CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 2843	**Date: December 27, 2013**
	Change Request 8513

SUBJECT: Medicare Claims Processing Pub. 100-04, Chapter 22 Update

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to publish an update to Pub.100-04, Chapter 22 to reflect changes to Medicare Fee-For-Service's Remittance Advice due to implementation of Operating Rules under the Patient Protection and Affordable Care Act. In addition, general changes are being made across the chapter to standardize language around the use of contractors and general standard wording. Please note that some chapters were only modified to change how we refer to contractors. This update also included the addition of the Council for Affordable Quality Healthcare (CAQH) Committee for Operating Rules Information Exchange (CORE) Operating Rules requirements.

EFFECTIVE DATE: January 28, 2014
IMPLEMENTATION DATE: January 28, 2014

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/Section 10 Background
R	22/Section 20 General Remittance
R	22/Section 30 Remittance Balancing
R	22/Section 40 Electronic Remittance Advice
R	22/Section 40/40.1 ASC X12 835
R	22/Section 40/40.2 Generating an ERA if Required Data is Missing or Invalid
R	22/Section 40/40.3 Electronic Remittance Advice Data sent to Banks
R	22/Section 40/40.4 Medicare Standard Electronic PC-Print Software for Institutional Providers
R	22/Section 40/40.5 Medicare Remit Easy Print Software for Professional Providers
R	22/Section 40/40.6 Asc X12 835 Implementation Guide (IG) or Technical Report 3 (TR3)
R	22/Section 50 Standard Paper Remittance Advice
R	22/Section 50/50.1 The Do-Not-Forwrd Initiative
R	22/Section 50/50.2 SPR Formats
R	22/Section 50/50.2/50.2.1 A/B MAC (A)/A/B Mac (HH) SPR Format
R	22/Section 50/50.2/50.2.2 A/B MAC (B)/DME MAC SPR Format
R	22/Section 60 Remittance Advice Codes
R	22/Section 60/60.1 Group Code
R	22/Section 60/60.2 Claim Adjustment Reason Codes
R	22/Section 60/60.3 Remittance Advice Remark Codes
R	22/Section 60/60.4 Requests for additional Codes
R	22/Section 70 ASC X12 Version 4010A1
R	22/Section 80 CAQH CORE Mandated Operating Rules
N	22/Section 80/80.1 CAQH CARE 350 - Health Care Claim Payment /Advice (835) Infrastructure Rule
N	22/Section 80/80.1.1 Version X12/5010X221 Companion Guide
N	22/Section 80/80.2 Uniform Use of CARCs and Rarcs Rule
N	22/Section 80/80.3 EFT Enrollment Data Rule
N	22/Section 80/80.4 ERA Enrollment Form

III. FUNDING:
For Medicare Administrative Contractors (MACs):

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

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 2843	Date: December 27, 2013	Change Request: 8513

SUBJECT: Medicare Claims Processing Pub. 100-04, Chapter 22 Update

EFFECTIVE DATE: January 28, 2014
IMPLEMENTATION DATE: January 28, 2014

I. GENERAL INFORMATION

A. Background: The Centers for Medicare and Medicaid Services (CMS) is in the process of implementing the Operating Rules for Electronic Remittance Advice (ERA) under Affordable Care Act.

This Change Request (CR) instructs the contractors that Chapter 22 – Remittance Advice – of the Claims Processing Manual has been updated to reflect changes to Medicare Fee-For-Service's Remittance Advice – both Electronic Remittance Advice (ERA) and Standard Paper Remittance Advice (SPR) - to accommodate the new Operating Rules for Electronic Remittance Advice (ERA) under Affordable Care Act (ACA). Version 4010 has been removed from this update and Council for Affordable Quality Healthcare (CAQH) Committee for Operating Rules Information Exchange (CORE) Operating Rules have been added.

B. Policy: Health Insurance Portability and Accountability Act (HIPAA) Legislation Published in the Federal Register; 45 CFR Part 162

The related new CAQH CORE Operating Rules requirements are found in new sections 80 - 80.4 of this transmittal.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
8513.1	Contractors shall make sure that all new requirements contained within Pub. 100-04 Chapter 22-Remittance Advice – have been appropriately implemented.	X	X		X					CEDI
8513.2	Contractor shall be aware of the changes in terminology for ASC X12 transactions and for terminology for identifying Medicare Administrative Contractors.	X	X		X					CEDI

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility

		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	None					

IV. SUPPORTING INFORMATION

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

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

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

V. CONTACTS

Pre-Implementation Contact(s): Sumita Sen, Sumita.Sen@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR) or Contractor Manager, as applicable.

VI. FUNDING

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

Medicare Claims Processing Manual
Chapter 22 - Remittance Advice

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(Rev .2843, Issued: 12-27-13,)

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10 - Background

(Rev .2843, Issued: 12-27-13, Effective: 01-28-14, Implementation: 01-28-14)

A/B Medicare Administrative Contractors (A/B MACs), and Durable Medical Equipment Medicare Administrative Contractors (DME MACs) 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, there is an associated remittance advice item. Adjustment is defined as:

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

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 and DME MACs also send informational RAs to nonparticipating physicians, suppliers, and non-physician practitioners billing non-assigned claims (billing and receiving payments from beneficiaries instead of accepting direct Medicare payments), unless the beneficiary or the provider requests that the remittance advice 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 IOM 100-04, Chapter 30) applies.

MACs are allowed to charge up to a maximum of $25.00 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. Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) administrative provisions, the Secretary of Health and Human Services has adopted ASC X12 Health Care Claim Payment/Advice (835) version 5010A1 to be the standard effective from January 1, 2012, replacing the current standard – ASC X12 835, version 4010A1. Medicare has implemented the new version.

CMS has implemented the new HIPAA standard following the ASC X12 Technical Report 3 (TR3) for transaction 835 version 5010A1, and requires the use of this format exclusively for Electronic Remittance Advices (ERAs) on or after full implementation. CMS has also established a policy that the paper formats shall mirror the ERAs as much as possible, and all MACs shall use the paper formats – Standard Paper Remit or SPR - established by CMS.

The new HIPAA compliant version of the ASC X12 835 includes some changes from the earlier standard version. For a side-by-side comparison of the 4010A1 and the 5010A1 flat files, go to:

http://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/18_5010D0.html

One major change for Medicare is a new REF segment at the 2110 Loop (Health Care Policy Identification) to report the actual Local Coverage Determination (LCD) and/or National Coverage Determination (NCD) code for LCD/NCD related denials. A new PER segment at the 1000A Loop (Payer Website) provides the MAC specific web address to help providers identify the exact reason for denial. The ASC X12 TR3 for version 5010 is available for a fee from Washington Publishing Company (WPC). Their Web site:

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

ERRATA: After a lot of discussion about modifications needed to implement the new HIPAA standard (version 5010) correctly, the ASC X12 released the Errata for publication in early August of 2010, and they have been adopted by the Department of Health and Human Services (DHHS) in October 2010. In simple terms, the Erratas are modifications to some of the TR3s – Transaction 835 is one of them. CMS implemented the changes if applicable to Medicare and also updated the relevant flat files to reflect the modifications whether the specific modification impacted Medicare or not. It is important to note that under these guidelines, both the sender and the receiver need to adopt if they are to perform a successful exchange of information. ASC X12 835 ERRATA has only one impact for Medicare – the version changed from 5010 to 5010A1.

Provider Identification:

Medicare requires claims to contain National Provider Identifiers (NPIs) to be accepted for adjudication. NPIs received on the claims are cross walked to Medicare assigned legacy numbers for adjudication. Adjudication is based on each unique combination of NPI/legacy number if there is no one-to-one relationship between the two. Any ERA or SPR sent after version 5010A1 has been implemented will have one of the 3 provider identifications: (1)Federal Taxpayer's Identification Number; (2) Centers for Medicare and Medicaid Services PlanID; (3) Centers for Medicare and Medicaid Services National Provider Identifier (NPI) as the provider ID instead of any Medicare assigned provider number at the provider level. NPI will be sent as the provider identification at the claim level. As the Rendering Provider Identifier at the service line level, any one of the following identifiers: (1) Centers for Medicare and Medicaid Services National Provider Identifier; (2) Social Security Number; (3) Federal Tax Payer's Identification Number; (4) Medicare Provider Number; (5) Provider UPIN Number – will be sent.

