CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1063	**Date: SEPTEMBER 22, 2006**
	Change Request 5308

SUBJECT: Ending the Contingency Plan for Remittance Advice and Charging for PC Print, Medicare Remit Easy Print, and Duplicate Remittance Advice

I. SUMMARY OF CHANGES: This Change Request (CR) updates the IOM (100-04) for ending the contingency plan for Electronic Remittance Advice (ERA), and instructs contractors about charging for PC Print, Medicare Remit Easy Print (MREP), and duplicate Remittance Advice (RA). The manual updates listed here incorporate updates that were included in CR 5081 and CR 5247.

NEW / REVISED MATERIAL
EFFECTIVE DATE: October 1, 2006
IMPLEMENTATION DATE: October 23, 2006

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

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	Chapter / Section / Subsection / Title
R	22/Table of Contents
R	22/10/Background
R	22/20/General Remittance Completion Requirements
R	22/30/Remittance Balancing
R	22/40/Electronic Remittance Advice
R	22/40/40.1/ANSI ASC X12N 835
R	22/40/40.2/Generating an ERA if Required Data is Missing or Invalid
R	22/40/40.4/Medicare Standard Electronic PC Print Software for Institutional Providers
N	22/40/40.5/Medicare Remit Easy Print Software for Professional Providers and Suppliers

N	22/40/40.6/835 Implementation Guide
R	22/50/Standard Paper Remittance Advice
R	22/50/50.1/The Do Not Forward (DNF) Initiative
R	22/50/50.2/SPR Formats
R	22/50/50.2/50.2.1/Part A (A/B MACs/FIs/RHHIs) SPR Format
R	22/50/50.2/50.2.2/Part B(A/B MAC/Carrier/DMERC/DME MAC) SPR Format
R	22/50/50.3/Part A (A/B MAC/FI/RHHI) SPR Crosswalk to the 835
R	22/50/50.4/Part B (A/B MAC/Carrier/ DMERC/DME MAC) SPR Crosswalk to the 835
R	22/60/Remittance Advice Codes
R	22/60/60.1/Claim Adjustment Reason Codes
R	22/60/60.2/Remittance Advice Remark Codes
R	22/60/60.3/Group Codes
R	22/60/60.4/Requests for Additional Codes
R	22/70/A/B MAC/FI/RHHI ERA Requirement Changes to Accommodate OPPS and HH PPS
R	22/70/70.1/Scope of Remittance Changes for HH PPS
R	22/70/70.3/Items Not Included in HH PPS Episode Payment
R	22/70/70.4/835 Version 004010A1 Line Level Reporting Requirements for the Request for Anticipated Payment (RAP) Payment for an Episode
R	22/70/70.5/835 Version 004010A1 Line Level Reporting Requirements for the Claim Payment in an Episode (More Than Four Visits)
R	22/70/70.6/835 Version 004010A1 Line Level Reporting Requirements for the Claim Payment in an Episode (Four or Fewer Visits)
R	22/70/70.7/PPS Partial Episode Payment (PEP) Adjustment
R	24/Table of Contents
R	24/40/40.1/General HIPAA EDI Requrements
R	24/40/40.2/Continued Support of Pre-HIPAA EDI Formats
R	24/40/40.3/40.3.1/Electronic Remittance Advice
R	24/40/40.3/40.3.2/Standard Paper Remittance (SPR) Notices
R	24/40/40.3/40.3.3/Remittance Advice Remark Codes
R	24/40/40.7/Electronic Funds Transfer (EFT)
R	24/60/60.6/60.6.1/Medicare Remit Easy Print Software for Professional Providers and Suppliers
R	24/60/60.6/60.6.2/Medicare Standard Electronic PC Print Software for Institutional

	Providers

III. FUNDING:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2007 operating budget.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

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

Attachment – Business Requirements

Pub. 100-04	Transmittal: 1063	Date: September 22, 2006	Change Request: 5308

SUBJECT: Ending the Contingency Plan for Remittance Advice and Charging for PC Print, Medicare Remit Easy Print, and Duplicate Remittance Advice.

I. GENERAL INFORMATION

A. Background: This non-system Change Request (CR) instructs contractors about charging for PC Print and Medicare Remit Easy Print softwares and for generating and mailing provider requested duplicate remittance advice. It also updates chapters 22 and 24 of the Claims Processing Manual to include the end of contingency for Electronic Remittance Advice (ERA) effective October 1, 2006. This CR incorporates all manual updates that were included in CR 5081 and CR 5247.

Under Health Insurance Portability and Accountability Act (HIPAA) of 1996, an ERA sent to a provider on or after October 16, 2003 must be a standard HIPAA compliant ERA. The ERA standard adopted under HIPAA was ANSI ASC X12N transaction 835 version 004010A1. CMS implemented a contingency plan as of October 16, 2003 to continue to accept and send HIPAA-compliant and non HIPAA-compliant transactions from/to trading partners beyond October 16, 2003, for a limited time. CMS ended the contingency period for claims in October 2005. In a Joint Signature Memorandum (JSM/TDL-06518) issued on June 28, 2006, CMS instructed contractors and shared system maintainers that the contingency period for ERA will end on September 30, 2006. On or after October 1, 2006 any electronic remittance advice must be in the standard HIPAA format, otherwise only a paper remittance advice shall be generated.

There is no current CMS instruction for contractors to charge for generating duplicate remittance advice (when a provider has already been sent a remittance advice – either in electronic or paper format) and mailing in case of paper remittance advice. Contractors are now allowed to charge to recoup their cost to generate a duplicate remittance advice if the request comes from a provider or any entity working on behalf of the provider. Contractors may charge up to $25.00 to recoup the cost for each mailing if PC Print or Medicare Remit Easy Print software is mailed on a CD/DVD at the request of a provider or any entity working on behalf of the provider when the requested software is available to download for free.

B. Policy: CMS is ending the contingency plan for ERA effective October 1, 2006. On or after October 1, 2006, contractors shall send ERA in standard HIPAA format only or paper.

Contractors are allowed to charge for:

- generating and mailing, if applicable, duplicate remittance advice (either electronic or paper) to cover cost when generated at the request of a provider or any entity working on behalf of the provider;
- making PC Print or Medicare Remit Easy Print software available to providers by CD/DVD or any other means when the software is available for free to download. Contractors may charge up to $25.00 for each mailing to recoup their cost.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	DME MAC
5308.1	FIs, RHHIs, carriers, DMERCs, and DME MACs shall send only HIPAA compliant ERA (ANSI ASC X12N 835 version 004010A1) to all electronic remittance receivers effective October 1, 2006 per JSM-TDL 06518. Exception: Contractors under Healthcare Integrated General Ledger Accounting System (HIGLAS) will have a waiver till October 5, 2006 per JSM-TDL 06669. All contractors under HIGLAS shall send only HIPAA compliant ERA to all electronic remittance receivers on or after October 6, 2006.	X	X	X	X	X	X	X		X
5308.2	Contractors will modify any references on their Websites to free HIPAA guides from http://www.wpc-edi.com/HIPAA The HIPAA guides are still available from Washington Publishing Company (WPC), but they can not be downloaded for free.	X	X	X	X					X

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
5308.3	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLNMatters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin and incorporated into any educational events on this topic. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.									

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: October 1, 2006 **Implementation Date:** October 23, 2006 **Pre-Implementation Contact(s):** Sumita Sen, 410-786-5755, sumita.sen@cms.hhs.gov **Post-Implementation Contact(s):** Sumita Sen, 410-786-5755, sumita.Sen@cms.hhs.gov	**No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2007 operating budgets.**

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

Medicare Claims Processing Manual

Chapter 22 - Remittance Advice

Table of Contents

(Rev. 1063, 09-22-06)

10 - Background

(Rev.1063, Issued: 09-22-06, Effective: 10-01-06, Implementation: 10-23-06)

A/B Medicare Administrative Contractors (A/B MACs), carriers, Durable Medical Equipment Regional Carriers (DMERCs), *Durable Medical Equipment Medicare Administrative Contractors (DME MACs*), Fiscal Intermediaries (FIs), and *Regional Home Health Intermediaries* (*RHHIs)* send to providers, physicians, and suppliers, as a companion to claim payments, a notice of payment, referred to as the Remittance Advice (RA). RAs explain the payment and any adjustment(s) made *during claim adjudication*. For each claim or line item payment, *and/or adjustment (including denial)*, there is an associated remittance advice item. Payments *and/or adjustments* for multiple claims can be reported on one transmission of the remittance advice. RA notices can be produced and transferred in either paper or electronic format.

A/B MACs, carriers, DMERCs*, and DME MACs* also send informational RAs to *non-participating* physicians, *suppliers, and non-physician practitioners billing non-assigned claims (billing and receiving payments from patients instead of accepting* direct Medicare payments), unless the beneficiary or *the provider* requests that the remittance notice be suppressed. An informational RA is identical to other RAs, but must carry a standard message to notify *providers* that they do not have appeal rights beyond those afforded when limitation on liability (rules regulating the amount of liability that an entity can accrue because of medical services which are not covered by Medicare – see Chapter 30) applies.

Medicare contractors are allowed to charge for generating and mailing, if applicable, duplicate remittance advice (both electronic and paper) to recoup cost when generated at the request of a provider or any entity working on behalf of the provider.

The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA, Title II) required the Department of Health and Human Services (HHS) to establish national standards for electronic health care transactions and national identifiers for providers, health plans, and employers. HIPAA also addresses the security and privacy of health data. Adopting these standards would improve the efficiency and effectiveness of the nation's health care system by encouraging the widespread use of electronic data interchange in health care.

Under the HIPAA Administrative Provisions, the Secretary of Health and Human Services has established *the standard for claim payment transaction. The adopted is the ANSI ASC X12N 835 version 004010A1*, and an *I*mplementation *G*uide *(IG*) for this HIPAA compliant version of transaction 835 (Health Care Claim/Payment Advice) is available to use. An *IG* is a reference document governing the implementation of an electronic format. It contains all information necessary to use the subject format, e.g., instructions and structures. This HIPAA compliant 835 has been established as a national standard for use by all health plans including Medicare *A/B MACs,* carriers*,* DMERCs,

DME MACs, FIs, and RHHIs . Medicare requires the use of this format exclusively for Electronic Remittance Advices (ERAs). Medicare has also established a policy that the paper formats shall mirror the ERAs as much as possible, and *A/B MACs*, carriers, DMERCs, *DME MACs,* FIs *and RHHIs* shall use the formats established by Medicare. The HIPAA compliant version of the 835 includes some significant changes from earlier versions of the 835 supported by Medicare. See appendix D of the 835 version *004010A1IG* for a summary of these changes. *The IG is available from Washington Publishing Company (WPC). Their Web site: http://www-wpc-edi.com/HIPAA*

In addition, *CMS has developed* a companion document for contractors and the Shared System Maintainers to explain the business requirements for Medicare following the ANSI X12N *IG* for Transaction 835 *, and is available at the Web site: http://www.cms.hhs.gov/ElectronicBillingEDITrans/11_Remittance.asp#TopOfPage Go to "Downloads and click on the file you want.*

By October 2002, carriers, DMERCs FIs and , had to be able to issue HIPAA compliant 835 version *004010A1* transactions in production mode to any provider or clearinghouse that requested production data in that version. Here after, all contractors must upgrade to most current versions as directed by CMS temporary instructions. HIPAA requires CMS policy to change such that only *the current* version of electronic format will be maintained, not the *current and the previous* version.

Effective October 2006, unless a provider has requested that Medicare revert to issuance of Standard Paper Remittance (SPR), *all Electronic Remittance Advice (ERA) receivers would receive their ERAs in the HIPAA compliant format – ANSI ASC X12N 835 version 004010A1. Medicare contractors shall stop generating and sending ERAs in any other format or version effective October 1, 2006.*

20 - General Remittance Completion Requirements

(Rev.1063, Issued: 09-22-06, Effective: 10-01-06, Implementation: 10-23-06)

The following general field completion and calculation rules apply to both paper and electronic versions of the remittance advice, except as otherwise noted. See the current implementation guide for specific requirements:

- Any adjustment applied to the submitted charge and/or units must be reported in the claim and/or service adjustment segments with the appropriate group, reason, and remark codes explaining the adjustments. Every provider level adjustment must likewise be reported in the provider level adjustment section of the remittance advice. Intermediary (*A/B MAC* /FI/*RHHI*) RAs do not report service line adjustment data, only summary claim level adjustment information *is reported*
- The computed field "Net" *reported in the Standard Paper Remittance (SPR) notice* must include "ProvPd" (Calculated Pmt to Provider, CLP04 in the 835) and interest, late filing charges and previously paid amounts.

