

X12 Segment Name: **ISA** Interchange Control Header

Loop: ----

Max. Use: 1

X12 Purpose: To start and identify an interchange of zero or more functional groups and interchange-related control segments.

Usage: **Mandatory**

Example: **ISA*00*.....*00*.....*ZZ*9000000553.....*ZZ*
MEDSERVER.....*970505*0436*U*00305*125000102*0*P*>~**

- Comments:
1. The ISA is a fixed record length segment and all positions within each of the data elements must be filled. If no meaningful data is available for an element you must fill it with the requisite number of blanks. (In the example above, the periods represent blanks.)
 2. The first element separator in the ISA defines the element separator to be used through the entire exchange.
 3. The segment terminator used after the ISA defines the segment terminator to be used throughout the entire exchange.

Element Attributes	Data Element Usage	Flat File Map
ISA01 ID 2 2 M	Authorization Information Qualifier Code to identify the type of information in the Authorization Information. Codes: 00 No Authorization Information Present (No Meaningful Information in I02)	Translator Generated (TG)
ISA02 AN 10 10 M	Authorization Information Information used for additional identification or authorization of the interchange; the type of information is set by the Authorization Information Qualifier (I01). Enter ten spaces.	TG
ISA03 ID 2 2 M	Security Information Qualifier Code to identify the type of information in the Security Information. Codes: 00 No security Information Present (No meaningful Information in I04)	TG

ISA04	I04	Security Information	TG
AN 10	10 M	This is used for identifying the security information about the interchange sender or the data in the interchange; the type of information is set by the Security Information Qualifier (I03). Enter ten spaces.	
ISA05	I05	Interchange ID Qualifier	TG
ID 2	2 M	Qualifier to designate the system/method of code structure used to designate the sender or receiver ID element being qualified. Codes: ZZ Mutually Defined	
ISA06	I06	Interchange Sender ID	01-03 or
AN 15	15 M	Identification code published by the sender for other parties to use as the receiver ID when routing data to the sender; the sender always codes this value in the sender ID element. When sending transactions through a Value Added Network (VAN), this number will be the intermediary's VAN ID as mutually defined or as issued by the VAN. When not going through a VAN, use the HCFA-assigned intermediary number. The HCFA-assigned intermediary number will be the default value.	TG for VAN ID
ISA07	I05	Interchange ID Qualifier	TG
ID 2	2 M	Qualifier to designate the system/method of code structure used to designate the sender or receiver ID element being qualified. Codes: ZZ Mutually Defined	

ISA08 AN 15	I07 15 M	Interchange Receiver ID Identification code published by the receiver of the data. When sending, it is used by the sender as their sending ID, thus other parties sending to them will use this as a receiving ID to route data to them. The identification code assigned by the intermediary to the receiver of this transmission by trading partner agreement. Use one of the following values: VAN ID, EDI Submitter ID, Provider Chain ID or Provider ID.	05-02 for Provider Chain ID or TG for other valid values
ISA09 DT 6	I08 6 M	Interchange Date Interchange Creation Date Date of the interchange. Format YYYYMMDD	TG
ISA10 TM 4	I09 4 M	Interchange Time Interchange Creation Time Time of the interchange Format HHMM	TG
ISA11 ID 1	I10 1 M	Interchange Control Standards Identifier Code to identify the agency responsible for the control standard used by the message that is enclosed by the interchange header and trailer Codes: U U.S. EDI Community of ASC X12, TDCC and UCS	TG
ISA12 ID 5	I11 5 M	Interchange Control Version Number ANSI Version Code This version number covers the interchange control segments The version code may vary if or when HCFA chooses to adopt the next ASC X12 version. For version 3051, enter '00305' in this field. Codes: 00305	TG

ISA13	I12	Interchange Control Number	TG
N0 9	9 M	A control number assigned by the interchange sender The Interchange Control Number in ISA13 must be identical to the one found in the associated Interchange Trailer IEA02. This element cannot be left blank.	
ISA14	I13	Acknowledgment Requested	TG
ID 1	1 M	Code sent by the sender to request an interchange acknowledgment (TA1) Medicare does not require providers to send functional acknowledgments. Providers or clearinghouses may send functional acknowledgments at their options. However, for Medicare they are neither required nor requested. Codes: 0 No Acknowledgment Requested	
ISA15	I14	Test Indicator	TG
ID 1	1 M	Code to indicate whether data enclosed by this interchange envelope is test or production Codes: P Production Data T Test Data	
ISA16	I15	Component Element Separator	TG
AN 1	1 M	This field provides the delimiter used to separate component data elements within a composite data structure; this value must be different than the data element separator and the segment terminator. Cannot be left blank. ">" is recommended.	

X12 Segment Name: **GS** Functional Group Header
 Loop: ----
 Max. Use: 1
 X12 Purpose: To indicate the beginning of a functional group and to provide control information.
 Usage: **Mandatory**
 Example: **GS*HP*9000000363*MEDEX*970218*153206*1*X*003051~**
 Comments: **All fields must contain data. At the option of the sender, a new GS segment may be sent if the data in any GS element changes.**

Semantic Note: GS04 is the Group Date.
 Semantic Note: GS05 is the Group Time.
 Semantic Note: The data interchange control number GS06 in this header must be identical to the same data element in the associated Functional Group Trailer GE02.

X12 Comment: A functional group of related transaction sets, within the scope of X12 standards, consists of a collection of similar transaction sets enclosed by a functional group header and a functional group trailer.

Element Attributes	Data Element Usage	Flat File Map
GS01 0479 ID 2 2 M	Functional Identifier Code Code identifying a group of application related Transaction Sets. Codes: HP Health Care Claims Payment/Advice (835)	Translator Generated (TG)
GS02 0142 AN 2 15 M	Application Sender's Code Intermediary Number Code identifying party sending transmission. Codes agreed to by trading partners. (See Appendix A, data dictionary, for coding instructions.)	01-03
GS03 0124 AN 2 15 M	Application Receiver's Code Code identifying party receiving transmission. Codes agreed to by trading partners. The identification code assigned by the intermediary to the receiver of this transmission by trading partner agreement. The Medicare Provider Number should be obtained from N104. Use one of the	10-02 Provider ID 05-02 Prv Chain ID or TG for VAN ID, EDI Submitter ID

following values: VAN ID, EDI Submitter ID, Provider Chain ID or Provider ID.

GS04	0373	Date	TG
DT 6	6 M	Functional Group Creation Date Date (YYMMDD)	
GS05	0337	Time	TG
TM 4	8 M	Functional Group Creation Time Time expressed in 24-hour clock time as follows: HHMM, OR HHMMSS, or HHMMSSD, or HHMMSSDD, where H = hours (00-23), M = minutes (00-99), S = integer seconds (00-59) and DD = decimal seconds; decimal seconds are expressed as follows: D = tenths (0-9) and DD = hundredths (00-99). Use a minimum of four zeroes if there is no significant data for this field.	
GS06	0028	Group Control Number	TG
N0 1	9 M	Assigned number originated and maintained by the sender. The group control number, GS06, must be identical to the one found in the associated function trailer GE02.	
GS07	0455	Responsible Agency Code	TG
ID 1	2 M	Code used in conjunction with Data Element 0480 to identify the issuer of the standard. Codes: X Accredited Standards Committee X12	
GS08	0480	Version / Release / Industry Identifier	TG
AN 1	12 M	Code ANSI Version Code Code indicating the version, release, subrelease and industry identifier of the EDI standard being used, including the GS and GE segments. If the code in DE0455 in GS segment is X, then in DE0480 positions 1-3 are the version number, positions 4-6 are the release and subrelease level of the version and positions 7-12 are the industry or trade association identifiers (optionally assigned by user).	

The version code may vary, if or when
HCFA chooses to adopt the next ASC X12
Version.

Codes:

003051 Draft Standards Approved for
publication by ASC X12 Procedures
Review Board through February 1995.

X12 Segment Name: **ST** Transaction Set Header
 Loop: ----
 Max. Use: 1
 X12 Purpose: To indicate the start of a transaction set and to assign a control number.
 Usage: **Mandatory**
 Example: **ST*835*0019~**
 Comments: **Write one ST segment for each transaction set. All fields must contain data.**

Semantic Note: The transaction set identifier (ST01) is used by the translation routines of the interchange partners to select the appropriate transaction set definition, e.g., 810 selects the invoice transaction set.

Element Attributes	Data Element Usage	Flat File Map
ST01 0143 ID 3 3 M	Transaction Set Identifier Code Code uniquely identifying a Transaction Set Codes: 835 X12.835 Health Care Claim Payment/Advice	Translator Generated (TG)
ST02 0329 AN 4 9 M	Transaction Set Control Number Identifying control number that must be unique within the transaction set functional group assigned by the originator for a transaction set. The transaction set control number, ST02, must be identical to the same data element in the associated transaction set trailer, SE02.	TG

X12 Segment Name: **BPR** Beginning Segment for Payment Order/Remittance Advice
Loop: **----**
Max. Use: 1
X12 Purpose: (1) To indicate the beginning of a Payment Order/Remittance Advice Transaction Set and total payment amount or (2) to enable related transfer of funds and/or information from payer to payee to occur.
Purpose: **This segment contains the payment amount for a particular billing provider.**
Usage: **Mandatory**
Example: **BPR*I*500*C*CHK*****970430~**
Comments: **Write one BPR segment for each provider or chain entity.**

Syntax Note: P0607 - If either BPR06 or BPR07 is present, then the other must be present.
Syntax Note: C0809 - If BPR08 is present, then BPR09 must be present.
Syntax Note: P1213 - If either BPR12 or BPR13 is present, then the other must be present.
Syntax Note: C1415 - If BPR14 is present, then BPR15 must be present.
Syntax Note: P1819 - If either BPR18 or BPR19 is present, then the other must be present.
Syntax Note: C2021 - If BPR20 is present, then BPR21 must be present.

Semantic Note: BPR02 specifies the payment amount.
Semantic Note: When using this transaction set to initiate a payment, BPR06 through BPR16 may be required, depending on the conventions of the specific financial channel being used.
Semantic Note: BPR06 and BPR07 relate to the originating depository financial institution (ODFI).
Semantic Note: BPR08 is a code identifying the type of bank account or other financial asset.
Semantic Note: BPR12 and BPR13 relate to the receiving depository financial institution (RDFI).
Semantic Note: BPR14 is a code identifying the type of bank account or other financial asset.
Semantic Note: BPR15 is the account number of the receiving company to be debited or credited with the payment order.
Semantic Note: BPR16 is the date the originating company intends for the transaction to be settled, i.e., the Payment Effective Date.
Semantic Note: BPR17 is a code identifying the business reason for this payment.
Semantic Note: BPR18, BPR19, BPR20 and BPR21, if used, identify a third bank identification number and account to be used for return items only.
Semantic Note: BPR20 is a code identifying the type of bank account or other financial asset.

X12 Comment: BPR09 is the account of the company originating the payment. This account may be debited or credited depending on the type of payment order.