20 - General Remittance Completion Requirements

(Rev .2843, Issued: 12-27-13, Effective: 01-28-14, Implementation: 01-28-14)

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. Inpatient 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 Payment to Provider, CLP04 in the *ASC X12* 835) and interest, late filing charges and previously paid amounts.

- *MACs* 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 the *ASC X12* 835 does not have the capacity to report more than one crossover carrier, and the SPR mirrors the *ASC X12* 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 *MAC* 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 *ASC X12* 835) showing the amount paid for the voided claim.

- *The shared system maintainers and contractors must make sure that the HIPAA transactions 835 and 837 COB balance after a system change resulting from a policy change that may or may not be directly related to Electronic Data Interchange (EDI).*

30 - Remittance Balancing

(Rev .2843, Issued: 12-27-13, Effective: 01-28-14, Implementation: 01-28-14)

For Medicare the principles of remittance balancing are the same for both paper and electronic remittance formats. Balancing requires that the total paid amount is equal to the total submitted charges plus or minus payment adjustments for a single ASC X12 835 remittance in accordance with the rules of the standard *ASC X12* 835 format. Refer to Front Matter Section 1.10.2.1 for Balancing in the *ASC X12* 835 version *5010* TR3. Every HIPAA compliant *ASC* X12 835 transaction issued by a MAC must comply with the ASC X12 835 version *5010* TR3 requirements, i.e., these remittances must balance at the service, claim and provider levels. The flat files generated by the shared systems must be balanced at the line, claim, and provider level – refer to *ASC X12/5010* Change Requests (CRs). As a failsafe measure claim adjustment reason codes A7 (Part A)/121 (Part B) and PLB reason code 90 may be used at the line, claim and provider level respectively to make sure that the *ASC X12* 835 is balanced. Shared System generated reports must track the usage of these codes, and A/B MACs and DME MACs must work closely with the shared system maintainers and CMS to resolve the issues resulting in out of balance situations.

40 – Electronic Remittance Advice - *ERA or ASC X12 835*

(Rev .2843, Issued: 12-27-13, Effective: 01-28-14, Implementation: 01-28-14)

Electronic Remittance Advice (ERA) transactions must be produced in the current HIPAA compliant ASC X12 835 version */5010.* Directions for version updates are posted when necessary in CMS Change Request (CR) instructions issued by CMS. A series of CRs have been issued with instructions about changes from version 4010A1 to version *5010A1*. Refer to http://www.wpc-edi.com/reference for implementation guides, record formats, and data dictionaries for the ASC *X12* 835. You can go to: http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/index.html to download relevant CRs.

Shared systems maintainers must provide appropriate provider file structures and switching mechanisms so that *MACs* can select and generate the ASC *X12* 835 and/or the automated clearing house (ACH) format when electronic funds transfer (EFT) applies. See the implementation guides for further information on the abbreviated *ASC X12* 835 and use of the *ASC X12* 835 for EFT.

Changes to content and format of ERAs may not be made by individual *MACs*. Changes will be made only by shared system maintainers, and then, only as directed by CMS.

40.1- *ASC X12 835*

((Rev .2843, Issued: 12-27-13, Effective: 01-28-14, Implementation: 01-28-14)

The *ASC X12* 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 *ASC X12* 835. *MACs* must translate that flat file into the variable length *ASC X12* 835 record for transmission to providers or their billing services or clearinghouse. See Chapter 24 for technical information about transmission of the *ASC X12* 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.

MAC requirements are:

- Send the remittance data directly to providers or their designated billing services or clearinghouses;

- Provide sufficient security to protect beneficiaries’ privacy. At the provider’s request, the *MAC* may send the *ASC X12* 835 through the banking system if its Medicare bank and the provider’s bank have that capability. The *MAC* does not allow any party to view beneficiary information, unless authorized by specific instructions from CMS

- 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 *MAC* or an associated business under the same corporate umbrella for supplemental services or software;

- A/B MACs *(A)* allow Part A providers to receive a Standard Paper Remittance Advice (SPR) in addition to the *ASC X12* 835 during the first *31* days of receiving ERAs and during other testing. After that time, A/B M*ACs (A)* do not send a hard copy version of the *ASC X12* 835, in addition to the electronic transmission, in production mode. They should contact CMS if this requirement causes undue hardship for a particular provider, and a waiver is needed;

- A/B MACs *and* DME MACs must suppress the distribution of SPRs to those Part B providers//suppliers (or a billing agent, clearing house or other entity receiving ERAs on behalf of those providers/suppliers) 45 days of receiving both SPR and ERA formats. 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 *and* DME MACs should contact CMS if a waiver is needed.”

- *MACs* 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 *ASC X12* 835 format.

- 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 *ASC X12* 835 data once in production mode; and

- Provide for sufficient back-up to allow for retransmission of garbled or misdirected transmissions.

Every *ASC* X12 835 transaction issued by A/B MACs *and* DME MACs must comply with the implementation guide (IG) requirements 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 *and* DME MACs 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 *ASC X12* 835, but they are required to validate data in the *ASC X12* 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 *ASC X12* 835. MACs 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 *ASC X12* 835 for submission of an invalid code, in which case the invalid code must be reported on the *ASC X12* 835;
- A code was valid when received, but was discontinued by the time the *ASC X12* 835 is issued, in which case, the received code must be reported on the *ASC X12* 835; or
- A code is received on a paper claim, and does not meet the required data attribute(s) for the HIPAA compliant *ASC X12* 835, in which case, "gap filling" would be needed if it were to be inserted in a compliant *ASC X12* 835.

Additionally A/B MACs and Common Electronic Data Interchange (CEDI) for DME MACs must follow the CMS instructions for Receipt, Control and Balancing.

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

(Rev .2843, Issued: 12-27-13, Effective: 01-28-14, Implementation: 01-28-14)

The *ASC* X12 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, a 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 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 *MACs*, 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. Shared System Maintainers must follow CMS gap-filling instruction. The *MAC* must notify the trading partners, if and when their files are affected, as to when and why gap-filling characters will appear in an *ASC X12* 835.

40.3 - Electronic Remittance Advice Data Sent to Banks

(Rev .2843, Issued: 12-27-13, Effective: 01-28-14, Implementation: 01-28-14)

Under the HIPAA Privacy requirements, U. S. health care payers are prohibited from sending table two *ASC X12* 835 data (portion of *ASC X12* 835 containing protected patient health care information) (or protected patient health care information in any other paper or electronic format) to a bank, unless:

- That bank also functions as a health care data clearinghouse;
- The provider has authorized the bank as a health care data clearinghouse to receive that data; and
- The bank has signed an agreement to safeguard the privacy and security of the data.

The definition of a financial clearinghouse, as used by banks for transfer of funds, differs from the definition of health care data clearinghouse as used by HIPAA. The HIPAA definition must be met if a bank is to be authorized for receipt of table two or equivalent patient health care data.

Table two contains protected patient information that is not approved for release to a bank that is not an authorized health care data clearinghouse. A *non-health* data clearinghouse bank cannot receive *ASC X12* 835 data, except as provided in table one.

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

(Rev .2843, Issued: 12-27-13, Effective: 01-28-14, Implementation: 01-28-14)

PC Print software enables institutional providers to print remittance data transmitted by Medicare. A/B MACs *(A)* are required to make PC Print software available to providers for downloading at no charge. A/B MACs *(A)* 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 include self-explanatory loading and use information for providers. It should not be necessary to furnish provider training for use of PC Print software. A/B MACs *(A)* must supply providers with PC-Print software within three weeks of request. The A/B MAC *(A)* Shared System (FISS) maintainer will supply PC Print software and a user's guide for all A/B MACs *(A)*. The FISS maintainer must assure that the PC Print software is modified as needed to correspond to updates in the ERA and SPR formats per CMS instruction.

