

# **Appendix A**

## **HCFA Part A Remittance Advice**

### **Data Dictionary**

**for the Version 4A.01**

### **Implementation Guide**

**for the X12 835 Version 003051**

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<u>DATA ELEMENT NAME</u>	<u>DEFINITION</u>
Account Number Qualifier (1-020-BPR08, -BPR14)	Account type code for account number in the data element which follows. Codes: DA = Demand Deposit SG = Savings
Acknowledgment Requested (0-010-ISA14)	Indicates whether X12.835 telecommunications acknowledgment is required.
Actual Number of Days or Units (2-064-QTY02)	The numeric value represents an actual number of days or units.
Actual Number of Non-covered Visits (2-120-QTY02)	A numeric value for the actual number of visits which are not covered for payment.
Adjustment Amount	See Claim Adjustment Amount, Line Adjustment Amount and Provider Adjustment Amount.
Adjustment Quantity	See Claim Adjustment Quantity and Line Adjustment Quantity.
Adjustment Reason Code	See Claim Adjustment Reason Code, Line Adjustment Reason Code and Provider Adjustment Reason Code.
Allowed Amount (2-110.C-AMT, 2-110.C-AMT02)	The maximum amount determined by the payer as being 'allowable' under the provisions of the contract prior to the determination of actual payment.
ANSI Version Code (0-010-ISA12, 0-020-GS08)	Code indicating the version, release, subrelease and industry identifier of the EDI standard being used.
Application Receiver's Code (0-020-GS03)	The identification code assigned by the intermediary to the receiver of the transaction by trading partner agreement.
Approved Units for Hemophelia Add On Amount (2-064-QTY02 when 2-064-QTY01 is 'FL')	The units approved for a Hemophelia Add On Amount.

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ASC Group Number  
(2-100.A-REF02)

The group number generated by the  
Medicare ASC Pricer program.

ASC Priced Amount  
(2-110.A-AMT02)

The allowed amount generated by the  
ASC PRICER program for an ASC claim.

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ASC Rate (2-100.B-REF02)	The percentage rate used to calculate payment for ASC claims.
Average DRG length of stay (2-007-TS210)	Average length of stay for DRGs for this provider for this type of bill summary, for this fiscal period, for this interchange transmission.
Average DRG weight (2-007-TS216)	Average DRG weight for DRGs for this provider for this type of bill summary, for this fiscal period, for this interchange transmission.
Century (1-070-, 2-050.A-, 2-050.B- & 2-080-DTM05)	The century designator of a date The century designator is the CC digits of a date expressed as MMDDCCYY.
Claim Adjustment Amount (2-020-CAS03, 06, 09, 12, 15, 18)	The adjustment amount for the associated claim adjustment reason code.
Claim Adjustment Group Code (2-020-CAS01 and 2-090-CAS01)	This code is used to establish financial liability for the adjustment amount returned.
Claim Adjustment Quantity (2-020-CAS04, 07, 10, 13, 16, 19)	The adjustment quantity for the associated claim adjustment reason code.
Claim Adjustment Reason Code (2-020-CAS02, 05, 08, 11, 14, 17)	A code that indicates the reason for the adjustment. (See Appendix B for standard claim adjustment reason codes.)
Claim Payment Amount (2-010-CLP04)	Net provider reimbursement amount for this claim.
Claim Status Code (2-010-CLP02)	Code specifying the status of a claim submitted by the provider to the payor for processing.
Claim Submitted Charge (2-010-CLP03)	The sum of the submitted charges for this claim.
Coinsurance Days (2-064-QTY02 when 2-064-QTY01 is 'CD')	The inpatient Medicare days occurring in a hospital after the 60th day and before the 91st day, or in a Skilled Nursing Facility after the 20th day and through the 100th day, in a single spell of illness.

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Cost Report Days (2-033-MIA15)	The number of days that may be claimed as Medicare patient days on a cost report.
Covered Charges (2-062-AMT02 when 2-062-AMT01 is 'AU')	Amount covered by the payer for the associated service or claim.
Covered Days (2-033-MIA01, 2-064-QTY02 when 2-064-QTY01 is 'CA')	Number of days covered by the primary payer or days that would have been covered had Medicare been primary.
Covered Units of Service (2-070-SVC05)	Number of units of service covered by the primary payer or that would have been covered had Medicare been primary.
Covered Visits (2-064-QTY02 when 2-120-QTY01 is 'VS')	Number of visits covered by the primary payer or visits that would have been covered had Medicare been primary.
Credit Debit Flag (1-020-BPR03)	Code indicating whether amount is credit or debit.
Data Indicator (1-020-BPR01)	Code Indicating what type of data is available in this transaction.
Date/Time Qualifier (1-070-, 2-050.A/B-, 2-080-DTM01)	Code specifying the type of date or time or both date and time.
Discharge Fraction (2-010-CLP13)	The number of days billed are divided by the Average Length of Stay.
Disproportionate Share Amount (2-033-MIA06)	Sum of operating capital disproportionate share amounts for this claim.
DRG (2-010-CLP11)	Diagnosis related group for this claim.
DRG Amount (2-033-MIA04)	Total of PPS operating and capital amounts for this claim.
DRG Weight (2-010-CLP12)	Diagnosis related group weight for this claim.
Effective Entry Date	The EFT billing cycle date, check