Element Attributes	Data Element Usage	Flat File Map
BPR01 ID 1 2 M	0305 Transaction Handling Code Data Indicator Code designating the action to be taken by all parties. Use code 'D' with the abbreviated 835 only. Codes: C Payment Accompanies Remittance Advice D Make Payment Only I Remittance Information Only P Prenotification of Future Transfers	13-11
BPR02 R 1 15 M	0782 Monetary Amount Provider Payment Total Monetary Amount This is the total actual check or EFT payment to the billing provider. This value cannot be less than zero.	13-02
BPR03 ID 1 1 M	0478 Credit/Debit Flag Code Code indicating whether amount is a credit or debit. Codes: C Credit	Translator Generated (TG)
BPR04 ID 3 3 M	0591 Payment Method Code Code identifying the method for the movement of payment instructions Codes: ACH Automated Clearing House (ACH) BOP Financial Institution Option CHK Check NON Non-Payment Data	13-03
BPR05 ID 1 10 C	0812 Payment Format Code Code identifying the payment format to be used Codes: CCD Cash Concentration/Disbursement (CCD) (ACH) CCP Cash Concentration/Disbursement plus Addenda (CCD+) (ACH) CTX Corporate Trade Exchange (CTX) (ACH)	TG

BPR06	0506	(DFI) ID Number Qualifier	TG
ID 2	2 C	Intermediary Bank ID Number Qualifier Code identifying the type of identification number of Depository Financial Institution (DFI). Codes: 01 ABA Transit Routing Number Including Check Digits (9 digits)	
BPR07	0507	(DFI) Identification Number	13-07
AN 3	12 C	Intermediary Bank ID Number Depository Financial Institution (DFI) identification number. Must be obtained from the Fiscal Intermediary system files.	
BPR08	0569	Account Number Qualifier	TG
ID 1	3 C	Intermediary Account Number Qualifier Code indicating the type of account. Codes: DA Demand Deposit	
BPR09	0508	Account Number	13-08
AN 1	35 C	Intermediary Bank Account Number Account number assigned. Must be obtained from fiscal intermediary system files.	
BPR10	0509	Originating Company Identifier	01-03
AN 10	10 C	Intermediary Number A unique identifier designating the company initiating the funds transfer instructions. The first character is a one-digit ANSI identification code designation (ICD) followed by the nine-digit identification number which may be an IRS employer identification number (EIN), a data universal numbering system (DUNS) or a user assigned number. The ICD for an EIN is '1', for a DUNS is '3' and for a user assigned number is '9'. BPR10 is mandatory when the 835 is sent to a bank and must be coordinated with the intermediaries bank. (See Appendix A, data dictionary, for coding instructions.)	

BPR11 0510 Originating Company Supplemental Code
Not Used

BPR12	0506	(DFI) ID Number Qualifier	TG
ID 2	2 C	Provider Bank ID Number Qualifier Code identifying the type of identification number of Depository Financial Institution (DFI). Codes: 01 ABA Transit Routing Number including Check Digits (9 digits)	
BPR13	0507	(DFI) Identification Number	13-04
AN 3	12 C	Receiving Bank ABA Number Depository Financial Institution (DFI) identification number. NOTE: Use for abbreviated 835 or when sending dollars and remittances through the bank.	
BPR14	0569	Account Number Qualifier	13-05
ID 1	3 C	Provider Bank Account Number Qualifier Code indicating the type of account. Codes: DA Demand Deposit SG Savings	
BPR15	0508	Account Number	13-06
AN 1	35 C	Provider Bank Account Number Account number assigned.	
BPR16	0373	Date	13-10
DT 6	6 M	Effective Entry Date Date (YYMMDD) This element identifies either the EFT effective entry date (billing cycle date), i.e., the date the funds are available to the provider, check issue date or statement of issue date.	
BPR17	1048	Business Function Code Not Used	
BPR18	0506	(DFI) ID Number Qualifier Not Used	
BPR19	0507	(DFI) Identification Number Not Used	

BPR20 0569 Account Number Qualifier
Not Used

BPR21 0508 Account Number
Not Used

X12 Segment Name: **TRN** Trace
 Loop: ----
 Max. Use: 1
 X12 Purpose: To uniquely identify a transaction to an application.
 Purpose: **This payer defined trace number permits a provider to associate the electronic remittance notice with an electronic funds transfer, paper check or paper non-payment voucher.**
 Usage: **Mandatory**
 Example: **TRN*1*8765320*9000000770~**

Semantic Note: TRN02 provides unique identification for the transaction.
 Semantic Note: TRN03 identifies an organization.
 Semantic Note: TRN04 identifies a further subdivision within the organization.

Element		Data Element Usage	Flat File Map
TRN01	0481	Trace Type Code	Translator
ID 1	2 M	Code identifying which transaction is being referenced Codes: 1 Current Transaction Trace Numbers	Generated (TG)
TRN02	0127	Reference Number	12-05
AN 1	30 M	Trace Number/Check Number Reference number or identification number as defined for a particular Transaction Set or as specified by the Reference Number Qualifier. Contains either the unique trace number from an EFT, the unique MICR check number from a paper check or the voucher number from a non-payment paper remittance.	
TRN03	0509	Originating Company Identifier	01-03
AN 10	10 M	Intermediary Number A unique identifier designating the company initiating the funds transfer instructions. The first character is a one-digit ANSI identification code designation (ICD)	

followed by the nine-digit identification number which may be an IRS employer identification number (EIN), a data universal numbering system (DUNS) or a user assigned number. The ICD for an EIN is '1', for a DUNS is '3' and for a user assigned number is '9'.

(See Appendix A, data dictionary, for coding instructions.)

TRN04 0127 Reference Number
Not Used

X12 Segment Name: **REF** Reference Numbers
 Name: **Implementation Guide Version Code**
 Loop: **----**
 Max. Use: **>1**
 X12 Purpose: To specify identifying numbers.
 Purpose: **To convey the implementation guide version code for this transaction.**
 Usage: **Mandatory**
 Example: **REF*F5*4A.01~**

Syntax Note: R0203 - At least one of REF02 or REF03 must be present.

Element Attributes	Data Element	Usage	Flat File Map
REF01	0128	Reference Number Qualifier	Translator
ID 2	2 M	Code qualifying the Reference Number. Codes: F5 Medicare Version Code Identifies the release of a set of information or requirements to distinguish from previous or future sets that may differ; the version in question is that which is being used by Medicare.	Generated (TG)
REF02	0127	Reference Number	01-02
AN 1	30 C	Implementation Guide Version Code Reference number or identification number as defined for a particular Transaction Set or as specified by the Reference Number Qualifier. This code identifies the implementation guide version code. Codes: 4A.01 Implementation Guide version code for this transaction.	
REF03	0352	Description Not Used	

X12 Segment Name: **DTM** Date/Time Reference
 Name: **Payer Cycle Date**
 Loop: **----**
 Max. Use: 1
 X12 Purpose: To specify pertinent dates and times.
 Purpose: **To identify the payer's processing cycle which created this remittance.**
 Usage: **Mandatory**
 Example: **DTM*405*980505***19~**

Syntax Note: R020306 - At least one of DTM02, DTM03 or DTM06 must be present.

Syntax Note: P0607 - If either DTM06 or DTM07 is present, then the other must be present.

Element	Attributes	Data Element Usage	Flat File Map
DTM01	0374	Date/Time Qualifier	Translator
ID 3	3 M	Code specifying type of date and/or time. Codes: 405 Production	Generated (TG)
DTM02	0373	Date	12-07
DT 6	6 M	Payer Cycle Date Date (YYMMDD) The date which identifies the payer's processing cycle which created this remittance.	
DTM03	0337	Time Not Used	
DTM04	0623	Time Code Not Used	
DTM05	0624	Century	12-06
N0 2	2 M	The first two characters in the designation of the year (CCYY).	
DTM06	1250	Date Time Period Format Qualifier Not Used	
DTM07	1251	Date Time Period Not Used	

X12 Segment Name: **N1 Name**
 Name: **Payer Name**
 Loop: **N1**
 Max. Use: 1
 X12 Purpose: To identify a party by type of organization, name and code
 Purpose: **To identify the payer of this remittance.**
 Usage: **Mandatory**
 Example: **N1*PR*SOMEWHERE INSURANCE COMPANY~**

Syntax Note: R0203 - At least one of N102 or N103 must be present.
 Syntax Note: P0304 - If either N103 or N104 is present, then the other must be present.

X12 Comment: This segment, used alone, provides the most efficient method of providing organizational identification. To obtain this efficiency the 'ID Code' (N104) must provide a key to the table maintained by the transaction processing party.
 X12 Comment: N105 and N106 further define the type of entity in N101.

Element	Attributes	Data Element Usage	Flat File Map
N101	0098	Entity Identifier Code	Translator
ID 2	2 M	Code identifying an organizational entity, a physical location or an individual. Codes: PR Payer	Generated (TG)
N102	0093	Name	01-04
AN 1	35 C	Payer Name Free-form name The intermediary's company name.	
N103	0066	Identification Code Qualifier	TG
ID 1	2 C	When effective the National Payer ID will be mandatory for Medicare. Codes: ZZ Mutually defined	
N104	0067	Identification Code	01-05
AN 2	20 C	National Payer ID The National Payer ID will be mandatory for Medicare when effective.	
N105	0706	Entity Relationship Code	
		Not Used	

N106 0098 Entity Identifier Code
Not Used

X12 Segment Name: **N1 Name**
 Name: **Payee Identification**
 Loop: **N1**
 Max. Use: 1
 X12 Purpose: To identify a party by type of organization, name and code
 Purpose: **To identify the payee or recipient of this remittance.**
 Usage: **Mandatory**
 Example: **N1*PE*INSTITUTIONAL ASSOCIATION*MP*17782365~**

Syntax Note: R0203 - At least one of N102 or N103 must be present.
 Syntax Note: P0304 - If either N103 or N104 is present, then the other must be present.

X12 Comment: This segment, used alone, provides the most efficient method of providing organizational identification. To obtain this efficiency the 'ID Code' (N104) must provide a key to the table maintained by the transaction processing party.
 X12 Comment: N105 and N106 further define the type of entity in N101.

Element	Attributes	Data Element Usage	Flat File Map
N101	0098	Entity Identifier Code	Translator
ID 2	2 M	Code identifying an organizational entity, a physical location or an individual. Codes: PE Payee	Generated (TG)
N102	0093	Name	11-02
AN 1	35 C	Payee Name Free-form name The name of the payee or recipient of this remittance.	
N103	0066	Identification Code Qualifier	TG
ID 1	2 M	Code designating the system/method of code structure used for Identification Code (67). Codes: MP Medicare Provider Number Number assigned to a health care provider for submitting claims	

covered by Medicare benefits.

N104 0067 Identification Code **10-02**

AN 2 20 M **Provider Number**
Code identifying a party or other code
The Medicare number of the payee.
This will be the National Provider
Identifier (NPI) when available.

N105 0706 Entity Relationship Code
Not Used

N106 0098 Entity Identifier Code
Not Used

X12 Segment Name: **N3** Address Information
 Loop: **N1**
 Max. Use: 1
 X12 Purpose: To specify the location of the named party
 Purpose: **To identify the postal address to which a check has been sent or will be sent.**
 Usage: **Conditional**
 Example: **N3*12 Hospital Drive~**
 Comments: **When available, provider address information must be provided.**

Element	Attributes	Data Element Usage	Flat File Map
N301	0166	Address Information	11-03
AN 1	35 M	Provider Address 1 Address Information	
N302	0166	Address Information	11-04
AN 1	35 C	Provider Address 2 Address Information	

X12 Segment Name: **N4** Geographic Location
 Loop: **N1**
 Max. Use: 1
 X12 Purpose: To specify the geographic place of the named party
 Purpose: **Used in conjunction with segment N3 to identify the postal address to which a check has been sent or will be sent.**
 Usage: **Conditional**
 Example: **N1*SOMEWHERE*TX*21239~**
 Comments: **When available, provider address information must be provided.**

Syntax Note: C0605 - If N406 is present, then N405 must be present.

X12 Comment: A combination of either N401 through N404, or N405 or N406, may be adequate to specify a location.
 X12 Comment: N402 is required only if city name (N401) is in the USA or Canada.