- The Medicare contractors report only *one crossover* payer *name* on *both* the *ERA and SPR,* even if coordination of benefits (COB) information is sent to more than one payer. The current HIPAA compliant version *of 835* does not have the capacity to report more than one crossover carrier, *and the SPR mirrors the 835.*
- The check amount is the sum of all claim-level payments, including claims and service-level adjustments, less any provider level adjustments.
- Positive adjustment amounts reduce the amount of the payment and negative adjustment amounts increase it.
- The contractor does not issue an RA for a voided or cancelled claim. It issues an RA for the adjusted claim with "Previously Paid" (CLP04 in the 835) showing the amount paid for the voided claim.

30 - Remittance Balancing

(Rev.1063, Issued: 09-22-06, Effective: 10-01-06, Implementation: 10-23-06)

For Medicare the principles of remittance balancing are the same for both paper and electronic remittance formats. Balancing requires that the total paid is equal to the total *submitted charges* plus or minus payment adjustments for a single 835 remittance in accordance with the rules of the *standard* 835 format.

Every HIPAA compliant X12N 835 transaction issued by a *Medicare contractor* must comply with the *ANSI ASC X12N* IG requirements, i.e., these remittances must balance at the service, claim and *provider* levels. Back end validation must be performed to ensure that these conditions are met.

Although issuance of out-of-balance RAs is not encouraged, providers have indicated that receipt of an out-of-balance RA is preferable to not receiving any RA to explain payment. It is permissible on an exception basis for carriers to issue an 835 that does not balance as long as immediate action is initiated to correct the problem that created the out-of-balance situation. However, these out-of-balance 835s must be rare exceptions, and not the rule. *A/B MAC* /carrier/ */DMERC/DME MAC* shared systems will treat production of an out-of-balance 835 as a priority problem, and will work closely with the *A/B MACs/carriers/DMERCs/DME MACs* and CMS to fix the problem as soon as possible.

A/B MAC /FI/*RHHI* shared system must make forced balancing adjustments at the line, claim and/or transaction level as applicable to make each 835 transaction balance. *A/B MAC* /FI/*RHHI* shared system must report the amount by which a line or claim is out of balance with adjustment reason code A7 (Presumptive Payment Adjustment) at the line or claim level. The *A/B MAC* /FI/*RHHI* shared system must report the amount by which a transaction is out-of-balance with reason code CA (manual claim adjustment) as a provider level adjustment (PLB). PLB Medicare composite reason code CS/CA will be reported in this situation.

A7 and CA may be used only on a temporary exception basis, pending diagnosis of the source of the balancing problem and *the A/B MAC* /FI/*RHHI* shared system programming to correct that problem. *A/B MAC* /FI/*RHHI* must notify effected providers and clearinghouses of the problem and the expected date of correction whenever A7 or CA is used to force 835s to balance. The shared system *would* treat production of an out-of-balance 835 as a priority problem, and *would* work closely with the *A/B MAC* /FI/*RHHI* and CMS to fix the problem as soon as possible.

40.1 - ANSI ASC X12N 835

(Rev.1063, Issued: 09-22-06, Effective: 10-01-06, Implementation: 10-23-06)

The 835 is a variable-length record designed for wire transmission and is not suitable for use in application programs. Therefore, shared systems generate a flat file version of the 835. Contractors must translate that flat file into the variable length 835 record for transmission to providers or their billing services or clearinghouse. See Chapter 24 for technical information about transmission of the 835.

The updated flat *files are* posted at:
http://www.cms.hhs.gov/ElectronicBillingEDITrans/11_Remittance.asp#TopOfPage
Go to "Downloads", and click on the file you want.

Contractor *requirements are*:

- Send the remittance data directly to providers or their designated billing services or clearinghouse;
- Provide sufficient security to protect beneficiaries' privacy. At the provider's request, the contractor may send the 835 through the banking system if its Medicare bank and the provider's bank have that capability. The contractor does not allow any party to view beneficiary information, unless authorized by specific instructions from CMS see §40.1 for additional information;
- Issue the remittance advice specifications and technical interface specifications to all requesting providers within three weeks of their request. Interface specifications must contain sufficient detail to enable a reasonably knowledgeable provider to interpret the RA, without the need to pay the contractor or an associated business under the same corporate umbrella for supplemental services or software;
- Send the 835 to providers over a wire connection. They do not use tapes or diskettes;
- FIs/RHHIs allow providers to receive a hard copy remittance in addition to the 835 during the first 30 days of receiving ERAs and during other testing. After that time, FIs/RHHIs do not send a hard copy version of the 835, in addition to the electronic transmission, in production mode. They should contact CMS if this requirement causes undue hardship for a particular FI/RHHI/A/B MAC provider;

•A/B MACs, carriers, DMERCs, and DME MACs must suppress the distribution of SPRs to those providers/suppliers (or a billing agent, clearing house or other entity representing those providers/suppliers) also receiving ERAs for 45 days or more. In rare situations (e.g., natural or man-made disasters) exceptions to this policy may be allowed at the discretion of CMS. A/B MACs/carriers/ DMERCs/DME MACs should send exception requests to RemittanceAdvice@cms.hhs.gov for review.

- Contractors may release an ERA prior to the payment date, but never later than the payment date;
- Ensure that their provider file accommodates the data necessary to affect EFT, either through use of the ACH or the 835 format. The abbreviated 835 contains no beneficiary-specific information; therefore, it may be used to initiate EFT and may be carried through the banking networks;
- Pay the costs of transmitting EFT through their bank to the ACH. Payees are responsible for the telecommunications costs of EFT from the ACH to their bank, as well as the costs of receiving 835 data once in production mode; and
- Provide for sufficient back-up to allow for retransmission of garbled or misdirected transmissions.

Every ANSI X12N 835 transaction issued by *A/B MACs,* carriers*,* DMERCs, *DME MACs, FIs, and RHHIs* must comply with the implementation guide (IG) requirements (see §40.4), i.e., each required segment, *and each situational segment when the situation applies*, must be reported. required or applicable situational data element in a required or situational segment must be reported, and the data in a data element must meet the minimum length and data attribute (AN, ID, R, etc.) specifications in the implementation guide.

Back end validation must be performed to ensure that these conditions are met. *A/B MACs,* carriers*,* DMERCs, *DME MACs, FIs, and RHHIs* are not required to validate codes maintained by their shared systems, such as Healthcare Common Procedure Coding System (HCPCS), that are issued in their shared system's flat file for use in the body of an 835, but they are required to validate data in the 835 envelope as well as the codes that they maintain, such as claim adjustment reason codes *and remittance advice remark codes*, that are reported in the 835. Medicare contractors do not need to re-edit codes or other data validated during the claim adjudication process during this back end validation. Valid codes are to be used in the flat file, unless:

- A service is being denied or rejected using an 835 for submission of an invalid code, in which case the invalid code must be reported on the 835;
- A code was valid when received, but was discontinued by the time the 835 is issued, in which case, the received code must be reported on the 835; or

- A code is received on a paper claim, and does not meet the required data attribute(s) for the HIPAA compliant 835, in which case, “gap filling” would be needed if it were to be inserted in a compliant 835.

40.2 - Generating an ERA if Required Data is Missing or Invalid

(Rev.1063, Issued: 09-22-06, Effective: 10-01-06, Implementation: 10-23-06)

A. *A/B MACs/*carriers/DMERCs/*DME MACs*

The ANSI X12N 835 IG contains specific data requirements, which must be met to build a HIPAA compliant ERA. A claim could be received on paper that lacks data or has data that does not meet the data attributes or length requirements for preparation of a HIPAA-compliant ERA. If not rejected as a result of standard or IG level editing, an *A/B MAC*/carrier/DMERC/*DME MAC* must either send an SPR advice or a “gap filled” ERA to avoid noncompliance with HIPAA.

For example, if a procedure code is sent with only four characters and the code set specified in the IG includes five character codes in the data element, and the code is not rejected by the front end and/or pre-pass edits, the claim would be denied due to the invalid procedure code. Preparation of an ERA with too few characters though would not comply with the IG requirements. The noncompliant ERA could be rejected by the receiver.

The shared system maintainers, working in conjunction with their contractors, must decide whether to generate an SPR, which is not covered by HIPAA, or to “gap fill” in this situation, depending on system capability and cost. Except in some very rare situations, “gap filling” would be expected to be the preferred solution. To “gap fill,” the shared systems must enter meaningless characters to meet the data element minimum length requirements in any outgoing ANSI X12N transaction if insufficient data is available for entry in a required data element. Shared system maintainers must work with their respective users to determine which characters will be used to gap fill required data elements. The selected meaningless character(s) must also meet the data requirements of the data elements where used, e.g., be alphanumeric (AN), decimal (R), identifier (ID), date (DT), or another data type as appropriate. The values may not include any special characters, low values, high values, or all spaces since this could result in translation problems. The contractors must notify the trading partners, if and when their files are affected, as to when and why these characters will appear in an 835.

40.4 - Medicare Standard Electronic PC Print Software *for Institutional Providers*

(Rev.1063, Issued: 09-22-06, Effective: 10-01-06, Implementation: 10-23-06)

PC Print software enables *institutional* providers to print remittance data transmitted by Medicare. *A/B MACs* /FIs/*RHHIs* are required to make PC Print software available to providers *for downloading* at no charge. FIs/*RHHIs*/*A/B MACs may charge up to $25.00*

per mailing to recoup cost if the software is sent to provider on a CD/DVD or any other means at provider's request when the software is available for downloading. This software must be able to operate on Windows-95, 98, 2000/Me, and Windows NT platforms, and include self-explanatory loading and use information for providers. It should not be necessary to furnish providers training for use of PC Print software.

A/B MACs /FIs/*RHHIs* must supply providers with PC-Print software within three weeks of request. The FI/RHHI/A/B MAC Shared System (FISS) maintainer will supply PC-Print software and a user's guide for all *A/B MACs* /FIs/*RHHIs* . The FISS maintainer must assure that the PC Print software is modified as needed to correspond to updates in the ERA and SPR formats.

Providers are responsible for any telecommunication costs associated with receipt of the 835, but the software itself *can be downloaded* at no cost.

The PC Print software enables providers to:

- Receive, over a wire connection, an 835 electronic remittance advice transmission on a personal computer (PC) and write the 835 file in American National Standard Code for Information Interchange (ASCII) to the provider's "A:" drive;
- View and print remittance information *on all claims included in the 835*; *• View and print remittance information for a single claim;*
- View and print *a summary of claims billed for each Type of Bill (TOB) processed on this ERA;*
- *• View and print a summary of provider payments.*

The receiving PC always writes an 835 file in ASCII. The providers may choose one or more print options, e.g., the entire transmission, a single claim, a summary by bill type, or a provider payment summary. If software malfunctions are detected, they are to be corrected through the FISS maintainer. Individual *A/B MACs* /FIs/*RHHIs* or data centers may not modify the PC Print software.

40.5 – Medicare Remit Easy Print Software for Professional Providers and Suppliers

(Rev.1063, Issued: 09-22-06, Effective: 10-01-06, Implementation: 10-23-06)

CMS has developed software that gives professional providers/suppliers a tool to view and print an ERA in a human readable format. This software is called Medicare Remit Easy Print (MREP). It has been developed in response to comments that CMS has received from the provider/supplier community demonstrating a need for paper documents to reconcile accounts, and facilitate claim submission to secondary/tertiary payers. The MREP Remittance Advice is based upon the current SPR format. This software became available on October 11, 2005 to the providers through their respective

carrier/DMERC. The software is scheduled to be updated three times a year to accommodate the Claim Adjustment Reason Code and Remittance Advice Remark Code tri-annual updates, and any applicable enhancement. In addition to these three regular updates, there will be an annual enhancement update, if needed.