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(1-020-BPR16)	issue date or statement of issue date.
Ending Service Date (2-050.B-DTM02)	The ending date of the period covered by the bill.
Fiscal Period End (2-005-TS303, 3-010-PLB02)	For TS303, end date of provider's fiscal year. For PLB02, last day of provider's fiscal year for which the accompanying provider level adjustments apply.
Functional Group Creation Date (0-020-GS04)	Date this functional group was created.
Functional Group Creation Time (0-020-GS05)	Time this functional group was created.
Group Control Number (0-020-GS06, 4-010-GE02)	Unique transmission number to be assigned by sender.
Group Set Count (4-010-GE01)	The count of all transactions sent within this functional group.
HCPCS Allowed Amount (2-035-MOA02)	Sum of line item allowed amounts for HCPCS codes billed on this claim.
HCPCS Modifier (2-070-SVC01-03,-04,-05)	A code to identify special circumstances related to the performance of the service.
Hemophelia Add On Amount (2-062-AMT02 when 2-062-AMT01 is 'ZK'.)	The amount paid for Hemophelia Add On units.
Hemophelia Add On Approved Units (2-064-QTY02 when 2-064-QTY01 is 'FL'.)	The units approved for a Hemophelia Add On.
HIC Number (2-030.A-NM109)	Health insurance claim number.
Identification Number (2-030.B-NM109)	A unique number that identifies the payer organization in NM103. The National Payer ID will be entered when effective.
Implementation Guide Version Code (1-060-REF02)	The version code for this Implementation Guide, i.e. 4A.00.

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Indirect Teaching Amount (2-033-MIA18)	Sum of operating and capital indirect teaching amounts for this claim.
Interchange Control Number (0-010-ISA13 and 4-020-IEA02)	Unique number that identifies transmission, assigned by the translator or the application system of the sender.
Interchange Creation Date (0-010-ISA09)	Date this interchange was created.
Interchange Creation Time (0-010-ISA10)	Time this interchange was created.
Interchange Group Count (4-020-IEA01)	A count of the number of functional groups included in an interchange.
Interchange Receiver ID (0-010-ISA08)	The identification code assigned by the intermediary to the receiver of this transmission by trading partner agreement.
Interchange Sender ID (0-010-ISA06)	Interchange code published by the sender for other parties to use as the receiver ID when routing data to the sender.
Interest Amount (2-062-AMT02 when 2-062-AMT01 is 'I')	The amount of interest (to provider and /or beneficiary) for this claim. This amount should not be a part of the claim payment amount.
Intermediary Account Number Qualifier (1-020-BPR08)	A code indicating the type of bank account.
Intermediary Bank Account Number (1-020-BPR09)	Bank account number of the Medicare intermediary sending this 835.
Intermediary Bank ID Number (0-020-BPR07)	Depository Financial Institution (DFI) used by the intermediary sending this 835.
Intermediary Number (0-020-GS02, 1-020-BPR10 and 1-040-TRN03; may also occur in 0-010-ISA06)	Medicare payer identification. The intermediary number must contain at least three digits. GS02 is defined in the 835 as "application sends code" (sender code). Medicare Part A requires the use of the

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	intermediary number in this element. The Min/Max requires 2/15, the intermediary number is 10. The intermediary number is again used in TRN03 which is defined as "originating company ID". Here the Min/Max is 10/10 and the first position must begin with a '9', consequently the intermediary number has a value of '90000xxxxx' (where x=current 5 position intermediary number and 0=future growth if needed).
Intermediary/Supplemental Insurer Name (2-030.B-NM103)	Identifies the other intermediary or supplemental insurer to whom the claim was forwarded..
Internal Control Number (2-010-CLP07)	A number assigned by the payer to identify a claim. The number is usually referred to as an Internal Control Number (ICN) or a Document Control Number (DCN).
Lifetime Psychiatric Days (2-033-MIA03)	Number of lifetime psychiatric days used for this claim.
Lifetime Reserve Days (2-064-QTY02 when 2-064-QTY01 is 'LA')	Number of lifetime reserve days used for this claim.
Line Adjustment Amount (2-090-CAS03, 06, 09, 12, 15, 18)	The adjustment amount for the associated line adjustment reason code.
Line Adjustment Quantity (2-090-CAS04, 07, 10, 13, 16, 19)	The adjustment quantity for the associated line adjustment reason code.
Line Adjustment Reason Code (2-090-CAS02, 05, 08, 11, 14, 17)	A code that indicates the reason for the adjustment. (See Appendix B for standard line adjustment reason codes.)
Line Paid Amount (2-070-SVC03)	Actual amount paid to provider for this service line.
Loop Number (2-003-LX01)	A number assigned for loop differentiation within a transaction set.
Medical Record Number	A unique number assigned to patient