Providers are responsible for any telecommunication costs associated with receipt of the *ASC X12* 835, but the software itself can be downloaded at no cost.

The PC Print software enables providers to:

- Receive, over a wire connection, an *ASC X12* 835 electronic remittance advice transmission on a personal computer (PC) and write the *ASC X12* 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 *ASC X12* 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 *ASC X12* 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 (A) or data centers may not modify the PC Print software. PC Print Software has been updated to accommodate *ASC X12* 835 version *5010*.

The software will also print the CORE defined business scenarios along with the texts for Claim Adjustment Reason and Remittance Advice Remark Codes reported on the 835 to explain any adjustment.

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

(Rev .2843, Issued: 12-27-13, Effective: 01-28-14, Implementation: 01-28-14)

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. This software became available on October 11, 2005 to the providers through their respective A/B MACs *and* CEDI. The software is scheduled to be updated three times a year to accommodate the Claim

Adjustment Reason Code *(CARC)* and Remittance Advice Remark Code *(RARC)* tri-annual updates, and any applicable enhancements. In addition to these three regular updates, there is also an annual enhancement update, if needed.

The MREP software enables providers to:

- View and print remittance information on all claims included in the *ASC X12* 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 *and* CEDI 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. MREP software has been updated to accommodate *ASC X12* 835 version *5010*.

The software will also print the CORE defined business scenarios along with the texts for Claim Adjustment Reason and Remittance Advice Remark Codes reported on the 835 to explain any adjustment.

40.6 - *ASC X12* 835 Implementation Guide *(IG) or Technical Report 3 (TR3)*

(Rev .2843, Issued: 12-27-13, Effective: 01-28-14, Implementation: 01-28-14)

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires that Medicare, and all other health insurance payers covered under HIPAA comply with the electronic data interchange standards for health care as established by the Secretary of Health and Human Services. The 5010A1 version of the ASC X12 835 Technical Report 3 TR3 has been established as the standard for compliance for *the 5010A1 version of the ASC X12 835remittance advice transaction...*. The formal name of this TR3 is *ASC X12 Standards for Electronic Data Interchange Technical Report Type 3—Health Care Claim Payment/Advice (835), and its* current HIPAA compliant version is available electronically at:

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

Although that TR3 or implementation guide contains requirements for use of specific segments and data elements within the segments, it was written for use by all health plans and not specifically for Medicare. However, a Companion Document has been prepared by CMS to clarify when conditional data elements and segments must be used for Medicare reporting 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 *ASC* X12 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.gov/ElectronicBillingEDITrans/30_CompanionGuides.asp#TopOfPage

50 - Standard Paper Remittance Advice

(Rev .2843, Issued: 12-27-13, Effective: 01-28-14, Implementation: 01-28-14)

The Standard Paper Remittance (SPR) is the hard copy version of an ERA. All A/B MACs *and* DME MACs must be capable of producing SPRs for providers who are unable or choose not to receive an ERA. A/B MACs *and* DME MACs suppress distribution of SPRs if a provider is also receiving ERAs for more than *31* days (institutional providers) or 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 *ASC X12* 835 version *5010A1* data fields.

50.1 - The Do Not Forward (DNF) Initiative

(Rev .2843, Issued: 12-27-13, Effective: 01-28-14, Implementation: 01-28-14)

As part of the Medicare DNF Initiative, A/B MACs 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 staff must notify the provider enrollment area, and 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, *MACs* remove the DNF flag after the address has been verified, and pay the provider any funds still being held due to a DNF flag. *MACs* 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 *MAC* 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 National Supplier Clearinghouse (NSC) has verified and updated all addresses for that provider's location. *MACs* must initially publish the requirement that providers must notify the A/B MAC or NSC of any changes of address, both on their Web sites and in their next regularly scheduled bulletins. MACs 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 .2843, Issued: 12-27-13, Effective: 01-28-14, Implementation: 01-28-14)

The following sections contain the separate SPR formats *for A/B MACs (A) and (HH), A/B MACs (B), and DME MACS.* These are the general formats. The actual SPRs may contain additional (or fewer) lines, i.e., the *MAC* 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 - A/B MAC *(A)*/A/B MAC *(HH)* SPR Format

(Rev .2843, Issued: 12-27-13, Effective: 01-28-14, Implementation: 01-28-14)

EXAMPLE:

MAC NAMEXXXXXXXXXXXXXXXXXXX *ADDRESS* 1XXXXXXXXXXXXXXXXXXXXXXXXXX CITYXXXXXXXXXXX ST ZIPXXXXXX
VER# XXXXXXX

BUSINESS CONTACT NAMEXXXXXXXXXXXXXX PHONE XXX-XXX-XXXX EXT XXX, FAX XXX-XXX-XXXX EXT XXX, EMAIL
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

PROVIDER/NPI PROVIDER NAME XXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXX XXXXXXXXXXXXXX XX XXXXX

PART A PAID DATE: MM/DD/CCYY REMIT#: 99999 PAGE: 99999

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

HIC NUMBER ICN NUMBER RC REM OUTCD NEW TECH COVD CHGS ESRD NET ADJ PATIENT RESP

FROM DT THRU DT 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

XXXXXXXXXXXXXXXXXX X X XXXXXXXXXXXXXXXXXXXX XXX XXXXX XXXX 9999999.99 9999999.99 9999999.99 9999999.99

XXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXX XXX XXXXX XX 9999999.99 9999999.99 9999999.99 9999999.99

MM/DD/CCYY MM/DD/CCYY X XXX XXX XXXXX 9999999.99 9999999.99 9999999.99 9999999.99 9999999.99

XX 999 9999 9999 XXX XXXXX 9999999.99 9999999.99 9999999.99 9999999.99 9999999.99

SUBTOTAL FISCAL YEAR – CCYY 99999999.99 99999999.99 99999999.99 99999999.99

99999999.99 99999999.99 99999999.99

99999999.99 99999999.99 99999999.99 99999999.99 99999999.99

999 9999 9999 99999999.99 99999999.99 99999999.99 99999999.99

SUBTOTAL PART A 99999999.99 99999999.99 99999999.99 99999999.99

99999999.99 99999999.99 99999999.99

99999999.99 99999999.99 99999999.99 99999999.99 99999999.99

999 9999 9999 99999999.99 99999999.99 99999999.99 99999999.99

WHEN THE REMITTANCE IS FOR A HOME HEALTH PROVIDER THERE WILL BE A SUBTOTAL BY HOME HEALTH TYPE OF BILLS 32X AND 33X

MAC NAMEXXXXXXXXXXXXXXXXXXX *ADDRESS* 1XXXXXXXXXXXXXXXXXXXXXXXXXX CITYXXXXXXXXXXX ST ZIPXXXXXX
VER# XXXXXXX

BUSINESS CONTACT NAMEXXXXXXXXXXXXXX PHONE XXX-XXX-XXXX EXT XXX, FAX XXX-XXX-XXXX EXT XXX, EMAIL
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

PROVIDER/NPI PROVIDER NAME XXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXX XXXXXXXXXXXXXX XX XXXXX

PART B PAID DATE: MM/DD/CCYY REMIT#: 99999 PAGE: 99999

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

HIC NUMBER ICN NUMBER RC REM OUTCD NEW TECH COVD CHGS ESRD NET ADJ PATIENT RESP

FROM DT THRU DT 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

XXXXXXXXXXXXXXXXXX X X XXXXXXXXXXXXXXXXXXXX XXX XXXXX XXXX 9999999.99 9999999.99 9999999.99 9999999.99

XXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXX XXX XXXXX XX 9999999.99 9999999.99 9999999.99 9999999.99