Element	Attributes	Data Element	Usage	Flat File Map
N401	0019	City Name		12-02
AN	2 30	Provider City	Free-form text for city name.	
N402	0156	State or Province Code		12-03
ID	2 2	Provider State	Code (Standard State/ Province)as defined by appropriate government agency.	
N403	0116	Postal Code		12-04
ID	3 11	Provider Zip Code	Code defining international postal zone code excluding punctuation and blanks (ZIP code for United States).	
N404	0026	Country Code	Not Used	
N405	0309	Location Qualifier	Not Used	
N406	0310	Location Identifier	Not Used	

X12 Segment Name: **LX** Assigned Number
 Name: **Loop Indicator**
 Loop: **LX Repeat: >1**
 Max. Use: 1
 X12 Purpose: To reference a line number in a transaction set
 Purpose: **To alert the receiver's translator program that a loop or series of segments follow that carry claim information.**
 Usage: **Conditional**
 Example: **LX*970513~**
 Comments: **If claim information is available, write one LX loop for each fiscal year/type of bill summary.**

Element	Attributes	Data Element	Usage	Flat File Map
LX01	0166	Assigned Number		YYMM = 14-04
N0	1 6 M	Loop Number		(use only 1st 4 positions)
		Number assigned for differentiation within a transaction set.		TT = 14-02
		Use a constant 'YYMMTT' for Medicare.		
		(YYMM = year/month of provider fiscal period for the date of service;		
		TT = type of bill summary)		

X12 Segment Name: **TS3** Transaction Statistics
Loop: LX
Max. Use: 1
X12 Purpose: To supply provider level control information
Purpose: **This segment conveys a provider level summary of transaction set monetary quantity control totals by fiscal year and type of bill summary. This segment is not to be used for balancing to the BPR segment.**
Usage: **Conditional**
Example: **TS3*17782365*11*970930*10*139348.44~**
Comments: **If the LX loop indicator is present, then the TS3 segment must be present. Segment TS3 precedes segment TS2. Write one TS3 segment for each type of bill summary and/or fiscal period for which you have claims for this transmission. Write one segment for each change in type of bill summary and/or fiscal period.**

Semantic Note: TS301 is the provider number.
Semantic Note: TS303 is the last day of the provider's fiscal year.
Semantic Note: TS304 is the total number of claims.
Semantic Note: TS305 is the total number of submitted charges.
Semantic Note: TS306 is the total number of covered charges.
Semantic Note: TS307 is the total number of non-covered charges.
Semantic Note: TS308 is the total number of denied charges.
Semantic Note: TS309 is the total provider payment.
Semantic Note: TS310 is the total amount of interest paid.
Semantic Note: TS311 is the total contractual adjustment.
Semantic Note: TS312 is the total Gramm-Rudman Reduction.
Semantic Note: TS313 is the total Medicare Secondary Payer (MSP) primary payer amount.
Semantic Note: TS314 is the total blood deductible amount in dollars.
Semantic Note: TS315 is the summary of non-lab charges.
Semantic Note: TS316 is the total coinsurance amount.
Semantic Note: TS317 is the Health Care Financing Administration Common Procedural Coding System (HCPCS) reported charges.
Semantic Note: TS318 is the total Health Care Financing Administration Common Procedural Coding System (HCPCS) Allowable amount.
Semantic Note: TS319 is the total deductible amount.
Semantic Note: TS320 is the total professional component amount.
Semantic Note: TS321 is the total Medicare Secondary Payer (MSP) patient liability met.
Semantic Note: TS322 is the total patient reimbursement.
Semantic Note: TS323 is the total Periodic Interim Payment (PIP) number of claims.
Semantic Note: TS324 is the total Periodic Interim Payment (PIP) adjustment.

Element				
Attributes		Data Element Usage		Flat File Map
TS301	0127	Reference Number		10-02
AN 1	30 M	Provider Number Reference number or identification number as defined for a particular Transaction Set, or as specified by the Reference Number Qualifier. Medicare Provider Number, or National Provider Identifier when available.		
TS302	1331	Facility Code Value		14-02
R 1	2 M	Type of Bill Summary Code identifying the type of facility where services were performed; the first and second positions of the Uniform Bill Type code or the Place of Service code from the Electronic Media Claims National Standard Format. First two digits of the type of bill.		
TS303	0373	Date		14-04
DT 6	6 M	Fiscal Period End Date (YYMMDD) End date of provider's fiscal year.		
TS304	0380	Quantity		14-06
R 1	15 M	Total Claims Numeric value of quantity Total number of claims for this provider for this type of bill summary for this fiscal period.		
TS305	0782	Monetary Amount		14-07
R 1	15 M	Total Submitted Charges Monetary Amount Sum of submitted charge amounts for this provider for this fiscal period.		
TS306	0782	Monetary Amount		14-08
R 1	15 C	Total Covered Charges Monetary Amount Total covered charges for this provider for this type of bill summary for this fiscal period.		

The covered charge that is Allowable by Medicare, i.e., the submitted charge minus the non-covered charge.

TS307	0782	Monetary Amount	14-09
R 1	15 C	Total Noncovered Charges Monetary Amount Sum of claim noncovered charges for this provider for this type of bill summary for this fiscal period.	
TS308	0782	Monetary Amount	14-10
R 1	15 C	Total Denied Charges Monetary Amount Total denied charge amounts for this provider for this type of bill summary for this fiscal period.	
TS309	0782	Monetary Amount	14-11
R 1	15 C	Total Provider Payment Monetary Amount Sum of provider payment amounts for this provider for this type of bill summary for this fiscal period. Includes total interest and amount can be less than zero.	
TS310	0782	Monetary Amount	15-05
R 1	15 C	Total Interest Included Monetary Amount Total of interest included amounts for this provider for this type of bill summary for this fiscal period.	
TS311	0782	Monetary Amount	15-06
R 1	15 C	Total Contractual Adjustment Monetary Amount Sum of contractual adjustment amounts for this provider for this type of bill summary for this fiscal period.	
TS312	0782	Monetary Amount	15-07
R 1	15 C	Total Gramm-Rudman Reduction Monetary Amount Sum of Gramm-Rudman reduction amounts for this provider for this type of bill summary for this fiscal period.	

TS313	0782	Monetary Amount	15-08
R 1	15 C	Total MSP Payer Amount Monetary Amount Sum of MSP payer(s) amounts for this provider for this type of bill summary for this fiscal period. Includes coinsurance and deductible amounts paid on behalf of the beneficiary.	
TS314	0782	Monetary Amount	15-09
R 1	15 C	Total Blood Deductible Amount Monetary Amount Sum of blood deductible amounts for this provider for this type of bill summary for this fiscal period.	
TS315	0782	Monetary Amount	16-10
R 1	15 C	Sum of Non-Lab Charges Monetary Amount Total covered charges minus sum of charges for line items paid on either clinical lab or orthotics and prosthetics fee schedules.	
TS316	0782	Monetary Amount	18-07
R 1	15 C	Total Coinsurance Amount Monetary Amount Sum of coinsurance amounts for this provider for this type of bill summary for this fiscal period.	
TS317	0782	Monetary Amount	18-08
R 1	15 C	Total HCPCS Submitted Charges Monetary Amount Sum of HCPCS submitted charges for this provider for this type of bill summary for this fiscal period. Includes HCPCS line items paid on either clinical lab or orthotics and prosthetics fee schedules.	
TS318	0782	Monetary Amount	18-09
R 1	15 C	Total HCPCS Allowable Amount Monetary Amount Sum of HCPCS Allowable amounts for this provider for this type of bill	

summary for this fiscal period.
Includes HCPCS line items paid on either
clinical lab or orthotics and prosthetics
fee schedules.

TS319	0782	Monetary Amount	18-10
R 1	15 C	Total Deductible Amount Monetary Amount Sum of cash deductible amounts for this provider for this type of bill summary for this fiscal period.	
TS320	0782	Monetary Amount	18-11
R 1	15 C	Total Professional Component Monetary Amount Sum of professional component amounts for this provider for this type of bill summary for this fiscal period.	
TS321	0782	Monetary Amount	19-08
R 1	15 C	Total MSP Patient Liability Met Monetary Amount Sum of MSP patient liability met amounts by patients for this provider for this type of bill summary for this fiscal period.	
TS322	0782	Monetary Amount	19-09
R 1	15 C	Total Patient Reimbursement Monetary Amount Total of patient refund amounts for this provider for this type of bill summary for this fiscal period.	
TS323	0782	Monetary Amount	19-11
R 1	15 C	Total PIP Claims Monetary Amount Total number of PIP claims for this provider for this type of bill summary for this fiscal period.	
TS324	0782	Monetary Amount	19-12
R 1	15 C	Total PIP Adjustment Monetary Amount Total value of provider payments	

for PIP claims for this provider for
this type of bill summary for this
fiscal period.
Claims payment amount for PIP claims.

X12 Segment Name: **TS2 Transaction Supplemental Statistics**
Name: **Inpatient PPS Statistics**
Loop: LX
Max. Use: 1
X12 Purpose: To provide supplemental summary level control information by provider fiscal year and bill type
Purpose: **This segment shows totals by type of bill summary by fiscal period for PPS inpatient bills only. This segment is not to be used for balancing to the BPR segment.**
Usage: **Conditional**
Example: **TS2*12345*66119*50930**10976*1393****14~**
Comments: **Write only for inpatient bills where there is a companion TS3 for type of bill summary and fiscal period.**

Semantic Note: TS201 is the total Diagnosis Related Group (DRG) amount.

Semantic Note: TS202 is the total federal specific amount.

Semantic Note: TS203 is the total hospital specific amount.

Semantic Note: TS204 is the total disproportionate share amount.

Semantic Note: TS205 is the total capital amount.

Semantic Note: TS206 is the total indirect medical education amount.

Semantic Note: TS207 is the total number of outlier days.

Semantic Note: TS208 is the total day outlier amount.

Semantic Note: TS209 is the total cost outlier amount.

Semantic Note: TS210 is the Diagnosis Related Group (DRG) average length of stay.

Semantic Note: TS211 is the total number of discharges.

Semantic Note: TS212 is the total number of cost report days.

Semantic Note: TS213 is the total number of covered days.

Semantic Note: TS214 is the total number of non-covered days.

Semantic Note: TS215 is the total Medicare Secondary Payer (MSP) pass-through amount calculated for a non-Medicare payer.

Semantic Note: TS216 is the average diagnosis related group (DRG) weight.

Semantic Note: TS217 is the total prospective payment system (PPS) capital, federal-specific portion, diagnosis related group (DRG) amount.

Semantic Note: TS218 is the total prospective payment system (PPS) capital, hospital specific portion, diagnosis related group (DRG) amount.

Semantic Note: TS219 is the total prospective payment system (PPS) disproportionate share, hospital diagnosis related group (DRG) amount.

Element			Data Element Usage	Flat File Map
Attributes				
TS201	0782	Monetary Amount		15-10
R 1	15 M	Total DRG Amount		
		Monetary Amount		
		Total of claim level DRG amounts for this provider for this type of bill summary for this fiscal period.		
		Includes: operating federal specific amount, operating hospital specific amount, operating IME amount and operating disproportionate share amount.		
		TS201 does not include operating outlier amount.		
TS202	0782	Monetary Amount		16-05
R 1	15 C	Total Federal Specific Amount		
		Monetary Amount		
		Total of federal specific operating DRG amounts for this provider for this type of bill summary for this fiscal period.		
TS203	0782	Monetary Amount		16-06
R 1	15 C	Total Hospital Specific Amount		
		Monetary Amount		
		Total of hospital specific operating DRG amounts for this provider for this type of bill summary for this fiscal period.		
TS204	0782	Monetary Amount		16-07
R 1	15 M	Total Disproportionate Share Amount		
		Monetary Amount		
		Sum of operating disproportionate share amounts for this provider for type of bill summary for this fiscal period.		
TS205	0782	Monetary Amount		16-08
R 1	15 M	Total Capital Amount		
		Monetary Amount		
		Sum of claim PPS capital amounts for this provider for type of bill summary for this fiscal period.		
		Includes capital federal specific amount, capital hospital federal specific amount,		

capital hold harmless amount, capital IME amount, capital disproportionate share amount and capital exception amount. TS205 does not include capital outlier amount.

TS206 0782 Monetary Amount 16-09

R 1 15 C **Total Indirect Medical Education Amount**
Monetary Amount
Total of operating indirect teaching amounts for this provider for this type of bill summary for this fiscal period.

TS207 0380 Quantity 17-05

R 1 15 C **Total Outlier Days**
Numeric value of quantity
Sum of outlier days for this provider for this type of bill summary for this fiscal period.

