performed.
MA122 Did not complete or enter accurately the initial date "actual" treatment occurred.
MA123 Your center was not selected to participate in this study, therefore, we cannot pay for these services.
MA124 Processed for IME only.
MA125 Per legislation governing this program, payment constitutes payment in full.
MA126-127 Reserved for future use
MA128 Did not complete or enter accurately the six digit FDA approved, identification number.

MA129 This provider was not certified for this procedure on this date of service. Effective 1/1/98, we will begin to deny payment for such procedures. Contact _____ to correct or obtain CLIA certification. (Claim processor must provide the name and phone number of the State Agency to be contacted.)
MA130 Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Submit a new claim with the complete/correct information.
MA131 Physician already paid for services in conjunction with this demonstration claim. You must have the physician withdraw that claim and refund the payment before we can process your claim.
MA132 Adjustment to the pre-demonstration rate.
MA133 Claim overlaps inpatient stay. Rebill only those services rendered outside the inpatient stay.
MA134 Missing/incomplete/invalid provider number of the facility where the patient resides.

N1 You may appeal this decision in writing within the required time limits following receipt of this notice.
N2 This allowance has been made in accordance with the most appropriate course of treatment provision of the plan.
N3 Required/consent form incomplete, incorrect, or not on file.
N4 Prior insurance carrier EOB received was insufficient.
N5 EOB received from previous payer. Claim not on file.
N6 Under FEHB law (U.S.C. 8904(b)), we cannot pay more for covered care than the amount Medicare would have allowed if the patient were enrolled in Medicare Part A.
N7 Processing of this claim/service has included consideration under Major Medical provisions.
N8 Crossover claim denied by previous payer and complete claim data not forwarded. Resubmit this claim to this payer to provide adequate data for adjudication.
N9 Adjustment represents the estimated amount the primary payer may have paid.
N10 Claim/service adjusted because of the finding of a Review Organization/professional consult/manual adjudication.
N11 Denial reversed because of medical review.
N12 Policy provides coverage supplemental to Medicare. As member does not appear to be enrolled in Medicare Part B, the member is responsible for payment of the portion of the charge that would have been covered by Medicare.
N13 Payment based on professional/technical component modifier(s).
N14 Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.
N15 Services for a newborn must be billed separately.
N16 Family/member Out-of-Pocket maximum has been met. Payment based on a higher percentage.
N17 Per admission deductible.
N18 Payment based on the Medicare allowed amount.
N19 Procedure code incidental to primary procedure.
N20 Service not payable with other service rendered on the same date.

N21 Range of dates separated onto single lines.
N22 This procedure was added because it more accurately describes the services rendered.
N23 Patient liability may be affected due to coordination of benefits with primary carrier and/or maximum benefit provisions.
N24 Electronic Funds Transfer (EFT) banking information incomplete/invalid.
N25 This company has been contracted by your benefit plan to provide administrative claims payment services only. This company does not assume financial risk or obligation with respect to claims processed on behalf of your benefit plan.
N26 Itemized bill required for claim adjudication.
N27 Treatment number not indicated on claim.
N28 Consent form requirements not fulfilled.
N29 Required documentation/orders/notes/summary/report/invoice needed to adjudicate.
N30 Recipient ineligible for this service.
N31 Prescribing/referring/attending practitioner license number is absent/incorrect/incomplete.
N32 Provider performing service must submit claim.
N33 No record of health check prior to initiation of treatment.
N34 Incorrect claim form for this service.
N35 Program integrity/utilization review decision.
N36 Claim must meet primary payer's processing requirements before we can consider payment.
N37 Tooth number/letter required.
N38 Place of service missing.
N39 Procedure code is not compatible with tooth number/letter.
N40 Procedure requires X-Ray.
N41 Authorization request denied. (**Note:** N41 duplicates reason code message 39. . Message N41 is inactive effective with implementation of version 4010 of the X12 835. N41 may not be used after that date.)
N42 No record of mental health assessment.
N43 Bed hold or leave days exceeded.
N44 Payor's share of regulatory surcharges, assessments, allowances or health care-related taxes paid directly to the regulatory authority. (**Note:** N44 duplicates remark code message 137. Message N44 is inactive effective with implementation of version 4010 of the X12 835. N44 may not be used after that date.)
N45 Payment based on authorized amount.
N46 Missing/incomplete/invalid admission hour.
N47 Claim conflicts with another inpatient stay.
N48 Claim information does not agree with information received from other insurance carrier.
N49 Court ordered coverage information needs validation.
N50 Discharge information missing/incomplete/incorrect/invalid.
N51 Electronic interchange agreement not on file for provider/submitter.
N52 Patient not enrolled in the billing provider's managed care plan on the date of service.
N53 Incomplete/invalid street, city, state and/or zip code for the point of pickup.

N54 Claim information is inconsistent with pre-certified/authorized services.
N55 Procedures for billing with group/referring/performing providers were not followed.
N56 Procedure code billed is not correct for the service billed.
N57 Missing/incomplete/invalid prescribing/dispensed date.
N58 Patient liability amount missing, invalid, or not on file.
N59 Refer to your provider manual for additional program and provider information.
N60 A valid NDC is required for payment of drug claims effective October 2002.
N61 Rebill services on separate claims.
N62 Inpatient admission spans multiple rate periods. Resubmit separate claims.
N63 Rebill services on separate claim lines.
N64 The "from" and "to" dates must be different.
N65 Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider. Please contact the Health Plan prior to refiling the claim.
N66 Claim lacks necessary documentation.
N67 Professional provider services not paid separately. Included in facility payment under a demonstration project. Apply to that facility for payment, or resubmit your claim if: the facility notifies you the patient was excluded from this demonstration; or if you furnished these services in another location on the date of the patient's admission or discharge from a demonstration hospital. If services were furnished in a facility not involved in the demonstration on the same date the patient was discharged from or admitted to a demonstration facility, you must report the provider ID number for the non-demonstration facility on the new claim.
N68 Prior payment being cancelled as we were subsequently notified this patient was covered by a demonstration project in this site of service. Professional services were included in the payment made to the facility. You must contact the facility for your payment. Prior payment made to you by the patient or another insurer for this claim must be refunded to the payer within 30 days.
N69 PPS code changed by claims processing system. Insufficient visits or therapies.
N70 Home health consolidated billing and payment applies. Ancillary providers/suppliers must contact the HHA for reimbursement.
N71 Your unassigned claim for a drug or biological was processed as an assigned claim. The law requires you must take assignments on all claims for drugs and biologicals.
N72 PPS code changed by medical reviewers. Not supported by clinical records.
N73 A SNF is responsible for payment of outside providers who furnish these services/supplies to residents.
N74 Resubmit with multiple claims, each claim covering services provided in only one calendar month
N75 Missing or invalid tooth surface information
N76 Missing or invalid number of riders (for ambulance services)
N77 Missing or invalid designated provider number
N78 The necessary components of the child and teen checkup (EPSDT) were not completed.
N79 Service billed is not compatible with patient location information
N80 Missing or invalid prenatal screening information
N81 Procedure billed is not compatible with tooth surface code
N82 Provider must accept insurance payment as payment in full when a third party payer contract specifies full reimbursement.
N83 No appeal rights. Adjudicative decision based on the provisions of a demonstration project.
N84 Further installment payments forthcoming.
N85 Final installment payment.

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

N87 Home use of biofeedback therapy is not covered.

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

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

REQUESTS FOR ADDITIONAL CODES

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