MM/DD/CCYY MM/DD/CCYY X XXX XXX XXXXX 9999999.99 9999999.99 9999999.99 9999999.99 9999999.99

XX 999 9999 9999 XXX XXXXX 9999999.99 9999999.99 9999999.99 9999999.99 9999999.99

SUBTOTAL FISCAL YEAR – CCYY 99999999.99 99999999.99 99999999.99 99999999.99

99999999.99 99999999.99 99999999.99

99999999.99 99999999.99 99999999.99 99999999.99 99999999.99

999 9999 9999 99999999.99 99999999.99 99999999.99 99999999.99

SUBTOTAL PART B 99999999.99 99999999.99 99999999.99 99999999.99

99999999.99 99999999.99 99999999.99

99999999.99 99999999.99 99999999.99 99999999.99 99999999.99

999 9999 9999 99999999.99 99999999.99 99999999.99 99999999.99

WHEN THE REMITTANCE IS FOR A HOME HEALTH PROVIDER THERE WILL BE A SUBTOTAL BY HOME HEALTH TYPE OF BILLS 34X

MAC NAMEXXXXXXXXXXXXXXXXXXX *ADDRESS* 1XXXXXXXXXXXXXXXXXXXXXXXXXX CITYXXXXXXXXXXX ST ZIPXXXXXX
VER# XXXXXXX

BUSINESS CONTACT NAMEXXXXXXXXXXXXXX PHONE XXX-XXX-XXXX EXT XXX, FAX XXX-XXX-XXXX EXT XXX, EMAIL XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

PROVIDER/NPI PROVIDER NAME XXXXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXX XXXXXXXXXXXXXX XX XXXXX

S U M M A R Y PAID DATE: MM/DD/CCYY REMIT#: 99999 PAGE: 99999

CLAIM DATA: PASS THRU AMOUNTS:

CAPITAL : 99,999,999.99 PROVIDER PAYMENT RECAP :

DAYS : RETURN ON EQUITY : 99,999,999.99

COST : 999999999 DIRECT MEDICAL EDUCATION : 99,999,999.99 PAYMENTS :

COVDY : 999999 KIDNEY ACQUISITION : 99,999,999.99 DRG OUT AMT : 99,999,999.99

NCOVDY : 999999 BAD DEBT : 99,999,999.99 INTEREST : 99,999,999.99

NON PHYSICIAN ANESTHETISTS: 99,999,999.99 PROC CD AMT : 99,999,999.99

CHARGES : TOTAL PASS THRU : 99,999,999.99 NET REIMB : 99,999,999.99

COVD : 99,999,999.99 TOTAL PASS THRU : 99,999,999.99

NCOVD : 99,999,999.99 PIP PAYMENT : 99,999,999.99 PIP PAYMENTS : 99,999,999.99

DENIED : 99,999,999.99 SETTLEMENT PAYMENTS : 99,999,999.99 SETTLEMENT PYMTS : 99,999,999.99

ACCELERATED PAYMENTS : 99,999,999.99 ACCELERATED PAYMENTS: 99,999,999.99

REFUNDS : 99,999,999.99 REFUNDS : 99,999,999.99

PROF COMP : 99,999,999.99 PENALTY RELEASE : 99,999,999.99 PENALTY RELEASE : 99,999,999.99

MSP PYMT : 99,999,999.99 TRANS OUTP PYMT : 99,999,999.99 TRANS OUTP PYMT : 99,999,999.99

DEDUCTIBLES : 99,999,999.99 HEMOPHILIA ADD-ON : 99,999,999.99 HEMOPHILIA ADD-ON : 99,999,999.99

COINSURANCE : 99,999,999.99 NEW TECH ADD-ON : 99,999,999.99 NEW TECH ADD-ON : 99,999,999.99

VOID/REISSUE : 99,999,999.99 VOID/REISSUE : 99,999,999.99

935 PAYMENTS : 99,999,999.99 935 PAYMENTS : 99,999,999.99

BALANCE FORWARD : 99,999,999.99

PAT REFUND : 99,999,999.99 WITHHOLD FROM PAYMENTS : WITHOLD : 99,999,999.99

INTEREST : 99,999,999.99 CLAIMS ACCOUNTS RECEIVABLE: 99,999,999.99

CONTRACT ADJ : 99,999,999.99 ACCELERATED PAYMENTS : 99,999,999.99 NET PROVIDER PAYMENT : 99,999,999.99

PROC CD AMT : 99,999,999.99 PENALTY : 99,999,999.99 (PAYMENTS MINUS WITHOLD)

NET REIMB : 99,999,999.99 SETTLEMENT : 99,999,999.99 CHECK/EFT NUMBER : 9999999999

THIRD PARTY PAYMENT : 99,999,999.99

AFFILIATED WITHHOLDING : 99,999,999.99

935 WITHHOLDING : 99,999,999.99

FEDERAL PAYMENT LEVY : 99,999,999.99

NON-TAX FPLP : 99,999,999.99

TOTAL WITHHOLD : 99,999,999.99

Note: when there is a dollar value in the Federal Payment Levy or Non-Tax FPLP a phone number will be in this section.

SPR and 4010A1/5010A1 Comparison:

Line	Remittance Field	Loop ID	835 V 5010A1	Loop ID	835 V 4010A1	Comments
Line 1	*MAC* Name	1000A	N102	RT10	Field 14	
	MAC Address	1000A	N301	RT10	Field 17	
	MAC City	1000A	N401	RT10	Field 19	
	MAC State	1000A	N402	RT10	Field 20	
	MAC Zip Code	1000A	N403	RT10	Field 21	
	VER #		ISA12			
Line 2	*MAC* Business Contact Name	1000A	PER02	N/A	N/A	Not Used in 4010A1.
	Telephone Number and	1000A	PER04/ 06/08	N/A	N/A	Not Used in 4010A1.

Line	Remittance Field	Loop ID	835 V 5010A1	Loop ID	835 V 4010A1	Comments
	Extension					
	FAX Number and Extension	1000A	PER04/ 06/08	N/A	N/A	Not Used in 4010A1.
	Email Address	1000A	PER04/ 06	N/A	N/A	Not Used in 4010A1.
Line 3	Provider Number/NPI	1000B	N104	RT15	Field 16	
	Provider Name	1000B	N102	RT15	Field 14	
	Provider Address	1000B	N301	RT15	Field 17	
	Provider City	1000B	N401	RT15	Field 19	
	Provider State	1000B	N402	RT15	Field 20	
	Provider Zip Code	1000B	N403	RT15	Field 21	
Line 4	Section Header (Part A or Part B)					This is system set.
	Paid Date	Header	BPR16	RT01	Field 28	
	Remit #	Header	TRN02	RT01	Field 31	
	Page:					This is system set.
Line 5	Patient Name	2100	NM103/ 04/05	RT40	Field 15, 16, 17	
	Patient Control Number	2100	CLP01	RT30	Field 13	
	RC (Adjustment Reason Code)	2100	CAS02/ 05/08/11 /14/17	RT31	Fields 14, 17, 20, 23	
	REM (Remark Code)	2100	MIA05/ MOA03	RT42/ RT43	Field 17/15	MIA for Inpatient Claims and MOA for Outpatient Claims
	DRG #	2100	CLP11	RT30	Field 20	
	DRG OUT AMT	2100	MIA14	RT44	Field 32	
	Coinsurance	2100	CAS02/ 05/08/11 /14/17	RT31/ RT51	Fields 14, 17, 20, 23, etc.	When CAS Adjustment equals 2
	Pat Refund					This is system set. Bene Reimburse ment Amt, claim page 10.