TS208 0782 Monetary Amount 17-06

R 1 15 C **Total Day Outlier Amount**
Monetary Amount
Sum of day outlier amounts for this provider for this type of bill summary for this fiscal period.

TS209 0782 Monetary Amount 17-07

R 1 15 C **Total Cost Outlier Amount**
Monetary Amount
Sum of cost outlier amounts for this provider for this type of bill summary for this fiscal period.

TS210 0380 Quantity 17-08

R 1 15 C **Average DRG Length of Stay**
Numeric value of quantity
Geometric average length of stay for DRGs for this provider for this type of bill summary for this fiscal period for this interchange transmission.

TS211 0380 Quantity 18-05

R 1 15 C **Total Discharges**
Numeric value of quantity
Sum of discharges for this provider for

this type of bill summary for this fiscal period.

Use discharge counts as output by PPS-Pricer.

TS212	0380	Quantity	18-06
R 1	15 C	Total Cost Report Days	
		Numeric value of quantity	
		Sum of cost report days for this provider for this type of bill summary for this fiscal period.	

TS213	0380	Quantity	19-05
R 1	15 C	Total Covered Days Numeric value of quantity Sum of covered days for this provider for this type of bill summary for this fiscal period.	
TS214	0380	Quantity	19-06
R 1	15 C	Total Noncovered Days Quantity Sum of noncovered days for this provider for this type of bill summary for this fiscal period.	
TS215	0782	Monetary Amount	19-07
R 1	15 C	Total MSP Pass-Through Monetary Amount Sum of MSP pass-through amounts for this provider for this type of bill summary for this fiscal period.	
TS216	0380	Quantity	14-05
R 1	15 C	Average DRG Weight Numeric value of quantity Average DRG weight for DRGs for this provider for this type of bill summary for this fiscal period.	
TS217	0782	Monetary Amount	17-09
R 1	15 C	Total PPS Capital FSP DRG Amount Monetary Amount Sum of PPS capital federal specific DRG amounts for this provider for this type of bill summary for this fiscal period.	
TS218	0782	Monetary Amount	17-10
R 1	15 C	Total PPS Capital HSP DRG Amount Monetary Amount Sum of PPS capital hospital specific DRG amounts for this provider for this type of bill summary for this fiscal period.	
TS219	0782	Monetary Amount	17-11
R 1	15 C	Total PPS DSH DRG Amount	

Monetary Amount
Sum of PPS capital disproportionate share amounts for this provider for this type of bill summary for this fiscal period.

X12 Segment Name: **CLP** Claim Level Data
 Loop: CLP Repeat: >1
 Max. Use: 1
 X12 Purpose: To supply information common to all services of a claim
 Usage: **Mandatory**
 Example: **CLP*76543SMITH*1*500*200**MA*9602M1234567*13*1*01~**
 Comments: **This is the first segment written for each claim.**

Semantic Note: CLP03 is the amount of submitted charges this claim.
 Semantic Note: CLP04 is the amount paid this claim.
 Semantic Note: CLP05 is the patient responsibility amount.
 Semantic Note: CLP07 is the payer's internal control number.
 Semantic Note: CLP12 is the diagnosis-related group (DRG) weight.

Element Attributes	Data Element Usage	Flat File Map
CLP01 1028 AN 1 38 M	Claim Submitter's Identifier Patient Control Number Identifier used to track a claim from creation by the health care provider through payment. Claim identifier originally assigned by the provider. It is carried through the payer's system and returned to the provider to allow account posting. If the Patient Control Number is not submitted on the incoming claim, enter a zero in this element.	20-05 or TG
CLP02 1029 ID 1 2 M	Claim Status Code Code identifying the status of an entire claim review organization Codes: 1 Processed as Primary 2 Processed as Secondary 3 Processed as Tertiary 4 Denied 19 Processed as Primary and Crossed Over 20 Processed as Secondary and Crossed	20-09

Over
 21 Processed as Tertiary and Crossed
 Over
 22 Reversal of Previous Payment

CLP03 0782 Monetary Amount 40-02
 R 1 15 M Claim Submitted Charges
 Monetary amount.
 The total submitted charges for this claim.

CLP04 0782 Monetary Amount 40-04
 R 1 15 M Claim Payment Amount
 Monetary amount.
 The total net payment to the provider
 represented in this field does not
 include interest. This amount can be
 less than zero.

CLP05 0782 Monetary Amount
 Not Used.

CLP06 1032 Claim Filing Indicator Code Translator
 ID 1 2 M Code indicating type of claim. Generated (TG)
 Code:
 MA Medicare Part A

CLP07 0127 Reference Number 21-02
 AN 1 30 M Internal Control Number
 Reference number or identification
 number as defined for a particular
 Transaction Set, or as specified by the
 Reference Number Qualifier.
 The intermediary assigned identifier
 for this claim.

CLP08 1331 Facility Code Value 20-08
 AN 1 2 M Type of Bill Summary (1st 2 digits)
 Code identifying the type of facility
 where services were performed.
 The first and second positions of the
 Uniform Bill Type code.

CLP09 1325 Claim Frequency Type Code 20-08

ID 1 1 M **Type of Bill Frequency** (3rd digit)
Code specifying the frequency of the
claim.
**This is the third position of the
Uniform Billing Claim Form Bill Type.**

CLP10 1352 Patient Status Code **21-09**
ID 1 2 M **Patient Status**
Code indicating patient status as of
the "statement covers through date".

CLP11 1354	Diagnosis Related Group (DRG) Code	21-13
ID 1 4 C	DRG Code indicating a patient's diagnosis group based on a patient's illness, diseases, and medical problems.	
CLP12 0380	Quantity	42-09
R 1 15 C	DRG Weight Numeric value of quantity.	
CLP13 0954	Percent	42-10
R 1 10 C	Discharge Fraction Percentage expressed as a decimal.	

X12 Segment Name: **CAS** Claims Adjustment
Name: **Claim level Adjustments**
Loop: CLP
Max. Use: 99
X12 Purpose: To supply adjustment reason codes and amounts as needed for an entire claim or for a particular service within the claim being paid.
Purpose: **To supply claim level adjustment reasons and amounts for payment adjustments required by Medicare policy. (Service-level adjustments are in 2-090-CAS; Provider level adjustments are in 3-010-PLB.)**
Usage: **Mandatory**
Example: **CAS*OA*93*0~ (no adjustments)**
Comments:

1. **Claim level payment adjustments are indicated in this segment. Adjustments should be entered in the sequence they are applied by the payer's system.**
2. **Adjustment reason codes provide the SPECIFIC reason for the immediately following adjustment amount.**
3. **Only reason codes in the national standard reason code list in Appendix B can be used in Medicare 835s. LOCAL REASON CODES MUST NOT BE USED.**
4. **Increases to payment are shown with a negative sign. (In adjustment segments, positive amounts decrease payment; negative amounts increase payment.)**
5. **At least one reason code is required for a claim. If there are no adjustments to report, use group code 'OA' and supply a value '93' in CAS02 and zero in CAS03.**
6. **When reasons and amounts with corresponding quantities are written, e.g., coinsurance days, write the appropriate quantity element.**
7. **WRITE ONE SEGMENT FOR EACH GROUP CODE. Write an additional CAS segment if you have more data to write. You must terminate each CAS segment at the first point after CAS03 for which there is no significant data to write for that group code.**
8. **This segment is mandatory for Medicare.**

Syntax Note: L050607 - If CAS05 is present, then at least one of CAS06 or CAS07 must be present.

Syntax Note: C0605 - If CAS06 is present, then CAS05 must be present.

Syntax Note: C0705 - If CAS07 is present, then CAS05 must be present.

Syntax Note: L080910 - If CAS08 is present, then at least one of CAS09 or CAS10 must be present.

Syntax Note: C0908 - If CAS09 is present, then CAS08 must be present.

Syntax Note: C1008 - If CAS10 is present, then CAS08 must be present.

Syntax Note: L111213 - If CAS11 is present, then at least one of CAS12 or CAS13 must be present.

Syntax Note: C1211 - If CAS12 is present, then CAS11 must be present.

Syntax Note: C1311 - If CAS13 is present, then CAS11 must be present.

Syntax Note: L141516 - If CAS14 is present, then at least one of CAS15

or CAS16 must be present.

Syntax Note: C1514 - If CAS15 is present, then CAS14 must be present.

Syntax Note: C1311 - If CAS16 is present, then CAS14 must be present.

Syntax Note: L171819 - If CAS17 is present, then at least one of CAS18
or CAS19 must be present.

Syntax Note: C1817 - If CAS18 is present, then CAS17 must be present.
 Syntax Note: C1917 - If CAS19 is present, then CAS17 must be present.

Semantic Note: CAS03 is the amount of adjustment.
 Semantic Note: CAS04 is the units of service being adjusted.
 Semantic Note: CAS06 is the amount of the adjustment.
 Semantic Note: CAS07 is the units of service being adjusted.
 Semantic Note: CAS09 is the amount of adjustment.
 Semantic Note: CAS10 is the units of service being adjusted.
 Semantic Note: CAS12 is the amount of the adjustment.
 Semantic Note: CAS13 is the units of service being adjusted.
 Semantic Note: CAS15 is the amount of adjustment.
 Semantic Note: CAS16 is the units of service being adjusted.
 Semantic Note: CAS18 is the amount of the adjustment.
 Semantic Note: CAS19 is the units of service being adjusted.

X12 Comment: Adjustment information is intended to help the provider balance the remittance information. Adjustment amounts should fully explain the difference between submitted charges and the amount paid.

X12 Comment: When the submitted charges are paid in full, the value for CAS03 should be zero.

Element	Attributes	Data Element Usage	Flat File Map
CAS01	1033	Claim Adjustment Group Code	50-02 (Multiple
ID 1	2 M	Code identifying the general category of payment adjustment(s) Codes:	50 records or
		CO Contractual Obligation - Payment adjustment where the provider did not meet a program requirements and is financially liable.	50/51 record sets
		CR Correction - Change to a previously processed claim.	may be required.)
		OA Other Adjustment - Any other adjustment.	
		PR Patient Responsibility Adjustment - Any adjustment where the patient has assumed or will be assuming financial responsibility.	
CAS02	1034	Claim Adjustment Reason Code	50-03
ID 1	5 M	Code identifying the detailed reason the adjustment was made. (See adjustment codes in Appendix B.)	

CAS03 0782 Monetary Amount 50-04
R 1 15 M **Claim Adjustment Amount**
Monetary amount

CAS04	0380	Quantity	50-05
R 1	15 C	Claim Adjustment Quantity Numeric value of quantity	
CAS05	1034	Claim Adjustment Reason Code	50-06
ID 1	5 C	Code identifying the detailed reason the adjustment was made. (See adjustment codes in Appendix B.)	
CAS06	0782	Monetary Amount	50-07
R 1	15 C	Claim Adjustment Amount Monetary amount	
CAS07	0380	Quantity	50-08
R 1	15 C	Claim Adjustment Quantity Numeric value of quantity	
CAS08	1034	Claim Adjustment Reason Code	50-09
ID 1	5 C	Code identifying the detailed reason the adjustment was made. (See adjustment codes in Appendix B.)	
CAS09	0782	Monetary Amount	50-10
R 1	15 C	Claim Adjustment Amount Monetary amount	
CAS10	0380	Quantity	50-11
R 1	15 C	Claim Adjustment Quantity Numeric value of quantity	
CAS11	1034	Claim Adjustment Reason Code	50-12
ID 1	5 C	Code identifying the detailed reason the adjustment was made. (See adjustment codes in Appendix B.)	
CAS12	0782	Monetary Amount	50-13
R 1	15 C	Claim Adjustment Amount Monetary amount	
CAS13	0380	Quantity	50-14
R 1	15 C	Claim Adjustment Quantity Numeric value of quantity	

CAS14	1034	Claim Adjustment Reason Code	51-02
ID 1	5 C	Code identifying the detailed reason the adjustment was made. (See adjustment codes in Appendix B.)	
CAS15	0782	Monetary Amount	51-03
R 1	15 C	Claim Adjustment Amount Monetary amount	
CAS16	0380	Quantity	51-04
R 1	15 C	Claim Adjustment Quantity Numeric value of quantity	
CAS17	1034	Claim Adjustment Reason Code	51-05
ID 1	5 C	Code identifying the detailed reason the adjustment was made. (See adjustment codes in Appendix B.)	
CAS18	0782	Monetary Amount	51-06
R 1	15 C	Claim Adjustment Amount Monetary amount	
CAS19	0380	Quantity	51-07
R 1	15 C	Claim Adjustment Quantity Numeric value of quantity	

X12 Segment Name: **NM1** Individual or Organizational Name
 Name: **Patient Name/Number**
 Loop: CLP
 Max. Use: 1
 X12 Purpose: To supply the full name of an individual or organizational entity
 Purpose: **To identify the patient for whom this claim was submitted**
Write one segment for each claim.
 Usage: **Mandatory**
 Example: **NM1*QC*1*SMITH*NANCY****HN*123456789A~**

Syntax Note: P0809 - If either NM108 or NM109 is present, then the other must be present.