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(2-040-REF02)	by the provider to assist in retrieval of medical records.
MSP Pass-through Amount (2-033-MIA07)	Interim cost pass-through amount used to determine MSP liability.
MSP Liability Met (2-062-AMT02 when 2-062-AMT01 is 'NJ'.)	The amount of patient and/or provider liability for the claim met by another payer.
National Payer ID (1-080.A-N104)	Unique national identifier assigned to each health care payer. The National Payer ID when effective.
Negative Reimbursement (2-062-AMT02 when 2-062-AMT01 is 'NL')	Amount when the claim payment is a negative.
Number of Noncovered Days (2-064-QTY02 when 2-064-QTY01 is 'NA')	Number of days of care not covered by the primary payer for this claim.
Number of Noncovered Visits (2-120-QTY02 when 2-120-QTY01 is 'NE')	Number of visits not covered by the primary payer for this service.
Old Capital Amount (2-033-MIA12)	The amount for old capital for this claim.
Outlier Amount (2-062-AMT02 when 2-062-AMT01 is 'ZZ')	Operating cost or day outlier amount for this claim, as output by PPS-PRICER.
Outlier Days (2-064-QTY02 when 2-064-QTY01 is 'OU')	Number of outlier days for this claim, as output by PPS-PRICER.
Patient Control Number (2-010-CLP01)	Patient's unique alpha-numeric identification number for this claim assigned by the provider to facilitate retrieval of individual case records and posting of payment.
Patient First Name (2-030.A-NM104)	The first name of the individual to whom the services were provided.
Patient Last Name (2-030.A-NM103)	The last name of the individual to whom the services were provided.
Patient Middle Initial (2-030.A-NM105)	The middle initial of the individual to whom the services were provided.
Patient Name/Change (2-030.A-NM101)	Code indicating if the patient name has changed.

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Patient Number/Change (2-030-NM108)	Code indicating if the patient number has changed.
Patient Paid Amount (2-062-AMT02 when 2-062-AMT01 is 'F5')	The amount the provider has received from the patient (or insured) toward payment of this claim.
Patient Status (2-010-CLP10)	A code indicating the patient's status as at the date of admission, outpatient service, or start of care.
Payee Name (1-080.B-N102)	The name of the payee or recipient of this remittance.
Payer Cycle Date (1-070-DTM02)	The date which identifies the payer's processing cycle which created this remittance.
Payer Name (1-080.A-N102)	Name of this payer.
Payment Format Code (1-020-BPR05)	Type of format chosen to send payment.
Payment Method Code (1-020-BPR04)	Method used for the movement of payment instructions.
Per Diem Amount (for claim: 2-062-AMT02 when 2-062-AMT01 is 'DY'; for service line: 2-110.B-AMT02 when 2-110.B-AMT01 is 'DY')	Per diem amount paid relative to this claim or service line.
PPS-Capital Amount (2-033-MIA08)	Total PPS capital amount payable for this claim as output by PPS PRICER.
PPS-Capital DSH DRG Amount (2-033-MIA11)	PPS-capital disproportionate share amount for this claim as output by PPS-PRICER.
PPS-Capital Exception Amount (2-033-MIA24)	A per discharge payment exception paid to the hospital. It is a flat-rate add-on to the PPS payment.
PPS-Capital FSP DRG Amount (2-033-MIA09)	PPS-capital federal specific portion for this claim as output by PPS-PRICER.
PPS-Capital HSP DRG Amount	Hospital-Specific portion for