Line	Remittance Field	Loop ID	835 V 5010A1	Loop ID	835 V 4010A1	Comments
	Contract Adj	2100/ 2110	CAS02/ 05/08/11 /14/17	RT31/ RT51	Fields 14, 17, 20, 23, etc.	When Group Code is CO as we do today
Line 6	HIC Number	2100	NM109	RT40	Field 19	
	ICN Number	2100	CLP07	RT30	Field 7	
	RC (Adjustment Reason Code)	2100	CAS02/ 05/08/11 /14/17	RT31	Fields 14, 17, 20, 23	
	REM (Remark Code)	2100	MIA20/ MOA04	RT42/ RT43	Field 32/116	MIA for Inpatient Claims and MOA for Outpatient Claims. RT42 for Inpatient and RT43 for Outpatient
	OUTCD		Populate as we do 4010A1		TS208 & TS209 Inpatient Only	Outlier
	New Tech/ECT		Populate as we do 4010A2			Value code 77
	COVD CHGS	2100	AMT01	RT44	Field 34	When qualifier equals AU
	ESRD Net Adj	2100	MOA08	RT43	Field 20	
Line 7	From DT	2100	DTM02	RT44	Field 18	When qualifier equals 232
	Thru DT	2100	DTM02	RT45	Field 19	When qualifier equals 233
	HICHG	2100	NM108	RT40	Field 22	
	TOB	2000	CLP08/ 09	RT30	Fields 18 & 19	
	RC (Adjustment Reason Code)	2100	CAS02/ 05/08/11 /14/17	RT31	Fields 14, 17, 20, 23	
	REM (Remark Code)	2100	MIA21/ MOA05	RT42/ RT43	Field 33/17	MIA for Inpatient Claims and MOA for Outpatient Claims

Line	Remittance Field	Loop ID	835 V 5010A1	Loop ID	835 V 4010A1	Comments
	Prof Comp	2100	MIA19/ MOA09	RT43	Field 21	
	MSP Paymt		Populate as we do 4010A1			MSP Value codes
	Ncovd Chgs	2100	QTY02	RT30	Field 27	When qualifier equals NE
	Interest	2100	AMT02	RT44	Field 30	When qualifier equals I
	Proc CD Amt	2100	MOA02			Payable amount from the line when HCPC present
Line 8	CLM Status	2100	CLP02	RT30	Field 14	
	Cost	2100	MIA15	RT42	Field 27	Value code amt.
	Covdy	2100	QTY01	RT44	Field 36	
	Ncovdy	2100	QTY02	RT44	Field 38	Value code 81
	RC (Adjustment Reason Code)	2100	CAS02/ 05/08/11 /14/17	RT31	Fields 14, 17, 20, 23	
	REM (Remark Code)	2100	MIA22/ MOA06	RT42/ RT43	Field 34/18	MIA for Inpatient Claims and MOA for Outpatient Claims
	DRG Amt	2100	MIA04	RT42	Field 16	
	Deductibles	2100	CLP05	RT31/ RT51	Fields 14, 17, 20, 23, etc.	When CAS Adjustment equals 1
	Denied Chgs			RT30	Field 28	Treat as current
	Pre Pay Adj	2100/ 2110	CAS02/ 05/08/11 /14/17	RT31/ RT51	Fields 14, 17, 20, 23, etc.	When CAS Adjustment equal A7.
	Net Reimb	2100	CLP04	RT30	Field 16	
Subtotal Fiscal Year						This is system calculated
Subtotal Part A or Part B for Home Health Type of Bills when Provider is a Home Health Provider						This is system calculated

Line	Remittance Field	Loop ID	835 V 5010A1	Loop ID	835 V 4010A1	Comments
Subtotal Part A or Part B						This is system calculated
Summary Page						
Line 1	*MAC* Name	1000A	N102	RT10	Field 14	
	MAC Address	1000A	N301	RT10	Field 17	
	MAC City	1000A	N401	RT10	Field 19	
	MAC State	1000A	N402	RT10	Field 20	
	MAC Zip Code	1000A	N403	RT10	Field 21	
	VER #		ISA12			
Line 2	*MAC* Business Contact Name	1000A	PER02	N/A	N/A	
	Telephone Number and Extension	1000A	PER04/ 06/08	N/A	N/A	
	FAX Number and Extension	1000A	PER04/ 06/08	N/A	N/A	
	Email Address	1000A	PER04/ 06	N/A	N/A	
Line 3	Provider Number/NPI	1000B	N104	RT15	Field 16	
	Provider Name	1000B	N102	RT15	Field 14	
	Provider Address	1000B	N301	RT15	Field 17	
	Provider City	1000B	N401	RT15	Field 19	
	Provider State	1000B	N402	RT15	Field 20	
	Provider Zip Code	1000B	N403	RT15	Field 21	
Line 4	Section Header (Summary)					This is system set.
	Paid Date	Header	BPR16	RT01	Field 28	
	Remit #	Header	TRN02	RT01	Field 31	
	Page:					This is system set.
Line 5	Section Header (Claim Data:)					This is system set.
	Section Header (Pass Thru Amounts:)					This is system set.
	Section Header (Provider Payment Recap:)					This is system set.
Line 6			PLB03			This is system set.

Line	Remittance Field	Loop ID	835 V 5010A1	Loop ID	835 V 4010A1	Comments
	Capital :		PLB04/06/08/10/12/14	RT60	Fields 13, 16, 19, 22, etc.	When PLB03-1/05-1/07-1/09-1/11-1/13-1 is CV and PLB03-2/05-2/07-2/09-2/11-2/13-2 is CP. This is for 4010A1 and 5010A1.
Line 7	Header - Days :					This is system set.
	Return on Equity		PLB04/06/08/10/12/14	RT60	Fields 13, 16, 19, 22, etc.	When PLB03-1/05-1/07-1/09-1/11-1/13-1 is RE and PLB03-2/05-2/07-2/09-2/11-2/13-2 is RE. This is for 4010A1 and 5010A1.
Line 8	Cost :					The system calculates this amount from the claims detail.
	Direct Medical Education :		PLB04/06/08/10/12/14	RT60	Fields 13, 16, 19, 22, etc.	When PLB03-1/05-1/07-1/09-1/11-1/13-1 is DM and PLB03-2/05-2/07-2/09-2/11-2/13-2 is DM. This is for 4010A1 and 5010A1.

Line	Remittance Field	Loop ID	835 V 5010A1	Loop ID	835 V 4010A1	Comments
	Header - Payments					This is system set.
Line 9	Covdy :					The system calculates this amount from the claims detail.
	Kidney Acquisition :		PLB04/06/08/10/12/14	RT60	Fields 13, 16, 19, 22, etc.	When PLB03-1/05-1/07-1/09-1/11-1/13-1 is OA and PLB03-2/05-2/07-2/09-2/11-2/13-2 is KA. This is for 4010A1 and 5010A1.
	DRG Out Amt :					The system calculates this amount from the claims detail.
Line 10	Ncovdy :					The system calculates this amount from the claims detail.
	Bad Debt :		PLB04/06/08/10/12/14	RT60	Fields 13, 16, 19, 22, etc.	When PLB03-1/05-1/07-1/09-1/11-1/13-1 is BD and PLB03-2/05-2/07-2/09-2/11-2/13-2 is BD. This is for 4010A1 and 5010A1.

Line	Remittance Field	Loop ID	835 V 5010A1	Loop ID	835 V 4010A1	Comments
	Interest :		PLB04/06/08/10/12/14	RT20	Field 20	When PLB03-1/05-1/07-1/09-1/11-1/13-1 is L6 and PLB03-2/05-2/07-2/09-2/11-2/13-2 is IN. This is for 5010A1.
Line 11						
	Non Physician Anesthetists :		PLB04/06/08/10/12/14	RT60	Fields 13, 16, 19, 22, etc.	When PLB03-1/05-1/07-1/09-1/11-1/13-1 is CW and PLB03-2/05-2/07-2/09-2/11-2/13-2 is CR. This is for 4010A1 and 5010A1.
	Proc CD Amt :					The system calculates this amount from the claims detail.
Line 12	Header - Charges					This is system set.
	Total Pass Thru :					This is system calculated.
	Net Reimb :					This is system calculated.
Line 13	Covd :					The system calculates this amount from the claims detail.