Semantic Note: NM102 qualifies NM103.

Element	Attributes	Data Element Usage	Flat File Map
NM101	0098	Entity Identifier Code	20-10
ID 2	2 M	Patient Name/Change Code identifying an organizational entity, a physical location or an individual. Codes: QC Patient Name 74 Corrected Patient Name	
NM102	1065	Entity Type Qualifier	Translator
ID 1	1 M	Code qualifying the type of entity. Codes: 1 Person	Generated (TG)
NM103	1035	Name Last or Organization Name	20-04
AN 1	35 C	Patient Last Name Individual last name or organizational name.	
NM104	1036	Name First	20-02
AN 1	25 C	Patient First Name Individual first name.	
NM105	1037	Name Middle	20-03

AN 1 25 C **Patient Middle Initial**
Individual middle name or initial.

NM106 1038 Name Prefix
Not used

NM107 1039 Name Suffix
Not used

NM108 0066 Identification Code Qualifier **20-07**
ID 1 2 M **Patient Number/Change**
Code designating the system/method of code
structure used for Identification Code (67)
Codes:
 C Insured's Changed Unique
 Identification Number.
 HN Health Insurance Claim (HIC) Number
 Unique number assigned to individual
 for submitting claims covered by
 Medicare benefits.

NM109 0067 Identification Code **22-02**
AN 2 20 M **HIC Number**
Code identifying a party or other code
The patient's Health Insurance Claim Number.

X12 Segment Name: **NM1** Individual or Organizational Name
 Name: **Crossed Over/Transferred**
 Loop: CLP
 Max. Use: 1
 X12 Purpose: To supply the full name of an individual or organizational entity
 Purpose: **To identify the organizational name to whom this claim was forwarded.**
 Usage: **Conditional**
 Example: **NM1*TT*2*SOMEWHERE INSURANCE CO*****PI*67820485~**

Syntax Note: P0809 - If either NM108 or NM109 is present, then the other must be present.

Semantic Note: NM102 qualifies NM103.

Element	Attributes	Data Element Usage	Flat File Map
NM101	0098	Entity Identifier Code	Translator
ID 2	2 M	Code identifying an organizational entity a physical location or an individual For Medicare, 'TT' identifies the other intermediary or supplemental insurer to whom the claim was forwarded. Codes: TT Transfer To	Generated (TG)
NM102	1065	Entity Type Qualifier	TG
ID 1	1 M	Code qualifying the type of entity Codes: 2 Non-Person Entity	
NM103	1035	Name Last or Organization Name	23-02
AN 1	35 C	Intermediary/Supplemental Insurer Name Individual last name or organizational name	
NM104	1036	Name First Not Used	
NM105	1037	Name Middle Not Used	

NM106 1038 Name Prefix
Not used

NM107 1039 Name Suffix
Not used

NM108 0066 Identification Code Qualifier TG
ID 1 2 M Code designating the system/method of code
structure used for Identification Code (67)
Codes:
PI Payer Identification

NM109 0067 Identification Code 23-03
AN 2 20 M **Identification Number**
Code identifying a party or other code
**A unique number that identifies the
organization in NM103.**
**The National Payer ID will be entered
here when it becomes effective.**

X12 Segment Name: **MIA** Medicare Inpatient Adjudication
Loop: CLP
Max. Use: 1
X12 Purpose: To provide claim level data related to the adjudication of Medicare inpatient claims
Purpose: **This segment conveys claim level data pertinent to the adjudication of inpatient claims which is not part of the financial balancing of the 835.**
(Please refer to the CAS segment for payment adjustments.)
Usage: **Conditional**
Example: **MIA*8****MA02***1067*6782~**
Comments: **1. If adjudication information is present which does not affect inpatient claim payment, write one MIA segment for the claim.**
2. IF AN INPATIENT CLAIM IS NOT PAID IN FULL, AN APPEALS MESSAGE MUST BE SENT.
3. If a Medicare Secondary Payer (MSP) amount is a part of inpatient claim payment calculation, then the MSP value code which is used in bill processing will be returned in a MIA message code element as a five character code with the format MSPnn, where nn will carry the two character value code.

Semantic Note: MIA01 is covered days.
Semantic Note: MIA02 is lifetime reserve days.
Semantic Note: MIA03 is lifetime psychiatric days.
Semantic Note: MIA04 is Diagnosis Related Group (DRG) amount.
Semantic Note: MIA05 is the Health Care Financing Administration Claim Payment Remark code. See Code Source 411.
Semantic Note: MIA06 is the disproportionate share amount.
Semantic Note: MIA07 is the Medicare Secondary Payer (MSP) pass-through amount.
Semantic Note: MIA08 is the total Prospective Payment System (PPS) capital amount.
Semantic Note: MIA09 is the Prospective Payment System (PPS) capital, federal specific portion, Diagnosis Related Group (DRG) amount.
Semantic Note: MIA10 is the Prospective Payment System (PPS) capital, hospital specific portion, Diagnosis Related Group (DRG) amount.
Semantic Note: MIA11 is the Prospective Payment System (PPS) capital, disproportionate share, hospital Diagnosis Related Group (DRG) amount.
Semantic Note: MIA12 is the old capital amount.
Semantic Note: MIA13 is the Prospective Payment System (PPS) capital indirect medical education claim amount.
Semantic Note: MIA14 is hospital specific Diagnosis Related Group (DRG) amount.
Semantic Note: MIA20 is the Health Care Financing Administration Claim Payment Remark code. See Code Source 411.

Semantic Note: MIA21 is the Health Care Financing Administration Claim Payment Remark code. See Code Source 411.

Semantic Note: MIA16 is the federal specific Diagnosis Related Group (DRG) amount.

Semantic Note: MIA17 is the Prospective Payment System (PPS) Capital Outlier amount.

Semantic Note: MIA18 is the indirect teaching amount.

Semantic Note: MIA19 is the professional component amount billed but not payable.

Semantic Note: MIA20 is the Health Care Financing Administration Claim Payment Remark code. See Code Source 411.

Semantic Note: MIA21 is the Health Care Financing Administration Claim Payment Remark code. See Code Source 411.

Semantic Note: MIA22 is the Health Care Financing Administration Claim Payment Remark code. See Code Source 411.

Semantic Note: MIA23 is the Health Care Financing Administration Claim Payment Remark code. See Code Source 411.

Semantic Note: MIA24 is the capital exception amount.

Element	Attributes	Data Element Usage	Flat File Map
MIA01	0380	Quantity	21-03
R 1	15 M	Covered Days Numeric value of quantity	
MIA02	0380	Quantity	
		Not Used	
MIA03	0380	Quantity	21-06
R 1	15 C	Lifetime Psychiatric Days Numeric value of quantity	
MIA04	0782	Monetary Amount	42-02
R 1	15 C	DRG Amount Monetary amount	
MIA05	0127	Reference Number	22-03
AN 1	30 C	Remark Code Reference number or identification number as defined for a particular Transaction Set or as specified by the Reference Number Qualifier. Medicare Remark code pertaining to this	

claim. (Use standard code list in
Appendix B.)

MIA06	0782	Monetary Amount	42-07
R 1	15 C	Disproportionate Share Amount Monetary amount	
MIA07	0782	Monetary Amount	40-05
R 1	15 C	MSP Pass-through Amount Monetary amount	
MIA08	0782	Monetary Amount	43-02
R 1	15 C	PPS-Capital Amount Monetary amount	
MIA09	0782	Monetary Amount	43-04
R 1	15 C	PPS-Capital FSP DRG Amount Monetary amount	
MIA10	0782	Monetary Amount	43-05
R 1	15 C	PPS-Capital HSP DRG Amount Monetary amount	
MIA11	0782	Monetary Amount	43-06
R 1	15 C	PPS-Capital DSH DRG Amount Monetary amount	
MIA12	0782	Monetary Amount	43-08
R 1	15 C	Old-Capital Amount Monetary amount	
MIA13	0782	Monetary Amount	43-07
R 1	15 C	PPS-Capital IME Amount Monetary amount	
MIA14	0782	Monetary Amount	42-06
R 1	15 C	PPS(Operating)/Hospital-Specific DRG Amount Monetary amount	

MIA15	0380	Quantity	21-07
R 1	15 C	Cost Report Days Numeric value of quantity	
MIA16	0782	Monetary Amount	42-05
R 1	15 C	PPS(Operating)/Federal Specific DRG Amount Monetary amount	
MIA17	0782	Monetary Amount	43-03
R 1	15 C	PPS-Capital Outlier Amount Monetary amount This field excludes the operating outlier amount, which is reflected in the AMT segment.	
MIA18	0782	Monetary Amount	42-08
R 1	15 C	Indirect Teaching Amount Monetary amount	
MIA19	0782	Monetary Amount Not Used	
MIA20	0127	Reference Number	22-04
AN 1	30 C	Remark Code Reference number or identification number as defined for a particular Transaction Set or as specified by the Reference Number Qualifier. Medicare Remark code pertaining to this claim. (Use standard code list in Appendix B.)	
MIA21	0127	Reference Number	22-05
AN 1	30 C	Remark Code Reference number or identification number as defined for a particular Transaction Set or as specified by the Reference Number Qualifier. Medicare Remark code pertaining to this claim. (Use standard code list in Appendix B.)	
MIA22	0127	Reference Number	22-06
AN 1	30 C	Remark Code	

Reference number or identification number as defined for a particular Transaction Set or as specified by the Reference Number Qualifier.

Medicare Remark code pertaining to this claim.

(Use standard code list in Appendix B.)

MIA23 0127 Reference Number **22-07**

AN 1 30 C **Remark Code**

Reference number or identification number as defined for a particular Transaction Set or as specified by the Reference Number Qualifier.

Medicare Remark code pertaining to this claim.

(Use standard code list in Appendix B.)

MIA24 0782 Monetary Amount **43-09**

R 1 15 C **PPS-Capital Exception Amount**

Monetary amount

X12 Segment Name: **MOA** Medicare Outpatient Adjudication
 Loop: CLP
 Max. Use: 1
 X12 Purpose: To provide claim level data related to the adjudication of Medicare claims not related to an inpatient setting
 Purpose: **This segment conveys claim level data pertinent to the adjudication of non-inpatient claims which is not part of the financial balancing of the 835. (Please refer to the CAS segment for payment adjustments.)**
 Usage: **Conditional**
 Example: **MOA*.76*186.43*MA02*MA10*MA61~**
 Comments: **1. If adjudication information is present which does not affect claim payment, write one MOA segment for the claim.**
2. IF AN OUTPATIENT CLAIM IS NOT PAID IN FULL, AN APPEALS MESSAGE MUST BE SENT.
3. If a Medicare Secondary Payer (MSP) amount is a part of outpatient claim payment calculation, then the MSP value code which is used in bill processing will be returned in a MOA message code element as a five character code with the format MSPnn, where nn will carry the two character value code.