The MREP software enables providers to:

- *View and print remittance information on all claims included in the 835;*
- *View and print remittance information for a single claim;*
- *View and print a summary page*
- *View, print, and export special reports.*

This software can be downloaded free of cost, but A/B MACs/carriers/DMERCs/DME MACs may charge up to $25.00 per mailing to recoup cost if the software is sent to provider on a CD/DVD or any other means at provider's request when the software is available for downloading.

40.*6* - 835 Implementation Guide

(Rev.1063, Issued: 09-22-06, Effective: 10-01-06, Implementation: 10-23-06)

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 004010A1 Implementation Guide (IG) has been established as the standard for compliance for remittance advice transactions. The *IG for the current HIPAA compliant version of the 835 is available* electronically at *http://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 *plans* and not specifically for Medicare. However, a Companion Document was prepared by CMS 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.

The Medicare X12N 835 Version 004010A1 Companion Document 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 004010A1 segments and data elements. For information about the structure of the X12N format (i.e., definitions of segments, loops, and elements) or definitions for specific codes see the Implementation Guide.

When reviewing the Companion Document, keep in mind the following information about loop usage (e.g., required, not used, and situational definitions). For additional information on this subject see the Implementation Guide:

- Loop usage within X12N transactions and their implementation guides can be confusing. Care must be used to read the loop requirements in terms of the context or location within the transaction. The usage designator of a loop's beginning segment indicates the usage of the loop. Segments within a loop cannot be sent without the beginning segment of that loop.
- If the first segment is Required, the loop must occur at least once unless it is nested in a loop that is not being used. A note on the Required first segment of a nested loop will indicate dependency on the higher-level loop.
- If the first segment is Situational, there will be a Segment Note addressing use of the loop. Any required segments in loops beginning with a Situational segment occur only when the loop is used. Similarly, nested loops occur only when the higher-level loop is used.

Companion Documents for both Part A and Part B are available at:
http://www.cms.hhs.gov/ElectronicBillingEDITrans/11_Remittance.asp#TopOfPage

Go to "Downloads", and select the file to download.

50 - Standard Paper Remittance Advice

(Rev.1063, Issued: 09-22-06, Effective: 10-01-06, Implementation: 10-23-06)

The Standard Paper Remittance (SPR) is the hard copy version of an ERA. All *A/B MACs,* carriers*,* DMERCs, *DME MACs, FIs, and RHHIs* must be capable of producing SPRs for providers who are *unable or choose not to receive an ERA. A/B MACs,* carriers*,* DMERCs, *DME MACs, FIs, and RHHIs suppress distribution of SPRs if a provider is also receiving ERAs for more than 30 days (institutional providers) and 45 days (professional providers/suppliers) respectively.*

This instruction contains completion requirements, layout formats/templates, and information on the SPR as well as a crosswalk of the SPR data fields to the 835 version 004010A1 data fields.

50.1 - The Do Not Forward (DNF) Initiative

(Rev.1063, Issued: 09-22-06, Effective: 10-01-06, Implementation: 10-23-06)

As part of the Medicare DNF Initiative, *A/B MACs, carriers,* DMERCs and *DME MACs* must use "return service requested" envelopes for mailing all hardcopy remittance advices. When the post office returns a remittance advice due to an incorrect address, follow the same procedures followed for returned checks; that is:

- Flag the provider "DNF";

- *A/B MAC/carrier* staff must notify the provider enrollment area, and DMERCs/*DME MACs* must notify the National Supplier Clearing House (NSC);
- Cease generating any further payments or remittance advice to that provider or supplier until they furnish a new address that is verified; and
- When the provider returns a new address, contractors remove the DNF flag after the address has been verified, and pay the provider any funds still being held due to a DNF flag. Contractors must also reissue any remittance *that has* been held as well.

NOTE: Previously, CMS required corrections only to the "pay to" address. However, with the implementation of this new initiative, CMS requires corrections to all addresses before the contractor can remove the DNF flag and begin paying the provider or supplier again. Therefore, do not release any payments to DNF providers until the provider enrollment area or the NSC has verified and updated all addresses for that provider's location.

Contractors must initially publish the requirement that providers must notify the A/B MAC/carrier/FI/*RHHII* or NSC of any changes of address, both on their Web sites and in their next regularly scheduled bulletins. Contractors must continue to remind suppliers and providers of this requirement in their bulletins at least yearly thereafter.

See Chapter 1 for additional information pertaining to the DNF initiative.

50.2 SPR Formats

(Rev.1063, Issued: 09-22-06, Effective: 10-01-06, Implementation: 10-23-06)

The following sections contain the separate *Part B* (*A/B MAC*/carrier/DMERC/*DME MAC)* and Part A (*A/B MAC*/FIs/*RHHIs*) SPR formats. These are the general formats. The actual SPRs may contain additional (or fewer) lines, i.e., the contractor may need to add a line for additional reason code(s) or remark codes after first reason code *or remark code* line.

50.2.1 - *Part A* (*A/B MACs* /FIs/*RHHIs/*) SPR Format

(Rev.1063, Issued: 09-22-06, Effective: 10-01-06, Implementation: 10-23-06)

EXAMPLE

MEDICARE PART A P.O. BOX ABC123 LITTLE ROCK AR 72207 TEL# 0000000000 VER# 004010-A1

PROV # PROVIDER NAME PART A PAID DATE: XX/XX/XXXX REMIT#: XXXXX PAGE: 1

PATIENT NAME PATIENT CNTRL NUMBER RC REM DRG# DRG OUT AMT COINSURANCE PAT REFUND CONTRACT ADJ

HIC NUMBER ICN NUMBER RC REM OUTCD CAPCD NEW TECH COVD CHGS ESRD NET ADJ PER DIEM RTE

FROM DT THRU DT NACHG HICHG TOB RC REM PROF COMP MSP PAYMT NCOVD CHGS INTEREST PROC CD AMT

CLM STATUS COST COVDY NCOVDY RC REM DRG AMT DEDUCTIBLES DENIED CHGS PRE PAY ADJ NET REIMB

XXXXXXXXXX X X XXXXXXXXXXXXX XX XXXXX XXX .00 .00 .00 .00

XXXXXXXXXX XXXXXXXXXXXXXX XX X .00 .00 .00 .00

XX/XX/XXXX XX/XX/XXXX XX X XXX XX .00 .00 .00 .00 .00

X X XX XX .00 .00 .00 .00 .00

SUBTOTAL FISCAL YEAR - XXXX .00 .00 .00 .00

.00 .00 .00 .00

.00 .00 .00 .00 .00

X X .00 .00 .00 .00 .00

SUBTOTAL PART A .00 .00 .00 .00

14

.00 .00 .00 .00

.00 .00 .00 .00 .00

XX XX .00 .00 .00 .00 .00

15

EXAMPLE

MEDICARE PART B P.O. BOX ABC123 LITTLE ROCK AR 72207 TEL# 0000000000 VER# 004010-A1

PROV # (NPI) PROVIDER NAME PART B PAID DATE: XX/XX/XXXX REMIT#: XXXXX PAGE: 1

PATIENT NAME PATIENT CNTRL NUMBER RC REM DRG# DRG OUT AMT COINSURANCE PAT REFUND CONTRACT ADJ

HIC NUMBER ICN NUMBER RC REM OUTCD CAPCD NEW TECH COVD CHGS ESRD NET ADJ PER DIEM RTE

FROM DT THRU DT NACHG HICHG TOB RC REM PROF COMP MSP PAYMT NCOVD CHGS INTEREST PROC CD AMT

CLM STATUS COST COVDY NCOVDY RC REM DRG AMT DEDUCTIBLES DENIED CHGS PRE PAY ADJ NET REIMB

XXXXXXXXXXX X X XXXXXXXXXXX XX XXXX 000 .00 .00 .00 .00

XXXXXXXXXX XXXXXXXXXXXXXX XX .00 .00 .00 .00

XX/XX/XXXX XX/XX/XXXX XX X XXX XX .00 .00 .00 .00 .00

1 X XX .00 .00 .00 .00 .00

SUBTOTAL FISCAL YEAR - XXXX .00 .00 .00 .00

.00 .00 .00 .00

.00 .00 .00 .00 .00

X .00 .00 .00 .00 .00

SUBTOTAL PART B .00 .00 .00 .00

.00 .00 .00 .00

.00 .00 .00 .00 .00

X .00 .00 .00 .00 .00

16

EXAMPLE

MEDICARE PART A P.O. BOX ABC123 LITTLE ROCK AR 72207 TEL# 0000000000 VER# 4010-A1

PROV # PROVIDER NAME PAID DATE: XX/XX/XX REMIT#: XXXXX PAGE: 2

S U M M A R Y

CLAIM DATA: PASS THRU AMOUNTS:

CAPITAL : .00 PROVIDER PAYMENT RECAP :

DAYS : RETURN ON EQUITY : .00

COST : 0 DIRECT MEDICAL EDUCATION : .00 PAYMENTS :

COVDY : 2 KIDNEY ACQUISITION : .00 DRG OUT AMT : .00

NCOVDY : 0 BAD DEBT : .00 INTEREST : .00

NON PHYSICIAN ANESTHETISTS: .00 PROC CD AMT : .00

CHARGES : TOTAL PASS THRU : .00 NET REIMB : .00

COVD : .00 TOTAL PASS THRU : .00

NCOVD : .00 PIP PAYMENT : .00 PIP PAYMENTS : .00

DENIED : .00 SETTLEMENT PAYMENTS : .00 SETTLEMENT PYMTS : .00

ACCELERATED PAYMENTS : .00 ACCELERATED PAYMENTS : .00

REFUNDS : .00 REFUNDS : .00

PROF COMP : .00 PENALTY RELEASE : .00 PENALTY RELEASE : .00

MSP PAYMT : .00 TRANS OUTP PYMT : .00 TRANS OUTP PYMT : .00

DEDUCTIBLES : .00 HEMOPHILIA ADD-ON : .00 HEMOPHILIA ADD-ON : .00

COINSURANCE : .00 NEW TECH ADD-ON : .00 NEW TECH ADD-ON : .00

1718

BALANCE FORWARD : .00

PAT REFUND : .00 WITHHOLD FROM PAYMENTS : WITHHOLD : .00

INTEREST : .00 CLAIMS ACCOUNTS RECEIVABLE: .00 ADJUSTMENT TO BALANCE: .00

CONTRACT ADJ : .00 ACCELERATED PAYMENTS : .00 NET PROVIDER PAYMENT : .00

PROC CD AMT : .00 PENALTY : .00 (PAYMENTS MINUS WITHHOLD)

NET REIMB : .00 SETTLEMENT : .00

TOTAL WITHHOLD : .00 CHECK/EFT NUMBER

50.2.2 – *Part B* (*A/B MAC* /Carrier/ /DMERC/DME MAC) SPR Format

(Rev.1063, Issued: 09-22-06, Effective: 10-01-06, Implementation: 10-23-06)

A/B MAC/carrier/DMERC/DME MAC NAME
ADDRESS 1 MEDICARE
ADDRESS 2 REMITTANCE
CITY, STATE ZIP ADVICE
(9099) 111-2222
PROVIDER NAME PROVIDER #: 1234567890
ADDRESS 1 PAGE #: 1 OF 999

ADDRESS 2 CHECK/EFT #: 12345678901234567890
CITY, STATE ZIP REMITTANCE # 12345678901234567890 ((NOT A REQUIRED FIELD)
……
…….
*LINE 1 *
*LINE 2 *
*LINE 3 *
*LINE 4 *
*LINE 5 *
*LINE 6 *
*LINE 7 *
*LINE 8 *
*LINE 9 *
*LINE 10 *
*LINE 11 *
*LINE 12 *
*LINE 13 *