Line	Remittance Field	Loop ID	835 V 5010A1	Loop ID	835 V 4010A1	Comments
	Total Pass Thru :					This is system calculated.
Line 14	Ncovd :					The system calculates this amount from the claims detail.
	PIP Payment :		PLB04/06/08/10/12/14	RT60	Fields 13, 16, 19, 22, etc.	When PLB03-1/05-1/07-1/09-1/11-1/13-1 is PI and PLB03-2/05-2/07-2/09-2/11-2/13-2 is PP. This is for 4010A1 and 5010A1.
	PIP Payment :		PLB04/06/08/10/12/15	RT60	Fields 13, 16, 19, 22, etc.	When PLB03-1/05-1/07-1/09-1/11-1/13-1 is PI and PLB03-2/05-2/07-2/09-2/11-2/13-2 is PP. This is for 4010A1 and 5010A1.
Line 15	Denied :					The system calculates this amount from the claims detail.

Line	Remittance Field	Loop ID	835 V 5010A1	Loop ID	835 V 4010A1	Comments
	Settlement Payments :		PLB04/06/08/10/12/14	RT60	Fields 13, 16, 19, 22, etc.	When PLB03-1/05-1/07-1/09-1/11-1/13-1 is IS, PL, RA, C5 and PLB03-2/05-2/07-2/09-2/11-2/13-2 is IR, FS, TR, TS respectively.. This is for 4010A1 and 5010A1.
	Settlement Pymts :		PLB04/06/08/10/12/15	RT60	Fields 13, 16, 19, 22, etc.	When PLB03-1/05-1/07-1/09-1/11-1/13-1 is IS, PL, RA, C5 and PLB03-2/05-2/07-2/09-2/11-2/13-2 is IR, FS, TR, TS respectively.. This is for 4010A1 and 5010A1.
Line 16						
	Accelerated Payments :		PLB04/06/08/10/12/14	RT60	Fields 13, 16, 19, 22, etc.	When PLB03-1/05-1/07-1/09-1/11-1/13-1 is AP and PLB03-2/05-2/07-2/09-2/11-2/13-2 is AP. This is for 4010A1 and 5010A1.

Line	Remittance Field	Loop ID	835 V 5010A1	Loop ID	835 V 4010A1	Comments
	Accelerated Payments :		PLB04/06/08/10/12/15	RT60	Fields 13, 16, 19, 22, etc.	When PLB03-1/05-1/07-1/09-1/11-1/13-1 is AP and PLB03-2/05-2/07-2/09-2/11-2/13-2 is AP. This is for 4010A1 and 5010A1.
Line 17						
	Refunds :		PLB04/06/08/10/12/14	RT60	Fields 13, 16, 19, 22, etc.	When PLB03-1/05-1/07-1/09-1/11-1/13-1 is B2 and PLB03-2/05-2/07-2/09-2/11-2/13-2 is RF. This is for 4010A1 and 5010A1.
	Refunds :		PLB04/06/08/10/12/15	RT61	Fields 13, 16, 19, 22, etc.	When PLB03-1/05-1/07-1/09-1/11-1/13-1 is B2 and PLB03-2/05-2/07-2/09-2/11-2/13-2 is RF. This is for 4010A1 and 5010A1.
Line 18	Prof Comp :					The system calculates this amount from the claims detail.

Line	Remittance Field	Loop ID	835 V 5010A1	Loop ID	835 V 4010A1	Comments
	Penalty Release :		PLB04/06 /08/10/12/ 14	RT60	Fields 13, 16, 19, 22, etc.	When PLB03-1/05-1/07-1/09-1/11-1/13-1 is L3 and PLB03-2/05-2/07-2/09-2/11-2/13-2 is RS. This is for 4010A1 and 5010A1.
	Penalty Release :		PLB04/06 /08/10/12/ 14	RT60	Fields 13, 16, 19, 22, etc.	When PLB03-1/05-1/07-1/09-1/11-1/13-1 is L3 and PLB03-2/05-2/07-2/09-2/11-2/13-2 is RS. This is for 4010A1 and 5010A1.
Line 19	MSP Paymt :					Sum of all detail MSP Pay.
	Trans OutP Pymt :		PLB04/06 /08/10/12/ 14	RT60	Fields 13, 16, 19, 22, etc.	When PLB03-1/05-1/07-1/09-1/11-1/13-1 is IR and PLB03-2/05-2/07-2/09-2/11-2/13-2 is IS. This is for 4010A1 and 5010A1.

Line	Remittance Field	Loop ID	835 V 5010A1	Loop ID	835 V 4010A1	Comments
	Trans OutP Pymt :		PLB04/06/08/10/12/14	RT60	Fields 13, 16, 19, 22, etc.	When PLB03-1/05-1/07-1/09-1/11-1/13-1 is IR and PLB03-2/05-2/07-2/09-2/11-2/13-2 is IS. This is for 4010A1 and 5010A1.
Line 20	Deductibles :					The system calculates this amount from the claims detail.
	Hemophilia Add-On :		PLB03-1/06/08/10/12/14 value HM	RT60	Fields 13, 16, 19, 22, etc.	When PLB03-1/05-1/07-1/09-1/11-1/13-1 is ZZ and PLB03-2/05-2/07-2/09-2/11-2/13-2 is ??. This is for 4010A1. Dollar amount based on HCPC submitted on claim.
	Hemophilia Add-On :		PLB03-1/04/06/08/10/12/14	RT60	Fields 13, 16, 19, 22, etc.	When PLB03-1/05-1/07-1/09-1/11-1/13-1 is ZZ and PLB03-2/05-2/07-2/09-2/11-2/13-2 is ??. This is for 4010A1.

Line	Remittance Field	Loop ID	835 V 5010A1	Loop ID	835 V 4010A1	Comments
						Dollar amount based on HCPC submitted on claim.
Line 21	Coinsurance :					The system calculates this amount from the claims detail.
	New Tech/ECT Add-On :		PLB04/06/08/10/12/14	RT60	Fields 13, 16, 19, 22, etc.	Sum of all detail.
	New Tech/ECT Add-On :		PLB04/06/08/10/12/15	RT61	Fields 13, 16, 19, 22, etc.	Sum of all detail.
Line 22						
	Void/Reissue :		PLB04/06/08/10/12/14	RT60	Fields 13, 16, 19, 22, etc.	When PLB03-1/05-1/07-1/09-1/11-1/13-1 is CS and PLB03-2/05-2/07-2/09-2/11-2/13-2 is RI. This is for 4010A1 and 5010A1.
	Void/Reissue :		PLB04/06/08/10/12/14	RT60	Fields 13, 16, 19, 22, etc.	When PLB03-1/05-1/07-1/09-1/11-1/13-1 is CS and PLB03-2/05-2/07-2/09-2/11-2/13-2 is RI. This is

Line	Remittance Field	Loop ID	835 V 5010A1	Loop ID	835 V 4010A1	Comments
						for 4010A1 and 5010A1.
Line 23						
	935 Payments :		PLB04/06/08/10/12/14	RT60	Fields 13, 16, 19, 22, etc.	When PLB03-1/05-1/07-1/09-1/11-1/13-1 is PL and PLB03-2/05-2/07-2/09-2/11-2/13-2 is 935. This is for 4010A1 and 5010A1.
	935 Payments :		PLB04/06/08/10/12/15	RT60	Fields 13, 16, 19, 22, etc.	When PLB03-1/05-1/07-1/09-1/11-1/13-1 is PL and PLB03-2/05-2/07-2/09-2/11-2/13-2 is 935. This is for 4010A1 and 5010A1.
Line 24						
	Balance Forward :		PLB04/06/08/10/12/15	RT60	Fields 13, 16, 19, 22, etc.	When PLB03-1/05-1/07-1/09-1/11-1/13-1 is FB and PLB03-2/05-2/07-2/09-2/11-

Line	Remittance Field	Loop ID	835 V 5010A1	Loop ID	835 V 4010A1	Comments
						2/13-2 is CO. This is for 4010A1 and 5010A1.
Line 25	Pat Refund :					This is system calculated from claim detail.
	Header - Withhold From Payments					This is system set.
	Withhold :					This is system calculated.
Line 26	Interest :					The system calculates this amount from the claims detail.
	Claims Accounts Receivable :		PLB04/06/08/10/12/14	RT60	Field 31	When PLB03-1/05-1/07-1/09-1/11-1/13-1 is E3 and PLB03-2/05-2/07-2/09-2/11-2/13-2 is CW. This is for 5010A1.
Line 27	Contract Adj :					The system calculates this amount from the claims detail.