Semantic Note: MOA01 is the reimbursement rate.
 Semantic Note: MOA02 is the claim Health Care Financing Administration (HCFA) Common Procedural Coding System (HCPCS) Allowable amount.
 Semantic Note: MOA03 is the HCFA Payment Remark code. See Code Source 411.
 Semantic Note: MOA04 is the HCFA Payment Remark code. See Code Source 411.
 Semantic Note: MOA05 is the HCFA Payment Remark code. See Code Source 411.
 Semantic Note: MOA06 is the HCFA Payment Remark code. See Code Source 411.
 Semantic Note: MOA07 is the HCFA Payment Remark code. See Code Source 411.
 Semantic Note: MOA08 is the End Stage Renal Disease (ESRD) payment amount.
 Semantic Note: MOA09 is the professional component amount billed but not Allowable.

Element	Attributes	Data Element Usage	Flat File Map
MOA01	0954	Percent	21-12
R 1	10 C	Reimbursement Rate Percentage expressed as a decimal.	

MOA02 0782 Monetary Amount 40-06
R 1 15 C **Claim HCPCS Allowed Amount**
Monetary amount

MOA03 0127 Reference Number 22-03
AN 1 30 C **Remark Code**
Reference number or identification number
as defined for a particular Transaction
Set or as specified by the Reference
Number Qualifier.
**Medicare Remark code pertaining to this
claim.**
(Use standard code list in Appendix B.)

MOA04 0127 Reference Number 22-04
AN 1 30 C **Remark Code**
Reference number or identification number
as defined for a particular Transaction
Set or as specified by the Reference
Number Qualifier.
**Medicare Remark code pertaining to this
claim.**
(Use standard code list in Appendix B.)

MOA05 0127 Reference Number 22-05
AN 1 30 C **Remark Code**
Reference number or identification number
as defined for a particular Transaction
Set or as specified by the Reference
Number Qualifier.
**Medicare Remark code pertaining to this
claim.**
(Use standard code list in Appendix B.)

MOA06 0127 Reference Number 22-06
AN 1 30 C **Remark Code**
Reference number or identification number
as defined for a particular Transaction
Set or as specified by the Reference
Number Qualifier.
**Medicare Remark code pertaining to this
claim.**

(Use standard code list in Appendix B.)

MOA07 0127 Reference Number 22-07

AN 1 30 C **Remark Code**

Reference number or identification number
as defined for a particular Transaction
Set or as specified by the Reference
Number Qualifier.

**Medicare Remark code pertaining to this
claim.**

(Use standard code list in Appendix B.)

MOA08 0782 Monetary Amount
Not Used

MOA09 0782 Monetary Amount
Not Used

X12 Segment Name: **REF** Reference Numbers
 Name: **Provider Claim Identification**
 Loop: CLP
 Max. Use: 1
 X12 Purpose: To specify identifying numbers
 Purpose: **To convey the medical record number the provider has assigned to this claim. The patient control number is conveyed in the CLP segment.**
 Usage: **Conditional**
 Example: **REF*EA*48672570~**
 Comments: **THE MEDICAL RECORD NUMBER MUST BE WRITTEN IF RECEIVED BY THE INTERMEDIARY.**

Syntax Note: R0203 - At least one of REF02 or REF03 must be present.

Element	Attributes	Data Element Usage	Flat File Map
REF01	0128	Reference Number Qualifier	Translator
ID 2	2 M	Code qualifying the Reference Number. Codes: EA Medicare Record Identification Number A unique number assigned to each patient by the provider of service (hospital) to assist in retrieval of medical records.	Generated (TG)
REF02	0127	Reference Number	20-06
AN 1	30 C	Medical Record Number Reference number or identification number as defined for a particular Transaction Set or as specified by the Reference Number Qualifier.	
REF03	0352	Description Not Used	

X12 Segment Name: **DTM** Date/Time Reference
 Name: **Beginning Service Date**
 Loop: CLP
 Max. Use: 1
 X12 Purpose: To specify pertinent dates and times.
 Purpose: **To convey the beginning date of the period covered by the bill.**
 Usage: **Mandatory**
 Example: **DTM*232*970505***19~**
 Comments: **This segment is written twice: the first for the 'beginning' date and the second for the 'ending' date.**

Syntax Note: R020306 - At least one of DTM02, DTM03 or DTM06 must be present.

Syntax Note: P0607 - If either DTM06 or DTM07 is present, then the other must be present.

Element	Attributes	Data Element Usage	Flat File Map
DTM01	0374	Date/Time Qualifier	Translator
ID 3	3 M	Code specifying type of date and/or time. Codes: 232 Claim Statement Period Start	Generated (TG)
DTM02	0373	Date	21-15
DT 6	6 M	Statement Covers Period (Start) Date (YYMMDD)	
DTM03	0337	Time Not Used	
DTM04	0623	Time Code Not Used	
DTM05	0624	Century	21-14
NO 2	2 M	The first two characters in the designation of the year (CCYY).	
DTM06	1250	Date Time Period Format Qualifier Not Used	

DTM07 1251 Date Time Period
Not Used

X12 Segment Name: **DTM** Date/Time Reference
 Name: **Ending Service Date**
 Loop: CLP
 Max. Use: 1
 X12 Purpose: To specify pertinent dates and times.
 Purpose: **To convey the ending date of the period covered by the bill.**
 Usage: **Mandatory**
 Example: **DTM*233*970507***19~**

Syntax Note: R020306 - At least one of DTM02, DTM03 or DTM06 must be present.
 Syntax Note: P0607 - If either DTM06 or DTM07 is present, then the other must be present.

Element	Attributes	Data Element Usage	Flat File Map
DTM01	0374	Date/Time Qualifier	Translator
ID 3	3 M	Code specifying type of date and/or time. Codes: 233 Claim Statement Period End	Generated (TG)
DTM02	0373	Date	21-17
DT 6	6 M	Statement Covers Period (End) Date (YYMMDD)	
DTM03	0337	Time Not Used	
DTM04	0623	Time Code Not Used	
DTM05	0624	Century	21-16
N0 2	2 M	The first two characters in the designation of the year (CCYY).	
DTM06	1250	Date Time Period Format Qualifier Not Used	
DTM07	1251	Date Time Period Not Used	

X12 Segment Name: **AMT** Monetary Amount
 Loop: CLP
 Max. Use: 8
 X12 Purpose: To indicate the total monetary amount
 Usage: **Conditional**
 Example: **AMT*F5*579~**
 Comments: **This segment is used to convey information only and is not part of the financial balancing of the 835. The information conveyed applies only to the current claim.**

Element Attributes	Data Element Usage	Flat File Map
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AMT01	0522	Amount Qualifier Code	Translator
ID 1	2 M	Code to qualify amount	Generated (TG)
		Codes: (Medicare Usage of X.12 Codes)	

- AU is used for reporting total covered charges for this claim.
- DY is used for reporting the provider per diem amount.
- F5 is used to report the amount the patient has already paid.
- I is the amount of interest paid for this claim not included in net reimbursement but reflected in the provider payment (BPR02) through the PLB segment with adjustment reason code 'IN'.
- NJ is used to report the Medicare Secondary Payer (MSP) liability met by another payer.
- NL is used to report negative reimbursement when CLP04 is a negative amount. (Note: If the transaction is reversed, it will reflect a credit balance.)
- ZK is used to report a Hemophilia Add-on Amount.
- ZZ is used to report either an operational cost or day outlier applicable to this claim.
- ZL is used for new technology add-on

AMT02	0782	Monetary Amount	
R 1	15 M	Total Covered Charges	AU = 43-10
		Per Diem Amount (Inpatient and partial hospitalization only)	DY = 22-09
		Patient Paid Amount	F5 = 23-04
		Interest Amount	I = 40-03
		MSP Liability Met Amount	NJ = 42-11
		Negative Reimbursement	NL = 22-08
		Hemophilia Add-on Amount	ZK = 22-10
		Outlier Amount (inpatient)	ZZ = 42-04
		New Technology Add-on	ZL = 40-07
AMT03	0478	Credit/Debit Flag Code	
		Not Used	

(Modified 11/1/00 as update to version 3051.4A.01)

X12 Segment Name: **QTY** Quantity
 Loop: CLP
 Max. Use: 6
 X12 Purpose: To specify quantity information
 Usage: **Conditional**
 Example: **QTY*FL*13~**

Element Attributes	Data Element Usage	Flat File Map
QTY01	0673 Quantity Qualifier	Translator
ID 2 2 M	Code specifying the type of quantity Codes: (Medicare Usage of X12 Codes)	Generated (TG)
	CA Covered - Actual Days covered on this claim.	
	CD Coinsurance Days - Actual days used on this claim.	
	FL Approved units for Hemophilia Add On	
	OU Outlier Days	
	LA Lifetime Reserve - Actual Medicare hospital insurance includes extra hospital days to be used if the patient has a long illness and is required to stay in the hospital over a specified number of days. This is the actual number of Lifetime Reserve days used for this claim.	
	NA Number of Non-covered Days	
QTY02	0380 Quantity	CA = 21-03
R 1 15 M	Numeric value of quantity Actual Number of Days or Units	CD = 21-08
		FL = 22-11
		OU = 42-03
		LA = 21-05
		NA = 21-04
QTY03	0355 Unit or Basis for Measurement Code Not Used	

X12 Segment Name: **SVC** Service Information
 Loop: **SVC Repeat: 999**
 Max. Use: 1
 X12 Purpose: To supply payment and control information to a provider for a particular service
 Usage: **Conditional**
 Examples: **SVC*HC>71010*154*134****1~ HCPCS Code only billed**
SVC*HC>71010*154*134*324**1~ HCPCS & Revenue Code billed**
SVC*NU>634*7436*1729**13~ Revenue Code only billed**
 Comments: 1. **SVC SEGMENTS ARE MANDATORY FOR ALL LINES OF A CLAIM IF MONETARY ADJUSTMENTS ARE APPLIED TO ANY ONE SERVICE LINE OF THE CLAIM.**
 2. **This segment must be terminated after the last element for which data is present.**
 3. **SVC06 will contain data only when the data differs from SVC01.**

Semantic Note: CLP01 is the Medical Procedure upon which adjudication is based.
 Semantic Note: CLP02 is the submitted service charge.
 Semantic Note: CLP03 is the amount paid for this service.
 Semantic Note: CLP04 is the National Uniform Billing Committee Revenue Code.
 Semantic Note: CLP05 is the paid units of service.
 Semantic Note: CLP06 is the original submitted Medical Procedure.
 Semantic Note: CLP07 is the original submitted Units of Service.

Element Attributes	Data Element Usage	Flat File Map
SVC01 C003 Composite M	Composite Medical Procedure Identifier Procedure Identifier To identify a medical procedure by its standardized codes and applicable modifiers.	
*-01 0235 ID 2 2 M	Product/Service ID Qualifier Code identifying the type/source of the descriptive number used in Product/Service ID (234) Codes: HC HCPCS Codes Coding scheme to group procedure(s) performed on an outpatient basis for payment to a hospital under Medicare. Primarily used for ambulatory surgical and diagnostic	Translator Generated (TG)

departments.

NU National Uniform Billing
Committee (NUBC) UB-92 Revenue
Codes

*-02	0234	Product/Service ID	30-04 (HCPCS)
AN 1	40 M	Procedure/Revenue Code Identifying number for a product or service The processed HCPCS procedure/revenue code for this service.	30-02 (Revenue Code)
*-03	1339	Procedure Modifier	30-05
AN 2	2 C	HCPCS Modifier This identifies special circumstances related to the performance of the service, as defined by trading partners. HCPCS modifier code for this procedure.	
*-04	1339	Procedure Modifier	30-06
AN 2	2 C	HCPCS Modifier This identifies special circumstances related to the performance of the service, as defined by trading partners. HCPCS modifier code for this procedure.	
*-05	1339	Procedure Modifier	30-07
AN 2	2 C	HCPCS Modifier This identifies special circumstances related to the performance of the service, as defined by trading partners. HCPCS modifier code for this procedure.	
*-06	1339	Procedure Modifier Not Used	
*-07	0352	Description Not Used	
SVC02	0782	Monetary Amount	30-10
R 1	15 M	Submitted Charge Monetary Amount The billed line charge submitted for this service.	