*LINE 14 *
*LINE 15 *
……
……
PERF PROV SERV DATE POS NOS PROC MODS BILLED ALLOWED DEDUCT COINS GRP/ RC-AMT PROV PD

NAME LLLLLLLLLLLL, FFFFFFFF HIC 123456789012 ACNT 12345678901234567890 ICN 123456789012345 ASG X MOA 11111 22222
33333 44444
55555
1234567890 MMDD MMDDYY 12 123 PPPPP aabbccdd 1234567.12 1234567.12 1234567.12 1234567.12 GPRRR 1234567.12 1234567.12
RENDERING PROVIDER
(PPPPP) REM: RRRRR RRRRR RRRRR RRRRR RRRRR
1234567890 MMDD MMDDYY 12 123 PPPPP aabbccdd 1234567.12 1234567.12 1234567.12 1234567.12 GPRRR 1234567.12 1234567.12
(PPPPP) REM: RRRRR RRRRR RRRRR RRRRR RRRRR
1234567890 MMDD MMDDYY 12 123 PPPPP aabbccdd 1234567.12 1234567.12 1234567.12 1234567.12 GPRRR 1234567.12 1234567.12
(PPPPP) REM: RRRRR RRRRR RRRRR RRRRR RRRRR
PT RESP 1234567.12 CLAIM TOTAL 1234567.12 1234567.12 1234567.12 1234567.12 1234567.12 1234567.12
ADJ TO TOTALS: PREV PD 1234567.12 INTEREST 1234567.12 LATE FILING CHARGE 1234567.12 NET 1234567.12
CLAIM INFORATION FORWARDED TO: XXXXXXXXXXXXXXXXXXXXXXX

A/B MAC/CARRIER/*DMERC/DME MAC* YYYY/MM/DD (999) 111-2222 MEDICARE PROVIDER #: 1234567890 PROVIDER NAME REMITTANCE CHECK/EFT #:12345678901234567890 PAGE #: 999 OF 999 ADVICE REMITTANCE # 12345678901234567890 (NOT A REQUIRED FIELD)
PERF PROV SERV DATE POS NOS PROC MODS BILLED ALLOWED DEDUCT COINS RC-AMT PROV PD
*

NAME LLLLLLLLLLLL, FFFFFFFF HIC 123456789012 ACNT 12345678901234567890 ICN 123456789012345 ASG X MOA 11111 22222

33333 44444
55555
1234567890 MMDD MMDDYY 12 123 PPPPP aabbccdd 1234567.12 1234567.12 1234567.12 1234567.12 GPRRR 1234567.12 1234567.12
RENDERING PROVIDER (PPPPP) REM: RRRRR RRRRR RRRRR RRRRR RRRRR

1234567890 MMDD MMDDYY 12 123 PPPPP aabbccdd 1234567.12 1234567.12 1234567.12 1234567.12 GPRRR 1234567.12 1234567.12
(PPPPP) REM: RRRRR RRRRR RRRRR RRRRR RRRRR
1234567890 MMDD MMDDYY 12 123 PPPPP aabbccdd 1234567.12 1234567.12 1234567.12 1234567.12 GPRRR 1234567.12 1234567.12
(PPPPP) REM: RRRRR RRRRR RRRRR RRRRR RRRRR
PT RESP 1234567.12 CLAIM TOTAL 1234567.12 1234567.12 1234567.12 1234567.12 1234567.12 1234567.12
ADJ TO TOTALS: PREV PD 1234567.12 INTEREST 1234567.12 LATE FILING CHARGE 1234567.12 NET 1234567.12
CLAIM INFORATION FORWARDED TO: XXXXXXXXXXXXXXXXXXXXXXX

TOTALS: # OF BILLED ALLOWED DEDUCT COINS TOTAL PROV PD PROV CHECK
CLAIMS AMT AMT AMT AMT RC-AMT AMT ADJ AMT AMT
99999 1234567.12 1234567.12 1234567.12 1234567.12 1234567.12 1234567.12 1234567.12 1234567.12
PROVIDER ADJ DETAILS: PLB REASON CODE FCN HIC AMOUNT
1111 12345678901234567 123456789012 1234567.12
2222 12345678901234567 123456789012 1234567.12
3333 12345678901234567 123456789012 1234567.12
4444 12345678901234567 123456789012 1234567.12
5555 12345678901234567 123456789012 1234567.12
GLOSSARY: GROUP, REASON, MOA, REMARK AND REASON CODES
XX TTT……..
XXX TTT……..
MXX TTT……..
XX TTT……..

A/B MAC/CARRIER/*DMERC/DME MAC* NAME YYYY/MM/DD (999) 111-2222 MEDICARE
PROVIDER #: 1234567890 PROVIDER NAME REMITTANCE
CHECK/EFT #:12345678901234567890 PAGE #: 999 OF 999 ADVICE
REMITTANCE # 12345678901234567890 (NOT A REQUIRED FIELD)
SUMMARY OF NON-ASSIGNED CLAIMS
PERF PROV SERV DATE POS NOS PROC MODS BILLED ALLOWED DEDUCT COINS GRP/RC-AMT PROV PD

NAME LLLLLLLLLLL, FFFFFFFF HIC 123456789012 ACNT 12345678901234567890 ICN 123456789012345 ASG X MOA 11111 22222 33333 44444 55555
1234567890 MMDD MMDDYY 12 123 PPPPP aabbccdd 1234567.12 1234567.12 1234567.12 1234567.12 GPRRR 1234567.12 1234567.12

RENDERING PROVIDER (PPPPP) REM: RRRRR RRRRR RRRRR RRRRR RRRRR 1234567890 MMDD MMDDYY 12 123 PPPPP aabbccdd 1234567.12 1234567.12 1234567.12 1234567.12 GPRRR 1234567.12 1234567.12
(PPPPP) REM: RRRRR RRRRR RRRRR RRRRR RRRRR 1234567890 MMDD MMDDYY 12 123 PPPPP aabbccdd 1234567.12 1234567.12 1234567.12 1234567.12 GPRRR 1234567.12 1234567.12
(PPPPP) REM: RRRRR RRRRR RRRRR RRRRR RRRRR PT RESP 1234567.12 CLAIM TOTAL 1234567.12 1234567.12 1234567.12 1234567.12 1234567.12 1234567.12
CLAIM INFORATION FORWARDED TO: XXXXXXXXXXXXXXXXXXXXXXX

50.3 – *Part A* (*A/B MAC* /FI/*RHHI/*) SPR Crosswalk to the 835

(Rev.1063, Issued: 09-22-06, Effective: 10-01-06, Implementation: 10-23-06)

This crosswalk provides a systematic presentation of SPR data fields and the corresponding fields in an 835 version 4010. It also includes some computed fields for provider use that are not present in an ERA. The comment column in the crosswalk provides clarification and instruction in some special cases.

Full Description (In Order Of Appearance)	SPR ID	SPR Field Size Characteristics	835 Location
SPR Page Headers			
A/B MAC//FI/*RHHIA* name/ address/city/state/zip/ phone number	as written	Alpha Numeric (AN) 132 characters	Name=1-080.A-N102 Other data elements are Fiscal Intermediary (FI) generated.
Provider number	as written	AN 13	1-080.B-N104
Provider name	as written	AN 25	1-080.B-N102
Literal Value: Part A	as written	AN 06	Literal value not included on 835, Medicare Part would be indicated by the type of bill
Paid date	as written	N MM/DD/CCYY	1-020-BPR16
Remittance advice	REMIT	Numeric (N) 9(l 0)	FI generated
Literal Value: Page	as written	AN 06	FI generated
SPR Pages 1 and 2			
Patient Last Name	PATIENT NAME	AN 18	2-030.A-NM103
Patient First Name		AN 01	2-030.A-NM104

Patient Mid. Initial		AN 01	2-030.A-NM105
Health insurance claim number	HIC#	AN 19	2-030.A-NM109

Statement covers period - start	FROM DT	N MMDDCCYY	2-050.A-DTM02

23Full Description (In Order Of Appearance) SPR ID SPR Field Size Characteristics 835 Location			
Statement covers period - end	THRU DT		N MMDDCCYY
Claim status code	CLM STATUS	AN02	2-010-CLP02
Patient control #	PATIENT CNTRL #	AN 20	2-010-CLP01
Internal control #	ICN	AN 23	2-010-CLP07
Patient name change	NACHG	AN 02	2-030.A-NM101 if ‘74’
HIC change	HICHG	AN 01	2-030.A-NM108 if ‘C’
Type of bill	TO	AN 03	2-010-CLP08
Cost report days	COST	N S9(3)	2-033-MIA15
Covered days/visits	COVDY	N S9(3)	2-064-QTY02 when ‘CA’ in prior data element
Noncovered days	NCOVDY	N S9(3)	2-064-QTY02 when ‘NA’ in prior data element
Reason code (4 occurrences)	RC	AN 05	2-020-CAS02, 05,08 and 11
Remark code (4 occurrences)	REM	AN 05	Inpatient: 2-033-MIA -05, 20, 21, 22, Outpatient: 2-035- MOA03, 04, 05, 06
DRG #	as written	N 9(3)	2-010-CLP1 1
Outlier code	OUTCD	AN 02	2-062-AMT01 if ‘ZZ’

24Full Description (In Order Of Appearance) SPR ID SPR Field Size Characteristics 835 Location			
Capital code	CAPCD	AN 01	2-033-MIA08
Professional component	PROF COMP	N S9(7).99	Total of amounts in 2-020 or 2-090, CAS03, 06, 09, 12, 15 or 18 when ‘89’ in prior data element

DRG operating and capital amount	DRG AMT	N S9(7).99	2-033-MIA04
DRG outlier amount	DRG OUT AMT	N S9(7).99	2-062-AMT02 when ‘ZZ’ in prior data element
MSP primary amount	MSP PAYMT	N S9(7).99	2-062-AMT02 when ‘NJ’ in prior data element
Cash deductible/ blood deductibles	DEDUCTIBLES	N S9(7).99	Total of 2-020 or 2-090, CAS03, 06, 09, 12, 15 or 18 when ‘66’ in prior data element
Coinsurance amount	COINSURANCE	N S9(7).99	Total of 2-020 or 2-090 CAS03, 06, 09, 12, 15 or 18 when ‘2’ in prior data element
Covered charges	COVD CHGS	N S9(7).99	2-060-AMT02 when ‘AU’ in prior data element
Noncovered charges	NCOVD CHGS	N S9(7).99	2-010-CLP03 minus 2-060-AMT02 when ‘AU’ in prior data element
Denied charges	DENIED CHGS	N S9(7).99	Total of 2-020 or 2-090-CAS03, 06, 09, 12, 15 or 18

25Full Description (In Order Of Appearance)	SPR ID	SPR Field Size Characteristics	835 Location
Patient refund	PAT REFUND	N S9(7).99	2-020 or 2-amount 090-CAS 03, 06, 09, 12, 15 or 18 when ‘100’ in prior data element
Claim ESRD	ESRD NET ADJ	N S9(7).99	2-020 or 2-reduction 090-CAS 03, 06, 09, 12, 15 or 18 when ‘118’ in prior data element
Interest	INTEREST	N S9(6).99	2-060-AMT02 when in prior data element
Contractual	CONTRACT ADJ	N S9(7).99	Total of 2-020 adjustment or 2-090 CAS03, 06, 09, 12, 15 and 17 when ‘CO’ in CASOI
Per Diem rate	PER DIEM RTE	N S9(7).99	2-062-AMT02 when ‘DY’ in prior data element
Procedure code amount	PROC CD AMT	N S9(7).99	2-035-MOA02
Net reimbursement	NET REIMB	N S9(7).99	2-010-CLP04

Cost report days	DAYS COST	N S9(3)	Total of claim level SPR Cost
Covered days/visits	DAYS COVDY	N S9(4)	Total of claim level SPR COVDY
Noncovered days	DAYS NCOVDY	N S9(4)	Total of claim level SPR NCOVDY
Covered charges	CHARGES COVD	N S9(7).99	Total of claim level SPR COVD CHGS
Noncovered charges	CHARGES	N S9(7).99	Total of claim level SPR NCOVD

26Full Description (In Order Of Appearance)	SPR ID	SPR Field Size	Characteristics	835 Location
NCOVD		CHGS		
Denied charges	CHARGES DENIED	N S9(7).99	Total of claim level SPR DENIED CHGS	
Professional component	PROF COMP	N S9(7).99	Total of claim level SPR PROF COMP	
MSP primary	MSP PAYMT	N S9(7).99	Total of claim amount level SPR MSP PAYMT	
Cash deductible/ blood deductibles	DEDUCTIBLES	N S9(7).99	Total of claim level SPR DEDUCTIBLES	
Coinsurance amount	COINSURANCE	N S9(7).99	Total of claim level SPR COINSURANCE	
Patient refund	PAT REFUND	N S9(7).99	Total of claim amount level SPR PAT REFUND	
Interest	INTEREST	N S9(7).99	Total of claim level SPR INTEREST	
Contractual adjustment	CONTRACT ADJ	N S9(7).99	Total of claim level SPR CONTRACT ADJ.	
Procedure code payable amount	PROC CD AMT	N S9(7).99	Total of claim level SPR PROC CD AMT	
Claim payment amount	NET REIMB	N S9(7).99	Total of claim level SPR NET REIMB	