Line	Remittance Field	Loop ID	835 V 5010A1	Loop ID	835 V 4010A1	Comments
	Accelerated Payments :		PLB04/06/08/10/12/14	RT60	Fields 13, 16, 19, 22, etc.	When PLB03-1/05-1/07-1/09-1/11-1/13-1 is AP and PLB03-2/05-2/07-2/09-2/11-2/13-2 is AW. This is for 4010A1 and 5010A1.
	Net Provider Payment :	Header	BPR02	RT01	Field 15	
Line 28	Proc CD Amt :					The system calculates this amount from the claims detail.
	Penalty :		PLB04/06/08/10/12/14	RT60	Fields 13, 16, 19, 22, etc.	When PLB03-1/05-1/07-1/09-1/11-1/13-1 is L3 and PLB03-2/05-2/07-2/09-2/11-2/13-2 is PW. This is for 4010A1 and 5010A1.
	(Payments Minus Withhold)					
Line 29	Net Reimb :					The system calculates this amount.

Line	Remittance Field	Loop ID	835 V 5010A1	Loop ID	835 V 4010A1	Comments
	Settlement :		PLB04/06/08/10/12/14	RT60	Fields 13, 16, 19, 22, etc.	When PLB03-1/05-1/07-1/09-1/11-1/13-1 is L3 and PLB03-2/05-2/07-2/09-2/11-2/13-2 is SW. This is for 4010A1 and 5010A1.
	Check/EFT Number :	Header	TRN02	RT01	Field 30	
Line 30						
	Third Party Payment :		PLB04/06/08/10/12/14	RT60	Fields 13, 16, 19, 22, etc.	When PLB03-1/05-1/07-1/09-1/11-1/13-1 is L3 and PLB03-2/05-2/07-2/09-2/11-2/13-2 is ??. This is for 4010A1 and 5010A1.
Line 31						
	Affiliated Withholding :		PLB04/06/08/10/12/14	RT60	Fields 13, 16, 19, 22, etc.	When PLB03-1/05-1/07-1/09-1/11-1/13-1 is OB and PLB03-2/05-2/07-2/09-2/11-2/13-2 is ??. This is for 4010A1 and 5010A1.

Line	Remittance Field	Loop ID	835 V 5010A1	Loop ID	835 V 4010A1	Comments
Line 32	935 Withholding:		PLB04/06/08/10/12/14	RT60	Fields 13, 16, 19, 22, etc.	When PLB03-1/05-1/07-1/09-1/11-1/13-1 is WO and PLB03-2/05-2/07-2/09-2/11-2/13-2 is 935. This is for 4010A1 and 5010A1.
Line 33						
	Federal Payment Levy :		PLB04/06/08/10/12/14	RT60	Fields 13, 16, 19, 22, etc.	When PLB03-1/05-1/07-1/09-1/11-1/13-1 is LE and PLB03-2/05-2/07-2/09-2/11-2/13-2 is Treasury Tax withhold. This is for 4010A1 and 5010A1.
Line 34						
	Non-Tax FPLP		PLB04/06/08/10/12/14	RT60	Fields 13, 16, 19, 22, etc.	When PLB03-1/05-1/07-1/09-1/11-1/13-1 is WU and PLB03-2/05-2/07-2/09-2/11-2/13-2 is Treasury Tax withhold. This is for 4010A1

Line	Remittance Field	Loop ID	835 V 5010A1	Loop ID	835 V 4010A1	Comments
						and 5010A1.
Line 35	Total Withhold :					This is system calculated.

50.2.2 - A/B MAC *(B)*/DME MAC SPR Format

(Rev .2843, Issued: 12-27-13, Effective: 01-28-14, Implementation: 01-28-14)

Example of updated SPR - Professional

Format of Carrier and Provider Identification Section

```
XXXXXXXXXXXXXXXXXXXXXXXXXXXX                    <-- (MAC Contact:)
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX <-- (MAC name)                    MEDICARE
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX <-- (MAC address 1)                REMITTANCE
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX <-- (MAC address 2)                 Advice
XXXXXXXXXXXXXXXXXXXXXXX, XX 99999-9999  <-- (MAC  city, state, and zip)
(999) 999-9999                  <-- (MAC  telephone number)
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX <-- (MAC  website URL)

(Provider
 name) -->   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                    PROVIDER #:  XXXXXXXXXX
        XXXXXXXXXX...          <-- (Provider address 1)                PAGE #:      1 OF 999
        XXXXXXXXXX...          <-- (Provider address 2)                DATE:       MM/DD/YY
(Provider -->    XXXXXXXXX..., XX  99999...                            CHECK/EFT #: XXXXXXXXX
city, state, and zip)
```

Format of Claim Detail Section

The addition of Health Care Policy Identifiers (HCPI) required 4 detail level HCPIs to be recorded on the claim record. The HCPIs added were a length of 11.

```
PERF PROV  SERV DATE  POS NOS  PROC   MODS  BILLED    ALLOWED  DEDUCT     COINS     GRP/RC-AMT    PROV PD
_____________________________________________________________________________________________________________
NAME XXXXXXXXXXXX, XXXXXXXX  HIC XXXXXXXXXXXX  ACNT XXXXXXXXXXXXXXXXX  ICN XXXXXXXXXXXX    ASG Y  MOA
XXXXX XXXXX
                                                XXXXX XXXXX XXXXX
XXXXXXXXXX MMDD MMDDYY XX 9999.9 XXXXX  AA  9999999.99 9999999.99 99999.99    99999.99  XX-XXX 99999.99 9999999.99
```

```
                (XXXXX)                          XX-XXX 99999.99
                                              XX-XXX 99999.99
REM: XXXXX XXXXX XXXXX XXxxx xxxxx                                  XX-XXX 99999.99
HCPI: XXXXXXXXXXX        XXXXXXXXXXX XXXXXXXXXXX  XXXXXXXXXXX                          XX-XXX 99999.99

XXXXXXXXXX MMDDYY   XX 9999.9 XXXXX  AA  9999999.99 9999999.99 99999.99   99999.99   XX-XXX 99999.99 9999999.99
                (XXXXX)                          XX-XXX 99999.99
                                              XX-XXX 99999.99
                                              XX-XXX 99999.99
                                              XX-XXX 99999.99
REM: xxxxx xxxxx xxxxx xxxxx xxxxx                                  XX-XXX 99999.99
HCPI  xxxxxxxxxxx xxxxxxxxxxx xxxxxxxxxxx xxxxxxxxxxx                XX-XXX 99999.99
PT RESP 9999999.99       CLAIM TOTAL   9999999.99 9999999.99  99999.99   99999.99          9999999.99 9999999.99

ADJ TO TOTALS:  PREV PD   9999999.99     INTEREST 9999999.99   LATE FILING CHARGE 9999999.99   OTHER  XX-XXX 9999999.99
CLAIM INFORMATION FORWARDED TO: XXXXXXXXXXXXXXXXXXXXXXXXXXXX                    NET 9999999.99
```

60 - *Remittance Advice Codes*

(Rev .2843, Issued: 12-27-13, Effective: 01-28-14, Implementation: 01-28-14)

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 *ASC X12* 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

Group Codes, 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 - *Group Codes*

(Rev .2843, Issued: 12-27-13, Effective: 01-28-14, Implementation: 01-28-14)

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 for a claim or service. MACs do not have discretion to omit appropriate codes and messages. MACs must use appropriate group, claim adjustment reason, and remittance advice remark codes to

communicate clearly why an amount is not covered by Medicare and who is financially responsible for that amount. 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.*

- *OA - Other Adjustments. This group code shall be used when no other group code applies to the adjustment.*

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

60.2 - *Claim Adjustment Reason Codes*

(Rev .2843, Issued: 12-27-13, Effective: 01-28-14, Implementation: 01-28-14)

Claim Adjustment Reason Codes (CARCs) are used on the Medicare electronic and paper remittance advice, and Coordination of Benefit (COB) claim transaction. The Claim Adjustment Status and Reason 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 U.S. health payers. 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. MACs 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, such as denials, reductions or increases in payment. These codes may be used at the service or claim level, as appropriate. Current ASC X12 835 structures only allow one reason code to explain any one specific adjustment amount.