SVC03 0782 Monetary Amount 30-09
R 1 15 M **Line Paid Amount**
Monetary amount
**Paid amount for preceding revenue
or HCPCS code.**

SVC04	0234	Product/Service ID	30-02
AN 1	15 C	Revenue Code Identifying number for a product or service. If only a Revenue Code is billed, it will not be repeated in SVC04.	
SVC05	0380	Quantity	30-14
R 1	15 C	Covered Units of Service Numeric value of quantity	
SVC06	C003	Composite Medical Procedure Identifier	
Composite C		Procedure Identifier To identify a medical procedure by its standardized codes and applicable modifiers.	
*-01	0235	Product/Service ID Qualifier	TG
ID 2	2 M	Code identifying the type/source of the descriptive number used in Product/Service ID (234). Codes: HC HCPCS Codes Coding scheme to group procedure(s) performed on an outpatient basis for payment to a hospital under Medicare. Primarily used for ambulatory surgical and diagnostic departments.	
*-02	0234	Product/Service ID	30-13
AN 1	40 M	Submitted Procedure Code Identifying number for a product or service The submitted procedure code for this service.	
*-03	1339	Procedure Modifier Not Used	
*-04	1339	Procedure Modifier Not Used	
*-05	1339	Procedure Modifier Not Used	
*-06	1339	Procedure Modifier Not Used	
*-07	0352	Description Not Used	

SVC07 0380 Quantity 30-08
 R 1 15 C Submitted Units of Service
 Numeric value of quantity

X12 Segment Name: DTM Date/Time Reference
 Name: Service Date
 Loop: SVC
 Max. Use: 1
 X12 Purpose: To specify pertinent dates and times.
 Purpose: To convey the date of service
 Usage: Conditional
 Example: DTM*472*970505***19~

Syntax Note: R020306 - At least one of DTM02, DTM03 or DTM06 must be present.

Syntax Note: P0607 - If either DTM06 or DTM07 is present, then the other must be present.

Element	Attributes	Data Element Usage	Flat File Map
DTM01	0374	Date/Time Qualifier	Translator
ID 3	3 M	Code specifying type of date and/or time. Use 472 to indicate a one-day service. Codes: 472 Service	Generated (TG)
DTM02	0373	Date	30-12
DT 6	6 C	Service Date Date (YYMMDD) To report the date of service for a service line (SVC segment).	
DTM03	0337	Time Not Used	
DTM04	0623	Time Code Not Used	
DTM05	0624	Century	30-11
N0 2	2 M	The first two characters in the	

designation of the year (CCYY).

DTM06 1250 Date Time Period Format Qualifier
Not Used

DTM07 1251 Date Time Period
Not Used

X12 Segment Name: **CAS** Claims Adjustment
Name: **Line Level Adjustments**
Loop: SVC
Max. Use: 99

X12 Purpose: To supply adjustment reason codes and amounts as needed for an entire claim or for a particular service within the claim being paid

Purpose: **To supply line level adjustment reasons and amounts for payment adjustments required by Medicare policy.**

Usage: **Conditional**

Example: **CAS*PR*02*1.3~**

Comments: **1. If a monetary adjustment is made to a service line of a claim, then the 2-090-CAS segment must be sent.**
2. Line level payment adjustments are indicated in this segment. Adjustments should be entered in the sequence they are applied by the payer's system.
3. Adjustment reason codes provide the SPECIFIC reason for the immediately following adjustment amount.
4. Only reason codes in the national standard reason code list in Appendix B can be used in Medicare 835s. LOCAL REASON CODES MUST NOT BE USED.
5. Additions to payment are shown with a negative sign.
6. WRITE ONE SEGMENT FOR EACH GROUP CODE. Write additional CAS segments if you have more data to write. You must terminate each CAS segment after the first monetary amount after which there is no significant data.
7. Non-covered visits are submitted in the 2-120-QTY segment.

Syntax Note: L050607 - If CAS05 is present, then at least one of CAS06 or CAS07 must be present.

Syntax Note: C0605 - If CAS06 is present, then CAS05 must be present.

Syntax Note: C0705 - If CAS07 is present, then CAS05 must be present.

Syntax Note: L080910 - If CAS08 is present, then at least one of CAS09 or CAS10 must be present.

Syntax Note: C0908 - If CAS09 is present, then CAS08 must be present.
 Syntax Note: C1008 - If CAS10 is present, then CAS08 must be present.
 Syntax Note: L111213 - If CAS11 is present, then at least one of CAS12 or CAS13 must be present.
 Syntax Note: C1211 - If CAS12 is present, then CAS11 must be present.
 Syntax Note: C1311 - If CAS13 is present, then CAS11 must be present.
 Syntax Note: L141516 - If CAS14 is present, then at least one of CAS15 or CAS16 must be present.
 Syntax Note: C1514 - If CAS15 is present, then CAS14 must be present.
 Syntax Note: C1311 - If CAS16 is present, then CAS14 must be present.
 Syntax Note: L171819 - If CAS17 is present, then at least one of CAS18 or CAS19 must be present.
 Syntax Note: C1817 - If CAS18 is present, then CAS17 must be present.
 Syntax Note: C1917 - If CAS19 is present, then CAS17 must be present.

Semantic Note: CAS03 is the amount of adjustment.
 Semantic Note: CAS04 is the units of service being adjusted.
 Semantic Note: CAS06 is the amount of the adjustment.
 Semantic Note: CAS07 is the units of service being adjusted.
 Semantic Note: CAS09 is the amount of adjustment.
 Semantic Note: CAS10 is the units of service being adjusted.
 Semantic Note: CAS12 is the amount of the adjustment.
 Semantic Note: CAS13 is the units of service being adjusted.
 Semantic Note: CAS15 is the amount of adjustment.
 Semantic Note: CAS16 is the units of service being adjusted.
 Semantic Note: CAS18 is the amount of the adjustment.
 Semantic Note: CAS19 is the units of service being adjusted.

X12 Comment: Adjustment information is intended to help the provider balance the remittance information. Adjustment amounts should fully explain the difference between submitted charges and the amount paid.
 X12 Comment: When the submitted charges are paid in full, the value for CAS03 should be zero.

Element	Attributes	Data Element Usage	Flat File Map
CAS01	1033	Claim Adjustment Group Code	33-02 (Multiple
ID 1	2 M	Line Adjustment Group Code	33 records or
		Code identifying the general category of payment adjustment(s)	33/34 record sets may be required.)
		Codes:	
		CO Contractual Obligation - Payment	

adjustment where the provider did not meet a program requirements and is financially liable.

CR Correction - Change to a previously processed line

OA Other Adjustment - Any other adjustment

PR Patient Responsibility Adjustment - Any adjustment where the patient has assumed or will be assuming financial responsibility.

CAS02	1034	Claim Adjustment Reason Code	33-03
ID 1	5 M	Line Adjustment Reason Code	
		Code identifying the detailed reason the adjustment was made.	
		(See codes in Appendix B.)	
CAS03	0782	Monetary Amount	33-04
R 1	15 M	Line Adjustment Amount	
		Monetary amount	
CAS04	0380	Quantity	33-05
R 1	15 C	Line Adjustment Quantity	
		Numeric value of quantity	
CAS05	1034	Claim Adjustment Reason Code	33-06
ID 1	5 C	Line Adjustment Reason Code	
		Code identifying the detailed reason the adjustment was made.	
		(See codes in Appendix B.)	
CAS06	0782	Monetary Amount	33-07
R 1	15 C	Line Adjustment Amount	
		Monetary amount	
CAS07	0380	Quantity	33-08
R 1	15 C	Line Adjustment Quantity	
		Numeric value of quantity	
CAS08	1034	Claim Adjustment Reason Code	33-09
ID 1	5 C	Line Adjustment Reason Code	
		Code identifying the detailed reason	

the adjustment was made.
(See codes in Appendix B.)

CAS09	0782	Monetary Amount	33-10
R 1	15 C	Line Adjustment Amount Monetary amount	
CAS10	0380	Quantity	33-11
R 1	15 C	Line Adjustment Quantity Numeric value of quantity	
CAS11	1034	Claim Adjustment Reason Code	33-12
ID 1	5 C	Line Adjustment Reason Code Code identifying the detailed reason the adjustment was made. (See codes in Appendix B.)	
CAS12	0782	Monetary Amount	33-13
R 1	15 C	Line Adjustment Amount Monetary amount	
CAS13	0380	Quantity	33-14
R 1	15 C	Line Adjustment Quantity Numeric value of quantity	
CAS14	1034	Claim Adjustment Reason Code	34-02
ID 1	5 C	Line Adjustment Reason Code Code identifying the detailed reason the adjustment was made. (See codes in Appendix B.)	
CAS15	0782	Monetary Amount	34-03
R 1	15 C	Line Adjustment Amount Monetary amount	
CAS16	0380	Quantity	34-04
R 1	15 C	Line Adjustment Quantity Numeric value of quantity	
CAS17	1034	Claim Adjustment Reason Code	34-05

ID 1 5 C **Line Adjustment Reason Code**
Code identifying the detailed reason
the adjustment was made.
(See codes in Appendix B.)

CAS18 0782 Monetary Amount **34-06**
R 1 15 C **Line Adjustment Amount**
Monetary amount

CAS19 0380 Quantity **34-07**
R 1 15 C **Line Adjustment Quantity**
Numeric value of quantity

X12 Segment Name: **REF** Reference Numbers
 Name: **ASC, APC or HIPPS Group Number**
 Loop: SVC
 Max. Use: 1
 X12 Purpose: To specify identifying numbers.
Purpose: To provide the Ambulatory Surgical Center (ASC), Ambulatory Patient Code (APC), or the Health Insurance Prospective Payment System (HIPPS) code assigned to this service.
 Usage: **Conditional**
 Example: **REF*1S*1~**
 Comments: **The ASC and APC group numbers are generated by the Medicare Pricer program. The HIPPS number is submitted on the claim. The applicable number must be reported for a Medicare service paid under the ASC, outpatient PPS or HIPPS payment methodology.**

Syntax Note: R0203 - At least one of REF02 or REF03 must be present.

Element Attributes	Data Element Usage	Flat File Map
REF01 ID 2 3 M	Reference Number Qualifier Code qualifying the Reference number Codes: 1S Ambulatory Patient Group (APG) Number	Translator Generated (TG)
REF02 AN 1 30 M	Reference Number Reference number or identification number as defined for a particular Transaction Set or as specified by the Reference Number Qualifier. ASC, APC, or HIPPS Number	30-15 ASC FISS to furnish APC & HIPPS # maps
<i>NOTE: Pricer supplies the APC only for a single HCPCS included in that APC. No APC is generated for the other HCPCS included in that APC.</i>		
REF03 0352	Description Not Used	

(Modified 11/1/00 as update to version 3051.4A.01)

X12 Segment Name: **REF** Reference Numbers
 Name: **ASC, APC or HIPPS Rate (percent)**
 Loop: SVC
 Max. Use: 1
 X12 Purpose: To indicate the total monetary amount.
Purpose: To convey the ASC, APC or the Health Insurance Prospective Payment System (HIPPS) percentage rate.
 Usage: **Conditional**
 Example: **REF*RB*100~**
 Comments: **This segment must be sent for Medicare ASC, HIPPS, and if a special rate applies, for APC claims.**

Syntax Note: R0203 - At least one of REF02 or REF03 must be present.