SPR Summary Data

27Full Description (In Order Of Appearance)	SPR ID	SPR Field Size	Characteristics	835 Location

Pass Thru Amounts

Capital pass thru	CAPITAL	N S9(7).99	3-010-PLB04, 06, 08 or 10 when ‘CP’ in prior data element
Return on equity	as written	N S9(7).99	3-010-PLB04, 06, 08 or 10 when ‘RE’ in prior data element
Direct medical education	as written	N S9(7).99	3-010-PLB04, 06, 08 or 10 when ‘DM’ in prior data element
Kidney acquisition	as written	N S9(7).99	3-010-PLB04, 06, 08 or 10 when ‘KA’ in prior data element
Bad debt		3-010-PLB04, 06, 08 or 10 when ‘BD’ in prior data element	
Nonphysician anesthetists	as written	N S9(7).99	3-010-PLB04, 06, 08 or 10 when ‘CR’ in prior data element
Hemophilia add on	as written	N S9(7).99	3-010-PLB04, 06, 08 or 10 when ‘ZZ’ in prior data element
Total pass through	as written	N S9(7).99	Total of the above pass through amounts.
Non-Pass Through Amounts			
PIP payment	as written	N S9(7).99	3-010-PLB04, 06, 08 or 10 when ‘PP’ in prior data element
Settlement amounts	SETTLEMENT PAYMENTS	3-010-PLB04, 06, 08 or 10 when ‘FP’ in prior data element	
Accelerated payments	as written	N S9(7).99	3-010-PLB04, 06, 08 or 10 when ‘AP’ in prior data element
Refunds	as written	N S9(7).99	3-010-PLB04, 06, 08 or 10 when ‘RF’ in prior data element

28Full Description (In Order Of Appearance)	SPR ID	SPR Field Size Characteristics	835 Location
Penalty release	as written	N S9(7).99	3-010-PLB04, 06, 08 or 10 when ‘RS’ in prior data element
Transitional outpatient payment	TRANS OP PYMT	N S9(7).99	3-010-PLB04, 06, 08 or 10 when ‘IR’ in prior data element

Withhold from Payment			
Claims accounts	as written	N S9(7).99	3-010-PLB04, 06, 08 or 10 when 'AA' in prior data element
Accelerated payments	as written	N S9(7).99	3-010-PLB04, 06, 08 or 10 when 'AW' in prior data element
Penalty	as written	N S9(7).99	3-010-PLB04, 06, 08 or 10 when 'PW' in prior data element
Settlement	as written	N S9(7).99	3-010-PLB04, 06, 08 or 10 when 'OR' in prior data element
Total withholding	TOTAL WTHLD	N S9(7).99	Total of the above withholding amounts
Provider Payment Recap			
Payments and withhold previously listed			
Net provider payment	as written	N S9(7).99	1-020-BPR02
Check/EFT number	as written	N S9(7).99	1-040-TRN02

See 835 implementation guides for data element definitions, completion and use.

50.4 – *Part B* (*A/B MAC* /Carrier/ / DMERC/*DME MAC)* SPR Crosswalk to the 835

(Rev.1063, Issued: 09-22-06, Effective: 10-01-06, Implementation: 10-23-06)

Part B 835 version *004010A1* field descriptions may be viewed at

http://www.cms.hhs.gov/ElectronicBillingEDITrans/11_Remittance.asp#TopOfPage
Go to "Downloads", and click on the file you want.

Remittance Field	835V4010 Field	LOOP ID	NSF V 2.01 Field #	COMMENT
A/B MAC* /carrier/ / DMERC/*DME MAC NAME		N102	1000A	100-07
A/B MAC/c/CARRIER/*A/B MAC*/*DMERC/DME MAC* ADDRESS 1			N301	1000A
A/B MAC/*DMERC/DME MAC* ADDRESS 2			N302	1000A
A/B MAC/carrier/*DMERC/DME MAC* CITY			N401	1000A
A/B MAC/CARRIER/*A/B MAC*/*DMERC/DME MAC* STATE			N402	1000A
A/B MAC/*CARRIER*/*DMERC/DME MAC* ZIP			N403	1000A
PROVIDER NAME		N102	1000B	200-06
PROVIDER ADDRESS 1			N301	1000B
PROVIDER ADDRESS 2			N302	1000B

PROVIDER CITY	N401	1000B
PROVIDER STATE	N402	1000B
PROVIDER ZIP	N403	1000B

PROVIDER #	REF02 when IC IN REF01		1000B	200-07
DATE (CHECK/EFT ISSUE DATE)		BPR16		200-09
CHECK/EFT TRACE #		TRN02		200-08
REMITTANCE #		This is not a required field		
BENEFICIARY LAST NAME (PATIENT LAST NAME)	NM103		2100	400-13
BENEFICIARY FIRST NAME (PATIENT FIRST NAME)	NM104		2100	400-14
HIC (INSURED IDENTIFICATION #)	NM109		2100	400-07
RENDERING PROVIDER IDENTIFIER		NM109 when XX in NM108		2100
RENDERING PROVIDER IDENTIFIER		REF02 when 1C IN REF01		2100
ACNT (PATIENT CONTROL #)	CLP01	2100	400-03	Use a single 0 if not received on 837 (CLM01)
ICN (PAYOR CLAIM CONTROL #)	CLP07		2100	400-22
ASG(ASSIGNMENT)	LX01		2000	500-24
MOA CODES (CLAIM REMARK CODES)	MOA		2100	400-23 THRU 400-27
RENDERING PROVIDER IDENTIFIER	REF02 when HPI IN REF01	2110	450-37	~~If more than 1 performig provider, insert # of 1st~~
RENDERING PROVIDER IDENTIFIER		REF02 when 1C IN REF01		2110
SERVICE DATE (FROM)	DTM02 when 150 in DTM01		2110	450-07
SERVICE DATE (THROUGH)	DTM02 when 151 in DTM01		2110	450-08
POS (PLACE OF SERVICE)	REF02 when LU IN REF01		2110	450-11
NUM (UNITS OF SERVICE)	SVC05		2110	450-17
PROC (PROCEDURE	SVC01-2		2110	450-13

CODE – PAID)				
MODS (MODIFIERS)	SVC01-3 THRU SVC01-6	2110	450-14 THRU 450-16	aabbccdd in the sample
SUBMITTED PROCEDURE CODE	SVC06-2	2110	451-09	(ppppp) in the sample format
BILLED (SUBMITTED LINE CHARGE)	SVC02		2110	450-18
ALLOWED (ALLOWED/CONTRACT AMT)	AMT02 when B6 in AMT01		2110	450-21
DEDUCT (DEDUCTIBLE AMT)	CAS03, 06, 09,12,15, 18 when 1 in CAS 02, 05, 08, 11, 14 or 17		2110	450-22
COINS (COINSURANCE AMT)	CAS03, 06, 09,12,15, 18 when 2 in CAS 02, 05, 08, 11, 14 or 17		2110	450-23
PROV PD (CALCULATED PMT TO PROVIDER)	SVC03		2110	450-28
RC (GROUP AND REASON CODES)	CAS01+ CAS02/05/08/11/14/17		2110	450-38 THRU 450-44
RC-AMT (REASON CODE AMTS)	CAS03, 06, 09,12,15, 18 when no 1 or 2 in CAS 02, 05, 08, 11, 14 or 17		2110	451-10 THRU 451-14
REM (LINE REMARK CODES)	LQ02		2110	451-16 THRU 451-20
PT RESP (PATIENT RESPONSIBILITY)	CLP05		2100	500-23
BILLED (SUBMITTED CLAIM LEVEL CHARGES)	CLP03		2100	500-05
ALLOWED (ALLOWED/CONTRACT AMT-CLAIM LEVEL)		2100		500-08
DEDUCT (DEDUCTIBLE AMT-CLAIM LEVEL))		2100		500-09
COINS (COINSURANCE AMT-CLAIM LEVEL)		2100		500-10

TOTAL RC AMOUNT	Computed. Excludes Interest, Late Filing Charges, Deductible, Coinsurance and *Prev. Paid*.

PROV PD (CALCULATED PMT TO PROVIDER - CLAIM LEVEL)	CLP04		2100	500-15
NET (ACTUAL PMT TO PROVIDER FOR CLAIM)	2100	500-19	This is a computed field including Interest, Late Filing Charge and *Prev. Paid.*	
PREVIOUSLY PAID			500-17 THRU 500-18	
INT (INTEREST PAID)	AMT02 when I in AMT01		2100	500-11
LATE FILING CHARGE	AMT02 WHEN KH IN AMT01		2110	451-07
INSURER TO WHOM CLAIM IS FORWARDED	NM103 when TT in NM101& 2 in NM102	2100	500-25	CRSSOVER CARRIER NAME
# OF CLAIMS			800-06	
TOAL BILLED AMT(BT SUBMITTED CHARGES)			800-08	
TOTAL ALLOWED AMT			800-11	
TOTAL DEDUCT AMT			800-12	
TOTAL COINS AMT			800-13	
TOTAL RC AMOUNT		Sum of all RC adjustments. Excludes interest, late filing charge, deductible, coinsurance, and *Prev. Paid*.		
PROV PD AMT			800-18	
PROVIDER ADJ AMT			COMPUTED	
CHECK AMT		BPR02	800-22	
PROVIDER LEVEL ADJUSTMENT REASON CODE	50 OR AP OR B2 OR CS OR FB OR IR OR J1 OR L6 OR LE OR SL OR WO IN PLB03-1, PLB05-1, PLB07-1, PLB09-1, PLB11-1, PLB13-1	700-06	This and the next three lines explain the provider level adjustments.	

FCN OR ADJ REASON (FINANCIAL CONROL #/PROV ADJ REASON)	PLB03-2, PLB05-2, PLB07-2, PLB09-2, PLB11-2, PLB13-2. POSITION 3-19	700-08
HIC	PLB03-2, PLB05-2, PLB07-2, PLB09-2, PLB11-2, PLB13-2 POSITION 20-30	700-04

PROVIDER LEVEL ADJUSTMENT AMOUNT	PLB04, PLB06, PLB 08, PLB10, PLB12, PLB14 WHEN 50 OR AP OR B2 OR CS OR FB OR IR OR J1 OR L6 OR LE OR SL OR WO IN PLB03-1, PLB05-1, PLB07-1, PLB09-1, PLB11-1, PLB13-1	700-07	Includes Interest, Late Filing Charge, Previously Paid and other adjustments as applicable

60 - Remittance Advice Codes

(Rev.1063, Issued: 09-22-06, Effective: 10-01-06, Implementation: 10-23-06)

The remittance advice provides explanation of any adjustment(s) made to the payment. The difference between the submitted charge and the actual payment must be accounted for in order for the 835 to balance. The term "adjustment" may mean any of the following:

- *denied*
- *zero payment*
- *partial payment*
- *reduced payment*
- *penalty applied*
- *additional payment*
- *supplemental payment*

Claim Adjustment Reason Codes and Remittance Advice Remark Codes are used to explain adjustments at the claim or service line level. Provider Level Adjustment or PLB Reason Codes are used to explain any adjustment at the provider level.

60.1 – *Claim* Adjustment Reason Codes

(Rev.1063, Issued: 09-22-06, Effective: 10-01-06, Implementation: 10-23-06)

Claim Adjustment Reason Codes (CARC) are used on the Medicare electronic and paper remittance advice *and Coordination of Benefit (COB) claim transaction. The Claim Adjustment Status Code Maintenance Committee maintains this code set*. A new code may not be added and the indicated wording may not be modified without the approval of this committee. These codes were developed for use by all health plans. As a result, they are generic, and there are a number of codes that do not apply to Medicare. *This code set is updated three times a year. Medicare contractors shall use only most current valid codes in ERA, SPR, and COB claim transactions.*

Any reference to procedures or services mentioned in the reason codes apply equally to products, drugs, supplies or equipment. References to prescriptions also include certificates of medical necessity (CMNs).