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

- *Can the information be conveyed by the use or modification of an existing reason code?*

- *Is the information available elsewhere in the ASC X12 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 ASC X12 trimester meeting in the months of January/February, June, and September/October. MACs must make sure that they are using the latest approved claim adjustment reason codes in ERA, SPR and COB transaction by implementing necessary code changes as instructed in the Recurring Code Update Change Requests (CRs) or any other CMS instruction and/or downloading the list from the WPC Website after each update. The Shared System Maintainers shall make sure that a deactivated code (either reason or remark) is not allowed to be used in any original business message, but is allowed and processed when reported in derivative business messages. Code deactivation may be implemented prior to the stop date posted at WPC web site to

follow Medicare release schedule. SSMs shall implement deactivation on the earlier date if the implementation date in the recurring code update CR is different than the stop date posted at the WPC Web site.

MACs 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 and coordination of benefits 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 ASC X12 835 reason or remark code might be mapped to one or more shared system codes, or vice versa, making it difficult for a MAC to determine each of the internal codes that may be impacted by remark or reason code modification, retirement or addition.

Shared systems must provide a crosswalk between the reason and remark codes to the shared system internal codes so that a MAC 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 MAC 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 ASC X12 835 version 4010 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 CMS 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. MACs 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. Some CARCs are so generic that the reason for adjustment cannot be communicated clearly without at least one remark code. These CARCs have a note added to the text for identification. A/B MACs and DME MACs must use at least one appropriate remark code when using one of these CARCs.

60.3 - *Remittance Advice Remark Codes*

(Rev .2843, Issued: 12-27-13, Effective: 01-28-14, Implementation: 01-28-14)

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. MACs must report appropriate remark code(s) that apply. There is another type of remark codes that does not add supplemental explanation for a specific adjustment but provide general adjudication information. These "Informational" remark codes start with the word "Alert" and can be reported without Group and Claim Adjustment Reason Code. An example of an "Informational" RARC would be:

> *MA01: Alert: If you do not agree with what we approved for these services, you may appeal our decision. To make sure that we are fair to you, we require another individual that did not process your initial claim to conduct the appeal. However, in order to be eligible for an appeal, you must write to us within 120 days of the date you received this notice, unless you have a good reason for being late.*

Remark codes at the service line level must be reported in the ASC X12 835 LQ segment. Remark codes that apply to an entire claim must be reported in either an ASC X12 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 MACs can actually report.

The remark code list is updated three times a year, and the list as posted at the WPC Website and gets updated at the same time when the reason code list is updated. Both code lists are updated on or around

March 1, July 1, and November 1. MACs must use the latest approved remark codes as included in the Recurring Code Update CR or any other CMS instruction or downloading the list from the WPC Website after each update. MAC 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.

60.4 - Requests for Additional Codes

(Rev .2843, Issued: 12-27-13, Effective: 01-28-14, Implementation: 01-28-14)

The CMS has national responsibility for maintenance of the remittance advice remark codes *and the Claim Adjustment Status Code Maintenance Committee maintains the claim adjustment reason codes*. Requests for new *or modification or deactivation of RARCs and CARCs should be sent to a mail box set up by CMS:*

Remittance_Advice.CMS.HHS.GOV.

MACs should send their requests to this mail box for any change in CARC, RARC or any code combination. Requests for codes must include the suggested wording for the new or revised message, and an explanation of how the message will be used and why it is needed *or justification for the request*.

To provide a summary of changes introduced in the previous four months, a code update instruction in the form of a change request (CR) is issued. Additionally, these recurring CRs will also notify A/B MACs/CEDI/DME MACs of any enhancement(s) being added to the MREP software. These CRs will establish the deadline for Medicare shared system and *MAC* 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 - *ASC X12 Version 4010A1*

(Rev .2843, Issued: 12-27-13, Effective: 01-28-14, Implementation: 01-28-14)

ASC X12 version 4010A1 was the standard before implementation of the current standard version 5010A1. There could be situations where a claim/service that has been paid and reported using version 4010A1 may need to be corrected. Under this situation, the same codes originally used are used in reversal, and any adjustment for the corrected claim/service would report the new/modified codes, if applicable.

80 - *CAQH CORE Mandated Operating Rules*

(Rev .2843, Issued: 12-27-13, Effective: 01-28-14, Implementation: 01-28-14)

Section 1104 of the Patient Protection and Affordable Care Act (ACA) establishes the development and implementations of "requirements for administrative transactions that will improve the utility of the existing HIPAA transactions and reduce administrative costs." A/B MACs/ CEDI/ and DME MACs are required to conform to the following CAQH Core Operating Rules impacting the transmittals of X12 835 transactions.

A complete list of ACA mandated operating rules are available at http://www.caqh.org/ORMandate_index.php.

80.1 - CAQH CORE 350 - Health Care Claim Payment/Advice (835) Infrastructure Rule

(Rev .2843, Issued: 12-27-13, Effective: 01-28-14, Implementation: 01-28-14)

This operating rule regulates the transmission of batch 835 transactions including the exchange of security identifiers and communications-level acknowledgments and error. This rule does not address the content of 835 communications beyond those required by the HIPAA mandated ASC X12 format. This rule designates a standard form of communication to ensure trading partner support by all A/B MACs, DME MACs, and CEDI contractors.

A complete list of requirements and technical direction for the Connectivity Rule are available at:

http://www.caqh.org/ORMandate_EFT.php

80.1.1 - Version X12/5010X221 Companion Guide
(Rev .2843, Issued: 12-27-13, Effective: 01-28-14, Implementation: 01-28-14)

CAQH CORE mandated operating rules require the usage of a companion guide for the ASC X12 835 standard transaction. This companion guide is to correspond with the already existing V5010 ASC X12 Implementation Guide.

A companion guide template is available at: http://www.caqh.org/pdf/CLEAN5010/MasterCompGuidTemp-v5010.pdf

80.2 - Uniform Use of CARCs and RARCs Rule
(Rev .2843, Issued: 12-27-13, Effective: 01-28-14, Implementation: 01-28-14)

The CAQH CORE mandated operating rules require the usage of a standardized CARC and RARC combinations when used on the ASC X12 835 transactions. These combinations are maintained in a list updated 3 times a year by CAQH CORE.

The complete CARC/RARC code combination list is available at: http://www.caqh.org/COREC odeCombinations.php

MACs should send their requests to CMS to add or modify any existing CORE code combination, and CMS will send these requests to CAQH CORE. MACs should send their requests to:
Remittance_Advice.CMS.HHS.GOV

80.3 - EFT Enrollment Data Rule
(Rev .2843, Issued: 12-27-13, Effective: 01-28-14, Implementation: 01-28-14)

CAQH CORE mandated operating rules establish standards for the enrollment of providers to electronic funds transfer (EFT) programs. The rule mandates the required data elements and the order in which they appear of EFT enrollment forms. The rule also mandates acceptable EFT enrollment submission formats.

A complete list of required data elements and submission formats are available at http://www.caqh.org/Host/CORE/EFT-ERA/EFT_Enrollment_Data_Rule.pdf

80.4 - ERA Enrollment Form
(Rev .2843, Issued: 12-27-13, Effective: 01-28-14, Implementation: 01-28-14)

CAQH CORE mandated operating rules establish standards for the enrollment of providers to ERA programs. The rule mandates the required data elements and the order in which they appear of ERA enrollment forms. The rule also mandates acceptable EFT enrollment submission formats.

A complete list of required data elements and submission formats are available at http://www.caqh.org/Host/CORE/EFT-ERA/ERA_Enrollment_Data_Rule.pdf