Element Attributes	Data Element Usage	Flat File Map
REF01 ID 2 3 M	Reference Number Qualifier Code qualifying the Reference number Codes: RB Rate Code Number	Translator Generated (TG)
REF02 AN 1 30 M	Reference Number Reference number or identification number as defined for a particular Transaction Set or as specified by the Reference Number Qualifier. ASC, APC or HIPPS Rate (percent) ASC Codes: HIPPS Codes: APC Codes: 0 0 percent 0 0 percent Applicable percent 50 50 percent 50 50 percent 100 100 percent 60 60 percent 150 150 percent 100 100 percent	30-16 ASC FISS to furnish Non-ASC rate maps
REF03 0352	Description Not Used	

(Modified 11/1/00 as update to version 3051.4A.01)

X12 Segment Name: **AMT** Monetary Amount
 Name: **ASC, APC or HIPPS Priced Amount**
 Loop: SVC
 Max. Use: 1
 X12 Purpose: To indicate the total monetary amount.
 Purpose: **To convey the ASC, ASC or HIPPS priced amount (the allowed amount) generated by Pricer.**
 Usage: **Conditional**
 Example: **AMT*B6*467~**
 Comments: **This segment must be sent on Medicare ASC and APC remittances, and on remittances for home health HIPPS sent at the end of a 60-day benefit period. (Do not report for the payment at the beginning of a home health HIPPS 60-day benefit period.)**

Element Attributes	Data Element Usage	Flat File Map
AMT01 ID 1 2 M	0522 Amount Qualifier Code Code to qualify amount Codes: B6 Allowed Amount - Actual Amount	Translator Generated (TG)
AMT02 R 1 15 M	0782 Monetary Amount ASC, APC or HIPPS priced amount	30-17 APC (when entries in 30-15 and 30-16) FISS to furnish the APC and HIPPS maps
AMT03	0478 Credit/Debit Flag Code Not Used	

(Modified 11/1/00 as update to version 3051.4A.01)

X12 Segment Name: **AMT** Monetary Amount
 Name: **Per Diem Amount**
 Loop: SVC
 Max. Use: 1
 X12 Purpose: To indicate the total monetary amount
 Usage: **Conditional**
 Example: **AMT*DY*89~**

Element Attributes	Data Element Usage	Flat File Map
AMT01 ID 1 2 M	0522 Amount Qualifier Code Code to qualify amount For Medicare, 'DY' is used for reporting provider per diem amount. Codes: DY Per Day Limit	Translator Generated (TG)
AMT02 R 1 15 M	0782 Monetary Amount Per Diem Amount Monetary amount	31-06
AMT03	0478 Credit/Debit Flag Code Not Used	

X12 Segment Name: **AMT** Monetary Amount
 Name: **Allowed Amount**
 Loop: SVC
 Max. Use: 1
 X12 Purpose: To indicate the total monetary amount
 Usage: **Conditional**
 Example: **AMT*B6*389~**
 Comments: **The amount carried in 2-110.C-AMT02 is for information purposes only. It is not included in the balancing routine of the remittance.**

Element Attributes	Data Element Usage	Flat File Map
AMT01 ID 1 2 M	0522 Amount Qualifier Code Code to qualify amount Codes: B6 Allowed Amount - Actual Amount	Translator Generated (TG)
AMT02 R 1 15 M	0782 Monetary Amount Allowed Amount Monetary amount	31-07
AMT03	0478 Credit/Debit Flag Code Not Used	

X12 Segment Name: **QTY** Quantity
 Name: **HHA Visits**
 Loop: SVC
 Max. Use: 2
 X12 Purpose: To specify quantity information
 Usage: **Conditional**
 Example: **QTY*NE*13~**

Element Attributes	Data Element Usage	Flat File Map
QTY01	0673 Quantity Qualifier	Translator
ID 2 2 M	Code specifying the type of quantity For Medicare, 'NE' is the number of line item noncovered visits and 'VS' is the number of line item covered visits. Codes: NE Noncovered - Estimated VS Visits	Generated (TG)
QTY02	0380 Quantity	
R 1 15 M	Numeric value of quantity Number of Actual Covered or Noncovered Visits.	NE = 31-05 VS = 31-04
QTY03	0355 Unit or Basis for Measurement Code	
	Not Used	

X12 Segment Name: **LQ** Industry Code
 Name: **Reference Line level Remark Codes**
 Loop: SVC
 Max. Use: 99
 X12 Purpose: Code to transmit standard industry codes
 Usage: **Conditional**
 Example: **LQ*HE*M1~**
 Comments: **1. Use the applicable HCFA maintained Reference Remark Codes.**
2. A limitation of liability message (M24-M27) must be used where applicable.

Element Attributes	Data Element Usage	Flat File Map
LQ01 1270 ID 1 3 M	Code List Qualifier Code Codes: HE Health Care Financing Administration Claim Payment Remark Codes	Translator Generated (TG)
LQ02 1271 AN 1 30 C	Industry Code Reference Line Remark Codes The HCFA maintained remark code to convey service specific information that does not involve a financial adjustment. (Use standard code list in Appendix B.)	32-02 thru 32-20

X12 Segment Name: **PLB** Provider Level Adjustment
Name: **Provider level Adjustments**
Loop: **----**
Max. Use: 99
X12 Purpose: To convey provider level adjustment information for debit or credit transactions such as, accelerated payments, cost report settlements for a fiscal year and timeliness report penalties unrelated to a specific claim or service.
Purpose: **To convey provider level adjustment reasons and amounts. These are adjustments to the total provider payment that are not attributable to a specific claim or service. (Service-level adjustments are provided in the CAS segment in the SVC loop, and claim level adjustments are provided in the CAS segment in the CLP loop.)**
Usage: **Conditional**
Example: **PLB*080001*970630*BD*-307.89*SW*4859*IN*-2.68~**
Comments: **1. All provider level adjustments to the payment amount must be indicated in this segment (use more than one iteration of the segment if necessary). Adjustments should be entered in the sequence they are applied by the payer's system.**
2. Adjustment reason codes provide the SPECIFIC reason for the immediately following adjustment amount.
3. Only reason codes in the national standard reason code list in Appendix B can be used in Medicare 835s. LOCAL REASON CODES MUST NOT BE USED.
4. Write another PLB segment if you have more than 6 code/amount pairs or if provider level adjustments occur for multiple fiscal year periods.
5. Any adjustments increasing payment, such as interest and pass throughs, should be reported as negative. Any adjustments decreasing payment, such as withholdings and penalties, should be reported as positive.

Syntax Note: P0506 - If either PLB05 or PLB06 is present, then the other must be present.

Syntax Note: P0708 - If either PLB07 or PLB08 is present, then the other must be present.

Syntax Note: P0910 - If either PLB09 or PLB10 is present, then the other must be present.

Syntax Note: P1112 - If either PLB11 or PLB12 is present, then the other must be present.

Syntax Note: P1314 - If either PLB13 or PLB14 is present, then the other must be present.

Semantic Note: PLB01 is the provider number assigned by the payer.

Semantic Note: PLB02 is the last day of the provider's fiscal year.

Semantic Note: PLB03 is the adjustment information as defined by the

payer.
Semantic Note: PLB04 is the adjustment amount.
Semantic Note: PLB06 is the adjustment information as defined by the
payer.
Semantic Note: PLB07 is the adjustment amount.

Semantic Note: PLB09 is the adjustment information as defined by the payer.

Semantic Note: PLB10 is the adjustment amount.

Semantic Note: PLB11 is the adjustment information as defined by the payer.

Semantic Note: PLB12 is the adjustment amount.

Semantic Note: PLB13 is the adjustment information as defined by the payer.

Semantic Note: PLB14 is the adjustment amount.

Element Attributes	Data Element Usage	Flat File Map
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PLB01 AN 1 30 M	0127 Reference Number Provider Number Reference number or identification number as defined for a particular Transaction Set or as specified by the Reference Number Qualifier. The Medicare assigned intermediary billing provider number. This will be the National Provider Identifier when effective.	81-02
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PLB02 DT 6 6 M	0373 Date Fiscal Period End Date (YYMMDD) Last day of provider's fiscal year for which the following provider level adjustments apply.	81-04
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PLB03 AN 1 30 M	0127 Reference Number Provider Adjustment Reason Code Reference number or identification number as defined for a particular Transaction Set or as specified by the Reference Number Qualifier. See data dictionary (Appendix B) for code values.	81-05
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PLB04 R 1 15 M	0782 Monetary Amount Provider Adjustment Amount Monetary Amount	81-06
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PLB05	0127 Reference Number	81-07
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AN	1	30	C	Provider Adjustment Reason Code Reference number or identification number as defined for a particular Transaction Set or as specified by the Reference Number Qualifier.	
PLB06		0782		Monetary Amount	81-08
R	1	15	C	Provider Adjustment Amount Monetary Amount	
PLB07		0127		Reference Number	81-09
AN	1	30	C	Provider Adjustment Reason Code Reference number or identification number as defined for a particular Transaction Set or as specified by the Reference Number Qualifier.	
PLB08		0782		Monetary Amount	81-10
R	1	15	C	Provider Adjustment Amount Monetary Amount	
PLB09		0127		Reference Number	81-11
AN	1	30	C	Provider Adjustment Reason Code Reference number or identification number as defined for a particular Transaction Set or as specified by the Reference Number Qualifier.	
PLB10		0782		Monetary Amount	81-12
R	1	15	C	Provider Adjustment Amount Monetary Amount	
PLB11		0127		Reference Number Not Used	
PLB12		0782		Monetary Amount Not Used	
PLB13		0127		Reference Number Not Used	

PLB14 0782 Monetary Amount
Not Used

X12 Segment Name: **SE** Transaction Set Trailer
 Loop: ----
 Max. Use: 1
 X12 Purpose: To indicate the end of the transaction set and provide the count of the transmitted segments, including the beginning ST and ending SE segments.
 Usage: **Mandatory**
 Example: **SE*52*0019~**
 Comments: **Write one SE segment for each transaction set.**

X12 Comment: SE is the last segment of each transaction set.

Element Attributes	Data Element Usage	Flat File Map
SE01 0096 NO 1 10 M	Number of Included Segments Transaction Segment Count Total number of segments included in a transaction set, including ST and SE segments.	Translator Generated (TG)
SE02 0329 AN 4 9 M	Transaction Set Control Number Identifying control number that must be unique within the transaction set functional group assigned by the originator for a transaction set The transaction set control number, SE02, must be identical to the same data element in the associated transaction set header, i.e., ST02.	TG

X12 Segment Name: **GE** Functional Group Trailer
 Loop: ----
 Max. Use: 1
 X12 Purpose: To indicate the end of a functional group and to provide control information.
 Usage: **Mandatory**
 Example: **GE*1*1~**
 Comments: **All elements must contain data.**

Semantic Note: The data interchange control number GE02 in this trailer must be identical to the same data element in the associated Functional Header GS06.

X12 Comment: The use of identical data interchange control numbers in the associated functional group header and trailer is designed to maximize functional group integrity. The control number is the same as that used in the corresponding header.

Element Attributes	Data Element Usage	Flat File Map
GE01 0097 NO 1 6 M	Number of Transaction Sets Included Group Set Count Total number of transaction sets included in the functional group or interchange (transmission) group terminated by the trailer containing this data element.	Translator Generated (TG)
GE02 0028 NO 1 9 M	Group Control Number Assigned number originated and maintained by the sender. The Group Control Number GE02 must be identical to the one found in the associated functional header GS06.	TG

X12 Segment Name: **IEA** Interchange Control Trailer
 Loop: ----
 Max. Use: 1
 X12 Purpose: To define the end of an interchange of zero or more functional groups and interchange-related control segments.
 Usage: **Mandatory**
 Example: **IEA*1*125000102~**

Element Attributes	Data Element Usage	Flat File Map
IEA01 N0 1 5 M	I16 Number of Included Functional Groups Interchange Group Count A count of the number of functional groups included in an interchange.	Translator Generated (TG)
IEA02 N0 9 9 M	I12 Interchange Control Number A control number assigned by the interchange sender. The Interchange Control Number IEA02 must be identical to the one found in the associated Interchange Header ISA13.	TG