These reason codes explain the reasons for any financial adjustments *at the claim and/or service line level*. Current 835 structure only allows one reason code to explain any one specific adjustment amount.

There are basic criteria that the Claim Adjustment Status Code Maintenance Committee considers when evaluating requests for new codes:

- Can the information be conveyed by the use or modification of an existing reason code?
- Is the information available elsewhere in the 835?
- Will the addition of the new reason code make any significant difference in the action taken by the provider who receives the message?

The list of Claim Adjustment Reason Codes can be found at:

http://www.wpc-edi.com/codes

The updated list is published *three times a year after the committee meets before the ANSI ASC X12 trimester meeting in the months of February, June, and September/October*. Medicare contractors must download the list after each update to make sure they are using the latest approved *claim* adjustment reason codes in 835 and standard paper remittance advice transactions.

Individual *A/B MACs,* carriers*,* DMERCs, *DME MACs, FIs, and RHHIs* are responsible for entering claim adjustment reason code updates to their shared system and entry of parameters for shared system use to determine how and when particular codes are to be

reported in remittance advice transactions. In most cases, reason and remark codes reported in remittance advice transactions are mapped to alternate codes used by a shared system. These shared system codes may exceed the number of the reason and remark codes approved for reporting in a remittance advice transaction. A particular 835 reason or remark code might be mapped to one or more shared system codes, or vice versa.

Shared systems must provide a crosswalk between the reason and remark codes to the shared system internal codes so that a *A/B MAC/* carrier/ DMERC/ *DME MAC/ FI/RHHI* can easily locate and update each internal code that may be impacted by a remittance advice reason/remark code change to eliminate the need for lengthy and error prone manual *A/B MAC*/carrier/*DMERC/DME MAC*/FI/*RHHI* searches to identify each affected internal code. Shared systems must also make sure that 5-position remark *codes can be accommodated at both the claim and service level for 835 version 004010A1 onwards.*

The effective date of programming for use of new or modified reason/remark codes applicable to Medicare is the earlier of the date specified in the contractor manual transmittal or CMS recurring code update change request or the Medicare Claims Processing Manual transmittal that implemented a policy change that led to the issuance of the new or modified code. Contractors must notify providers of the new and/or modified codes and their meanings in a provider bulletin or other instructional release prior to issuance of remittance advice transactions that include these changes.

A code may not be reported in a new remittance advice after the effective date of its retirement. If processing an adjustment involving a code that was retired after generation of the original remittance advice, the reversed claim may report the currently valid code supplanting the code that appeared in the initial notice. If easier from a mapping or programming perspective, an *A/B MACs/*carrier/DMERC/*DME MAC/FI/RHHI* has the option to eliminate use of a retired code in each supported remittance advice version, including those that pre-date the effective date of the retirement.

60.2 - Remittance Advice Remark Codes

(Rev.1063, Issued: 09-22-06, Effective: 10-01-06, Implementation: 10-23-06)

Remittance Advice Remark Codes (RARC) are used in a remittance advice to further explain an adjustment or relay informational messages that cannot be expressed with a claim adjustment reason code. Remark codes are maintained by CMS, but may be used by any health plan when they apply. Medicare contractors must report any remark code(s) that apply, subject to capacity limits in the standard.

Most remark codes were initially separated into service level (line 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.

Remark codes that apply at the service line level must be reported in the X12N 835 LQ segment. Remark codes that apply to an entire claim must be reported in either an X12N 835 MIA (inpatient) or MOA (non-inpatient) segment, as applicable. *Although the IG allows up to 5 remark codes to be reported in the MOA/MIA segment and up to 99 remark codes in the LQ segment, system limitation may restrict how many codes Medicare contractors can actually report*

The remark code list is updated three times a year, in the months following X12N trimester meetings. Medicare contractors must use the latest approved remark codes as included in the regular code *update Change Request* or in any other CMS instructions in their 835 version *004010A1* and subsequent versions, the corresponding standard paper remittance advice, *and the X12N Coordination of Benefit transaction (outbound 837*). Contractor and shared system changes must be made, as necessary, as part of a routine release to reflect changes such as retirement of previously used codes or newly created codes that may impact Medicare.

60.3 - Group Codes

(Rev.1063, Issued: 09-22-06, Effective: 10-01-06, Implementation: 10-23-06)

A group code is a code identifying the general category of payment adjustment. A group code must always be used in conjunction with a claim adjustment reason code to show liability for amounts not covered by Medicare or to identify a correction or reversal of a prior decision. Contractors do not have discretion to omit appropriate codes and messages. Contractors must use claim adjustment reason codes, group codes, value codes and remark codes and messages when they apply. Contractors must print an appeal code and message on the remittance *advice* for every claim. Contractors must use a limitation of liability code and message and a coordination of benefits code and message where applicable.

Valid Group Codes for use on Medicare remittance advice:

- *CO - Contractual Obligations. This group code shall be used when a contractual agreement between the payer and payee, or a regulatory requirement, resulted in an adjustment. Generally, these adjustments are considered a write off for the provider and are not billed to the patient.*
- *CR - Corrections and Reversals. This group code shall be used for correcting a prior claim. It applies when there is a change to a previously adjudicated claim. When correcting a prior claim, CLP02 (claim status code) needs to be 22. See ASC X12N Health Care Claim Payment/Advice Implementation Guide (835) section 2.2.8 for complete information about corrections and reversals.*
- *OA - Other Adjustments. This group code shall be used when no other group code applies to the adjustment.*

- *PR - Patient Responsibility. This group shall be used when the adjustment represent an amount that should be billed to the patient or insured. This group would typically be used for deductible and copay adjustments.*

60.4 - Requests for Additional Codes

(Rev.1063, Issued: 09-22-06, Effective: 10-01-06, Implementation: 10-23-06)

The CMS has national responsibility for maintenance of the remittance advice remark codes. Requests for new or changed remark codes should be submitted to CMS via the Washington Publishing Company Web page *http://www.wpc-edi.com/codes* 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.

To provide a summary of changes introduced in the previous four months, a *code update instruction in the form of a change request (CR)* will be issued if in the last four months (a) any new remark or reason code is introduced; and/or (b) an existing code is discontinued; and/or c) the wording for an existing code is modified, and at least one of these changes impact Medicare. *Additionally, these recurring CRs will also notify A/B MACs/* carriers/ DMERCs/ *DME MACs/ FIs/RHHIs of any enhancement(s) being added to the MREP software*. These *CRs* will establish the deadline for Medicare shared system and contractor changes to complete the reason and/or remark code updates that had not already been implemented as part of a previous Medicare policy change instruction.

70 – *A/B MAC* /FI/*RHHI* ERA Requirement Changes to Accommodate OPPS and HH PPS

(Rev.1063, Issued: 09-22-06, Effective: 10-01-06, Implementation: 10-23-06)

The type of bill in CLP08 identifies whether a service is an outpatient hospital, Community Mental Health Center (CMHC), Home Health Agency (HHA), or other category of *A/B MAC* /FI/*RHH*/ processed claim. A remittance advice does not typically identify which of the possible cost bases is being used for payment.

The CMS had to assure both these PPS payment systems could be accommodated in the 835 transaction when they were implemented in 2000.

Changes to accommodate these PPS systems include:

- Detailed service line level data will be reported only in *004010A1 version* of the 835. Detailed service line data is not reported in paper remittance advice notices. Current versions of the SPR and ERA continue to report claims-level summary data.
- 2-062-AMT02 modified to allow reporting of either inpatient or partial hospitalization per diem. *A/B MAC* /FIs/*RHHIs* also report the amount of any

outlier determined payable for the claim, by the Outpatient Prospective Payment System (OPPS) and Home Health (HH) Prospective Payment System (PPS) Medicare Contractor PRICER software (PRICER software calculates a payment amount), in a separate AMT loop with "ZZ" in AMT01 and the outlier amount in AMT02.

- 2-100.A-REF and REF02 modified to allow service line reporting of the Ambulatory Payment Classification (APC) and the Health Insurance Prospective Payment System (HIPPS), representing a Home Health Resource Group (HHRG) for HH PPS) group numbers. The APC will supplant the Ambulatory Surgical Center (ASC) group for outpatient hospital claims paid under PPS.
- 2-100.B-REF modified to allow service line reporting of the home health payment percentage. This segment applies to ASC and Home Health PPS payments, but does not apply to APC payments.
- 2-110.A-AMT modified to allow service line reporting of the allowed amount for APC and home health HIPPS payments.

For OPPS, the standard provider level adjustment reason codes in Appendix B have been expanded to include the ANSI X12N 835 code of BN (bonus) for the reporting of transitional OPPS payments (TOPS payments). This is a claim level segment and must be reported. TOPS payments will be discontinued after December 2003 for all but specified children's and cancer hospitals.

For OPPS, *A/B MAC* /FIs/*RHHIs* treat the amount determined payable for an OPPS service, whether APC, average wholesale price (AWP), etc., as the allowed amount for a service.

For OPPS, *A/B MAC* /FIs/*RHHIs* report services that do not have a related APC, and which are considered to be included in the payment for one or more other APCs, with Group Code CO and reason code 97 (payment included in the allowance for another service/procedure). If a non-APC service on the same claim is denied for another reason, such as not reasonable or necessary (CO 50), then report the specific reason code that applies to that denial rather than CO 97.

For OPPS, *A/B MAC* /FIs/*RHHIs* use the 835 bundling methodology to report APC payment when multiple HCPCS are included in a single APC. When bundling services into an APC grouping, they report service line information back to a provider in the same way as billed, so the provider may automatically identify the services involved and post payment information to patient accounts.

For OPPS, *A/B MAC* /FIs/*RHHIs* report each procedure billed in a remittance advice, even if bundled for payment into a single APC. However, they report the payment for all of the services in a single APC on the line for the first listed service in that APC. Since the payment for the entire APC will be higher than for that procedure code alone, *A/B*

MAC /FIs/*RHHIs* must enter group code OA (other adjustment) and reason code 94 (processed in excess of charges) for the amount of the excess (difference between the billed amount for the service and the allowed rate for the APC) as a negative amount to enable the line and claim to balance. They report the remaining procedures for that APC on the following lines of the remittance advice with group code CO and reason code 97 (payment included in the allowance for another service/procedure) for each. They repeat the process if there are multiple APCs for the same claim.

For Home Health, there may be situations in which a beneficiary is under a home health plan of care, but Common Working File (CWF) does not yet have a record of either a request for anticipated payment or a home health claim for the episode of care. To help inform therapy providers that the services they performed may be subject to consolidated billing, provide the following remark codes on the remittance advice for the conditions noted.

Remark Code	Message (the text may change if this code is modified in the future)	Conditions for Use
N116	This payment is being made conditionally because the service was provided in the home, and it is possible that the patient is under a home health episode of care. When a patient is treated under a home health episode of care, consolidated billing requires that certain therapy services and supplies, such as this, be included in the home health agency's (HHA's) payment. This payment will need to be recouped from you if we establish that the patient is concurrently receiving treatment under an HHA episode of care.	Provide this message on a remittance advice when CWF indicates that the service is payable, and all three of the following conditions are true: 1. The place of service is "12 home." 2. The HCPCS code is a therapy code subject to home health consolidated billing (refer to the most recent PM announcing affected services and codes). 3. The CWF has not returned a message indicating the presence of a request for anticipated payment (RAP).

70.1- Scope of Remittance Changes for HH PPS

(Rev.1063, Issued: 09-22-06, Effective: 10-01-06, Implementation: 10-23-06)

Additional HH PPS changes in the *HIPAA compliant* electronic remittance format are presented in the next few subsections of this manual, and are additions to joint requirements with OPPS in §70. However, CMS will not make additional paper remittance format changes, 835 version *004010A1* implementation guide changes, or PC-Print changes for HH PPS. All the statements below on home health billing apply only to type of bills submitted as 32X, which may be processed as 33X, or what was submitted prior to HH PPS on both 32X and 33X claims. Type of bill is reported on form locator 4 on the Form CMS-1450 (UB-92) claim form.

70.3 - Items Not Included in HH PPS Episode Payment

(Rev.1063, Issued: 09-22-06, Effective: 10-01-06, Implementation: 10-23-06)

By law, durable medical equipment (DME) is not included in payment of home health PPS episodes, though episodes are global payment for most other home health services and items. DME must be reported in a separate line/loop for the claim closing an episode. DME may not be included in the Request for Anticipated Payment (RAP) for an episode. DME will continue to be paid under the DME fee schedule as at present. *A/B MACs/*FIs/*RHHIs* continue to pay osteoporosis drug, flu injection, vaccines or outpatient benefits delivered by home health agencies, such as splints or casts, separately from home health PPS as 34X type of bill claims.

70.4 - 835 Version *004010A1* Line Level Reporting Requirements for the Request for Anticipated Payment (RAP) Payment for an Episode

(Rev.1063, Issued: 09-22-06, Effective: 10-01-06, Implementation: 10-23-06)

A/B MACs:/FIs/*RHHIs*

1. Enter “HC” (HCPCS revenue code qualifier) in 2-070-SVC01-01, and the Health Insurance PPS (HIPPS) code under which payment is being issued in 2-070-SVC01-02.
2. Enter “0” (zero) in 2-070-SVC02 for the HIPPS billed amount and the amount they are paying in SVC03.
3. Enter “0023” (home health revenue code) in SVC04.
4. Enter the number of covered days, as calculated by the shared system for the HIPPS, in SVC05, the covered units of service - this number should be 1, representing the same date used as the from and through date on the RAP.
5. Enter the billed HIPPS in 2-070-SVC06-02 with qualifier ‘HC’ in 2-070-SVC06-01 if the HIPPS has been down coded or otherwise changed during adjudication.
6. Enter the start of service date (claim from date) in 2-080-DTM for the 60-day episode. If a revenue code other than ‘0023’ is billed, they report the line item

date associated with that revenue code instead of the claim from date. The only line item receiving Medicare payment on RAP should be the single "0023" revenue code line.

7. Enter group code "OA" (other adjustment), reason code "94" (processed in excess of charges), and the difference between the billed and paid amounts for the service in 2-090-CAS. They report the difference as a negative amount.
8. Enter "1S" (ambulatory patient group qualifier) in 2-100.A-REF01 and the HIPPS code in 2-100.A-REF02.
9. Enter "RB" (rate code number qualifier) in 2-100.B-REF01 and the percentage code (0, 50, 60) in 2-100.B-REF02.
10. Enter the appropriate line level remark codes in 2-130-LQ. There are no messages specific to home health HIPPS payments. There are no appeal rights for initial percentage episode payments.

2-110-AMT (ASC, APC or HIPPS priced amount or per diem amount, conditional) does not apply, and should not be reported for either the first or the final remittance advice for a HIPPS episode. 2-120-QTY does not apply to a first bill/payment in an episode. This data element is used for home health payment only when payment is based on the number of visits (when four or fewer visits) rather than on the HIPPS.

70.5 - 835 Version *004010A1* Line Level Reporting Requirements for the Claim Payment in an Episode (More Than Four Visits)

(Rev.1063, Issued: 09-22-06, Effective: 10-01-06, Implementation: 10-23-06)

1. *A/B MACs*:/FIs/*RHHIs* reverse the initial payment for the episode. They repeat the data from the first bill in steps 1-7 in §70.4, but change the group code to 'CR' and reverse the amount signs, i.e., change positive amounts to negatives and negatives to positives.
2. *A/B MACs*:/FIs/*RHHIs* enter "CW" (claim withholding) and repeat the reversal amount from 2-070-SVC03 in 3-010-PLB for this remittance advice. This will enable the first 60-day payment to be offset against other payments due for this remittance advice.
3. The full payment for the episode can now be reported for the end of episode bill.

    a. *A/B MACs*:/FIs/*RHHIs* repeat steps 1-11 from §70.4 for the service as a reprocessed bill. They report this data in a separate claim loop in the same remittance advice. Up to six HIPPS may be reported on the second bill for an episode.

    b. In addition to the HIPPS code service loop, *A/B MACs*:/FIs/*RHHIs* also enter the actual individual HCPCS for the services furnished. They include a separate loop for each service. Revenue code "027X," "0623," "027X," and "062X" services may not be billed with a HCPCS, and must be reported in a separate SVC loop in the remittance advice.

c. *A/B MACs*:/FIs/*RHHIs* report payment for the service line with the HIPPS in the HCPCS data element at the 100 percent rate (or the zero rate if denying the service) in step 9.

d. *A/B MACs*:/FIs/*RHHIs* report group code "CO," reason code "97" (Payment included in the allowance for another service/procedure), and zero payment for each of the individual HCPCS in the 2-070-SVC segments. Payment for these individual services is included in that HIPPS payment. FIs/RHHIs do not report any allowed amount in 2-110.A-AMT for these lines. They do not report a payment percentage in the loops for HCPCS included in HIPPS payment(s).

e. *A/B MACs*:/FIs/*RHHIs* enter the appropriate appeal or other line level remark codes in 2-130-LQ. There are no messages specific to home health HIPPS payments.

f. If DME, oxygen or prosthetics/orthotics is paid, *A/B MACs*:/FIs/*RHHIs* report in a separate loop(s), and enter the allowed amount for the service in 2-110.A-AMT.

4. If PRICER determines that a cost outlier is payable for the claim, *A/B MACs*:/FIs/*RHHIs* report the amount PRICER determines payable in a claim adjustment reason code segment (2-020-CAS) with reason code "70' (cost outlier) and a negative amount to reflect additional payment supplementing the usual allowed rate.

5. If insufficient funds are due the provider to satisfy the withholding created in step 2 above, *A/B MACs*:/FIs/*RHHIs* carry the outstanding balance forward to the next remittance advice by entering "BF" (Balance Forward) in the next available provider adjustment reason code data element in 3-010-PLB. They report the amount carried forward as a negative amount.

70.6 - 835 Version *004010A1* Line Level Reporting Requirements for the Claim Payment in an Episode (Four or Fewer Visits)

(Rev.1063, Issued: 09-22-06, Effective: 10-01-06, Implementation: 10-23-06)

1. *A/B MACs*:/FIs/*RHHIs* follow §70.5 steps 1-2.

2. Now that the first payment has been reversed, *A/B MACs*:/FIs/*RHHIs* pay and report the claim on a per visit basis rather than on a prospective basis. They enter HC in SVC01-1, the paid HCPCS for the visit(s) in SVC01-2, submitted charge in SVC02, the paid amount in SVC03, appropriate revenue code (other than 0023) in SVC04, the number of visits paid in SVC05, the submitted HCPCS in SVC06-2 if different than the paid HCPCS shown in SVC01-2, and the number of visits submitted in SVC07 if different than the number of visits paid shown in SVC05.

3. *A/B MACs*:/FIs/*RHHIs* report the applicable service dates and any adjustments in the DTM and CAS segments.

4. The 2-100-REF segments do not apply to per visit payments.

5. *A/B MACs*:/FIs/*RHHIs* enter “B6” in 2-110.C-AMT01 and the allowed amount for the visit(s) in AMT02.

6. *A/B MACs*:/FIs/*RHHIs* report the number of covered and noncovered (if applicable) visits in separate loops in segment 2-120-QTY.

7. *A/B MACs*:/FIs/*RHHIs* enter the appropriate appeal or other line level remark codes in 2-130-LQ.

8. If insufficient funds are due the provider to satisfy the withholding created in §70.5 step 2, *A/B MACs*:/FIs/*RHHIs* carry the outstanding balance forward to the next remittance advice by entering “BF” (Balance Forward) in the next available provider adjustment reason code data element in 3-010-PLB. They report the amount carried forward as a negative amount.

70.7 - PPS Partial Episode Payment (PEP) Adjustment

(Rev.1063, Issued: 09-22-06, Effective: 10-01-06, Implementation: 10-23-06)

Medicare systems apply two codes to the ERA to indicate a PEP adjustment is being reported. The codes are defined as follows:

> *Claim Adjustment Reason Code* B20 - Payment adjusted because procedure/service was partially or fully furnished by another provider; and
>
> *Remittance Advice Remark Code* N120 - Payment is subject to home health prospective payment system partial episode payment adjustment. Beneficiary transferred or was *transferred*/discharged/readmitted during payment episode.

These are not applicable to the standard paper remittance advice.

Medicare Claims Processing Manual

Chapter 24 – General EDI and EDI Support Requirements, Electronic Claims and Coordination of Benefits Requirements, Mandatory Electronic Filing of Medicare Claims

Table of Contents

(Rev. 1063, 09-22-06)

40.1 - General HIPAA EDI Requirements

(Rev.1063, Issued: 09-22-06, Effective: 10-01-06, Implementation: 10-23-06)

The following HIPAA transaction standards must be supported by the Medicare carriers, DMERCs, *DME Medicare Administrative Contractors (DME MACs),* FIs, and *RHHIs* for the electronic exchange of data with Medicare providers/submitters/receivers/COB trading partners. Electronic transactions that do not fully comply with the implementation guide requirements for these formats will be rejected:

- X12N 837 implementation guide (IG) version *004010A1* for Institutional(I) and Professional (P) claims can be accessed via a link from www.cms.hhs.gov/ElectronicBillingEDITrans/08_HealthCareClaims.asp and coordination of benefits (COB) with other payers can be accessed via a link from www.cms.hhs.gov/ElectronicBillingEDITrans/12_COB.asp ;
- NCPDP Telecommunication Standard Specifications and IG version 5.1 and Batch Standard 1.1 for retail prescription drug claims (billed to DMERCs only) and COB (see § 40.1 of this chapter for additional information) can be accessed via a link from www.cms.hhs.gov/ElectronicBillingEDITrans/08_HealthCareClaims.asp ;
- *X12N 835* IG version *004010A1* for Remittance Advice (see Chapter 22 for additional information) and can be accessed via a link from www.cms.hhs.gov/ElectronicBillingEDITrans/11_Remittance.asp ; and
- X12N 276/277 IG version *004010A1* for Claim Status Inquiry & Response (see Chapter 31 for additional information) can be accessed via a link from www.cms.hhs.gov/ElectronicBillingEDITrans/10_ClaimStatus.asp

Medicare carriers, DMERCs, *DME MACs,* FIs, and *RHHIs* will not be involved in Medicare acceptance and processing of the X12N 270/271 IG version *004010A1* transactions for Beneficiary Eligibility Inquiry & Response but information on that transaction is available at www.cms.hhs.gov/ElectronicBillingEDITrans/09_Eligibility.asp. The 270 transaction will be accepted and processed, and a 271 returned by CMS directly. See Chapter 31 for further information.

Although not mandated by HIPAA, as noted in § 30.6, CMS also requires that carriers, DMERCs, DME MACS, RHHIs and FIs issue an X12 997 transaction to electronic claim submitters to acknowledge receipt of claims (except where waived by a submitter) and to report syntax errors related to any X12N transactions submitted to Medicare.

The initial HIPAA transactions regulation required that covered entities eliminate use of electronic formats and versions not adopted as national standards under HIPAA by October 16, 2002 (applies only to the transaction types addressed by HIPAA). Subsequent legislation in the Administrative Simplification Compliance Act (ASCA) permitted covered entities to apply for a 1-year extension to October 16, 2003, to enable them to complete implementation of the standards mandated by HIPAA. Most covered entities, including Medicare, did request that extension. As a significant portion of the

covered entities had still not completed implementation by October 16, 2003, to avoid disruption in health care payments and services, the Secretary of Health and Human Services (HHS) allowed payers to implement contingency plans effective October 16, 2003 to temporarily continue to support pre-HIPAA transaction standards. The contingency plans were permitted to allow additional implementation time for those providers and clearinghouses making a good faith effort to become compliant with the HIPAA transaction requirements to complete work in progress.

CMS *ended the contingency plan for inbound claims on October 1, 2005.* That means that all electronic claims sent to Medicare on or after October 1, 2005, that do not comply with the 837 version *004010A1 IG* or the NCPDP requirements *are to* be rejected. *The contingency plan for transaction 835 (Health Care Claim Payment/Advice) will end on October 1, 2006. Any electronic remittance advice generated on or after October 1, 2006 must be in the HIPAA compliant format (835 version 004010A1).*

The Medicare contingency plan for the *X12N* 276/277 (version 004010 support will need to be terminated), 837 claims that Medicare sends to another payer as provided for in a trading partner agreement, and the 270/271 transactions remain in effect pending further notice. CMS will issue advance notice to the health care industry when a decision is reached to terminate the remaining Medicare contingency plans.

See Pub.100-09, the Medicare Contractor Beneficiary and Provider Communications Manual, regarding contractor requirements for furnishing information to providers via the Internet and alternate methods to be used to furnish information to those providers that lack Internet access. Contractors are permitted to charge providers up to $25 to recoup their costs for manual distribution of free billing or PC Print software via diskette, CD, or other hard media which providers are normally expected to download via the Internet. Contractors are to notify new users of EDI that they should make arrangements to enable them to download later format, and most related coding updates, via the Internet.

An overview of any changes to existing specifications, including effective dates will be issued to providers via carriers, DMERC, *DME MAC,* FI, and *RHHI* bulletins, on their Web page, and will also be available via the Internet as Manual transmittals which can be viewed via a link from www.cms.hhs.gov/ElectronicBillingEDITrans/01_Overview.asp . to the page for each type of transaction. These overviews will identify the Web site address and record title where the specifications for the changes will be recorded.

40.2 - Continued Support of Pre-HIPAA EDI Formats

(Rev.1063, Issued: 09-22-06, Effective: 10-01-06, Implementation: 10-23-06)

Pending termination of the Medicare contingency plan for the HIPAA mandated transactions types other than *inbound* claims *and remittance advice* sent to *and from* Medicare, carriers, DMERCs, *DME MACs*, FIs *and RHHIs* are required to temporarily continue to support use of the following pre-HIPAA electronic transaction formats until the earlier of the effective date for CMS elimination of the HIPAA contingency plan that

applies to each noted format, or the date when no further providers, billing agents, or clearinghouses are using those formats:

- UB-92 version 6.0 flat file claims for coordination of benefits sent to other payers under trading partner agreements;
- X12N 270/271 IG version 003051 for eligibility query and response (carriers only);
- Proprietary format for eligibility data responses using the CMS standard eligibility data set; and
- X12N 276/277 version *004010.*

Carriers, , DMERCs, *DME MACs, FIs and RHHIs* must accept and provide these formats, where applicable for the noted transactions. See Chapters 22 (remittance advice), 25 (UB-92), 26 (CMS-1500), and 31(claim status and eligibility data) for additional information. Specifications for each of these transactions can be found on the Washington Publishing Company Web site at http://www.wpc-edi.com/HIPAA for those *X12N* IGs (other than the NCPDP) adopted as national standards under HIPAA. CMS also publishes all HIPAA IG "companion documents". To access a companion document for a specific transaction, go to www.cms.hhs.gov/ElectronicBillingEDITrans and select the specific transaction on the left side of that screen. There will be a link to the companion document at the bottom of the page for that transaction. "Companion documents" contain supplemental Medicare requirements and information for providers, vendors, clearinghouses, COB trading partners and/or Medicare carriers, DMERCs, *DME MACs,* FIs, *and RHHIs* on application of certain situational requirements, code usage, and Medicare interpretations of certain information in the IGs. Companion documents supplement but may not contradict the IGs. Companion documents are designed to clarify Medicare's expectations about use of situational loops, segments and data elements, and other Medicare-specific information that may impact reporting of data in the HIPAA transactions. Carriers, DMERCs, *DME MACs,* FIs and *RHHIs* are required to adhere to the requirements of the Medicare companion documents as well as the HIPAA standard transaction IGs.

X12*N* version *004010* IGs were initially adopted as first set of X12 national transaction standards under HIPAA, but were subsequently supplanted by an amended version, *004010A1.* Medicare shared system maintainers were required to complete programming changes for implementation of the X12 version *004010A1* IGs that apply to Medicare (837 claim/COB, 835, 276/277) by April 1, 2003. In some cases, individual extensions were approved as result of contractor transitions between shared systems, or due to local issues.

40.3.1 - Electronic Remittance Advice

(Rev.1063, Issued: 09-22-06, Effective: 10-01-06, Implementation: 10-23-06)

Remittance records must be provided to describe the claims for which payment is made. *On or after October 1, 2006 all Medicare contractors must send the Electronic Remittance Advice (ERA) in the ANSI ASC X12N 835 version 004010A1 format.* HIPAA

version implementation guides *are available from the Washington Publishing Company. Their Web site:* http://www.wpc-edi.com/HIPAA

40.3.2 - Standard Paper Remittance (SPR) Notices

(Rev.1063, Issued: 09-22-06, Effective: 10-01-06, Implementation: 10-23-06)

By October 2003, shared systems must use the HIPAA version 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. The FI Shared System must furnish the FIs/*RHHIs* at least 90 days advance notice of their SPR changeover date. FIs/*RHHIs* 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 change over *or any other change.*

The Medicare core system will continue to record a maximum of 17 characters for patient account numbers. Patient account numbers in excess of 17 characters will be populated from the repository established for coordination of benefits for both SPRs and ERAs. If a provider requests a SPR or ERA after a 20-character patient account number has been purged from the repository, the SPR/ERA will report the first 17-characters only. A similar limitation applies to reporting of provider line item control numbers in ERAs.

All other data elements included in SPRs and ERAs will be populated from the Medicare core system. By October 2003 shared systems must assure that all data elements that appear in both the SPR and the ERA for the same claim contain identical data. Fields shared by both formats for the same claim may not contain different data. As in the past, data not available in an ERA may not be reported in a SPR. SPRs *like ERA* will also be limited to reporting of one secondary payer, even when payment information for a claim is shared with more than one secondary payer under COB trading partners agreements.

40.3.3 – *Remittance Advice Remark Codes*

(Rev.1063, Issued: 09-22-06, Effective: 10-01-06, Implementation: 10-23-06)

Contractors can download the currently approved remark code list from http://www.wpc-edi.com/codes/. These messages may be used in both HIPAA format ERAs and standard paper remittances as soon as programming changes are completed. If carriers, DMERCs, *DME MACS, FIs and RHHIs* begin to use any of these codes for the first time, they must furnish advance notice to providers, including the code, the text, and under what situations the code will be used. Carriers, DMERCs, *DME MACS, FIs and RHHIs* must use only currently valid codes available at the WPC Web site mentioned above. CMS issues code update instruction every four months, informing of the changes made in the previous four months. In addition, contractors will be notified of new/modified codes that Medicare initiated in conjunction with a policy change, in the form of a *Change Request (CR* or manual instruction implementing the policy change.

Any remark code may be reported at either the claim or the line level *in the MOA/MIA or the LQ segment respectively.*

40.7 – Electronic Funds Transfer (EFT)

(Rev.1063, Issued: 09-22-06, Effective: 10-01-06, Implementation: 10-23-06)

Although EFT is not mandated by HIPAA, EFT is the preferred method of Medicare payment. *Carriers, DMERCs, DME MACs, FIs, and RHHIs* must obtain and retain a signed copy of Form CMS-588, Authorization Agreement for Electronic Funds Transfer, from each provider that elects use of EFT. Carriers, DMERCs, *DME MACs, FIs and RHHIs* may not require providers that elect EFT, but have not elected to use any other EDI transactions, to complete an EDI Enrollment Form. If the provider declines to accept electronic deposit to a bank account, the carrier, DMERC, *DME MAC,* FI *or RHHI* should attempt to convince the provider to accept direct deposit via EFT by discussing the benefits of EFT, e.g., faster payment, easier payment reconciliation.

Provider pick-up of Medicare checks, next day delivery, express mail, and courier services are not allowed except in special situations authorized by the CMS RO. EFT is the fastest means of Medicare payment. The only acceptable alternative to EFT is a paper check mailed by first class mail. See the Medicare Financial Management Manual, Pub. 100-06, Chapter 5, §160 for further information on EFT.

A carrier, DMERC, *DME MAC,* FI *or RHHI* must use a transmission format that is both economical and compatible with the servicing bank. Normally this will be either the National Automated Clearinghouse Association (NACHA) format, or the X12N 835 format. (Table 1 of the 835 can also be used to trigger EFT payment.) Carriers, , DMERCs, *DME MACs, FIs, and RHHIs* must transmit the EFT authorization to the originating bank upon the expiration of the payment floor applicable to the claim. They must designate a payment date (the date on which funds are deposited in the provider's account) of two business days later than the date of transmission.

60.6.1 - Medicare Remit Easy Print Software for *Professional Providers and Suppliers*

(Rev.1063, Issued: 09-22-06, Effective: 10-01-06, Implementation: 10-23-06)

CMS has developed software that gives providers/suppliers a tool to read and print an ERA in a readable format. This software is called Medicare Remit Easy Print (MREP). It has been developed in response to comments CMS received from the provider/supplier community that they need a paper document for accounts reconciliation, and claim submission for secondary/tertiary payments. Providers/suppliers who use the MREP software package, have the ability to print paper documentation that can be used to reconcile accounts receivable, as well as create document(s) that can be included with claim submission to secondary/tertiary payers. The MREP *remittance advice* is similar to

the current Standard Paper Remittance (SPR) format. This software became available on October 11, 2005, through respective Part B contractors and DMERCs.

Carriers, , DMERCs, *and DME MACs* must eliminate issuance of standard paper remittance advice notices (SPRs) to those providers/suppliers (or a billing agent, clearing house, or other entity representing those providers) also receiving ERA transactions for 45 days or more. Providers and suppliers must be encouraged to use MREP or other software to read, view, and print an electronic remittance advice to eliminate any need for SPRs.

This software can be downloaded for free from a CMS Web site. Providers must go through their contractors to access this Web site so that contractors can maintain a list of MREP users. Any MREP related message is communicated using this list, and contractors must create and maintain their individual MREP user list. Contractors are allowed to charge up to $25.00 to recoup their cost if the software has to be sent on a CD or DVD or any other means at the request of a provider when the software is available for download for free.

60.6.2 - Medicare Standard Electronic *PC Print Software for Institutional Providers*

(Rev.1063, Issued: 09-22-06, Effective: 10-01-06, Implementation: 10-23-06)

FIs *and RHHIs* are required to issue Windows-based software that a provider may use to convert an X12*N* 835 into a print document. See chapter 22 for further information on the content of the print version of institutional paper remittance advice notices.

The FIs *and RHHIs* must periodically notify providers that free PC Print software is available. An FI *or RHHI* must make the PC Print software available on their Web site for downloading by providers *for free*. If a provider has difficulty downloading software, or it cannot be posted on a Web site due to copyright restrictions, the provider may be sent a single copy of the PC Print software; this must be issued within three weeks of the provider's request. *Contractors are allowed to charge up to $25.00 to recoup any cost involved in sending a CD or DVD if a provider requests it and the software is available to download for free.*

The FI Shared System (FISS) maintainer distributes PC Print software and a user's guide to FIs/*RHHIs* through their data center. The software and instructions are designed to be self-explanatory to providers; it should not be necessary to furnish provider training for use of PC- Print software. Providers are responsible for any telecommunication costs associated with receipt of the X12N 835 and the cost to print paper remittance advices from the X12N 835 transactions they are sent. The FISS PC Print software does not contain copyright restrictions and can be posted on any FIs Web page for provider download.

The PC Print software enables providers to:

- Receive an 835 electronic remittance advice transmission on a personal computer (PC) over a wire connection and write the 835 file in American National Standard

Code for Information Interchange (ASCII) to the provider's A (floppy disk) or other drive;

- Print 835 data in an easily readable format;
- View and print provider payment summary information;
- View and print a single claim; and
- View and print a sub-total by bill type.

The receiving PC always writes an 835 file in ASCII. The providers may choose one or more print options, i.e., the entire transmission, a single claim, a summary by bill type, and/or a provider payment summary. All file and print formats follow the Medicare national standards described in the SPR specifications (see chapter 22). If software malfunctions are detected, FIs/*RHHIs* are to report them to the FISS maintainer for correction as needed. FIs/*RHHI*s and data centers are not permitted to modify the PC Print software. Nor will individual FIs/*RHHI*s be funded to develop or procure alternate PC Print software.