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(2-033-MIA10)	PPS-capital for this claim as output by PPS-PRICER.
PPS-Capital IME Amount (2-033-MIA13)	PPS-capital indirect medical expenses for this claim as output by PPS-PRICER.
PPS-Capital Outlier Amount (2-033-MIA17)	Total PPS capital day or cost outlier payable for this claim, excluding operating outlier amount.
PPS-Operating Federal Specific DRG Amount (2-033-MIA16)	Sum of federal operating portion of the DRG amount for this claim as output by PPS-PRICER.
PPS-Operating Hospital Specific DRG Amount (2-033-MIA14)	Sum of hospital specific operating portion of DRG amount for this claim as output by PPS-PRICER.
Procedure Identifier (2-070-SVC01, 06)	A composite data element used to identify a medical procedure by its standardized codes and applicable modifiers.
Procedure/Revenue Code (2-070-SVC01-02)	Either the processed HCPCS procedure code or revenue code for this service.
Provider Address 1 (1-100-N301)	Street Address of provider.
Provider Address 2 (1-100-N302)	Additional provider street address information.
Provider Adjustment Amount (3-010-PLB04, 06, 08, 10)	The adjustment amount for the associated provider adjustment reason code.
Provider Adjustment Reason Code (3-010-PLB03, 05, 07, 09)	A code that indicates the reason for the adjustment. (See Appendix B for standard provider adjustment reason codes.)
Provider Bank Account Number (1-020-BPR15)	EFT target account number.
Provider Bank Account Number Qualifier (1-020-BPR14)	A code indicating the type of bank account.
Provider City (1-110-N401)	The city name of the provider.

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Provider Number (1-080.B-N104, 2-005-TS301, 3-010-PLB01; may also occur in 0-020-GS03)	Medicare provider number.
Provider Payment Total (1-020-BPR02)	This is the total actual check or EFT payment to the billing provider. The value in this data element cannot be less than zero.
Provider State (1-110-N402)	The State Postal Code of the provider's state.
Provider Zip Code (1-110-N403)	The ZIP Code of the provider.
Receiving Bank ABA Number (1-020-BPR13)	Target bank identification assigned by the American Banking Association
Reference Line Remark Codes (2-130-LQ02)	A code used to return service specific information to the provider. They are used to clarify the adjustment reason codes returned in the line level CAS segment. (See Line Level Remark Codes from the HCFA Standard Reason, Remark and Message Code list in Appendix B.)
Reimbursement Rate (2-035-MOA01)	Rate used when payment is based upon a percentage of applicable charges.
Remark Code (2-033-MIA05, -20, -21, -22, -23 and 2-035-MOA03, -04, -05, -06, 07)	A code used to return claim specific information to the provider. Remark codes are used to clarify the adjustment reason codes returned in the claim level CAS segment. (See HCFA Standard Reason, Remark and Message Code lists in Appendix B for MIA/MOA remark codes and messages.)
Responsible Agency Code (0-020-GS07)	Code used in conjunction with data element GS06 to identify the issuer of the standard.
Revenue Code (2-070-SVC04)	A code that identifies a specific accommodation, ancillary service or billing calculation.
Service Date	Date on which a service was

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(2-080-DTM02)	performed.
Statement Covers Period (End) (2-050.B-DTM02)	Final service date on this claim.
Statement Covers Period (Start) (2-050.A-DTM02)	Beginning service date on this claim.
Submitted Charge (2-070-SVC02)	The billed line charge submitted for this service.
Submitted Procedure Code (2-070-SVC06-02)	The original HCPCS/CPT-4 code that was submitted by the provider to describe the service rendered.
Submitted Units of Service (2-070-SVC07)	This is the total number of units, times, days, visits, services, or treatments the service described by the submitted HCPCS codes, revenue code or procedure.
Sum of Non-Lab Charge (2-005-TS315)	Total covered charges minus sum of charges for line items paid on either clinical lab or orthotics and prosthetics fee schedules.
Test Indicator (0-010-ISA15)	Code indicating if test or production data being sent.
Total Blood Deductible Amount (2-005-TS314)	Sum of blood deductible amounts for this provider for this type of bill summary for this fiscal period.
Total Capital Amount (2-007-TS205)	Sum of claim PPS capital amount amounts for this provider for this type of bill summary, for this fiscal period.
Total Claims (2-005-TS304)	Total number of claims for this provider for this type of bill summary, for this fiscal period.
Total Coinsurance Amount (2-005-TS316)	Sum of coinsurance amounts for this provider, for this type of bill summary, for this fiscal period.
Total Contractual Adjustment (2-005-TS311)	Sum of contractual adjustment amounts for this provider for this type of bill summary for this fiscal period.

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Total Cost Outlier Amount (2-007-TS209)	Sum of outlier amounts from each claim for this provider, for this type of bill summary, for this fiscal period.
Total Cost Report Days (2-007-TS212)	Sum of cost report days for this provider, for this type of bill summary, for this fiscal period.
Total Covered Charges (2-005-TS306, 2-062-AMT02 when 2-062-AMT01 is 'AU')	For TS306, total covered charges for this provider, for this type of bill summary, for this fiscal period. For AMT02, total covered charges for this claim.
Total Covered Days (2-007-TS213)	Sum of covered days for this provider, for this type of bill summary, for this fiscal period.
Total Day Outlier Amount (2-007-TS208)	Sum of day outlier amounts for this provider, for this type of bill summary, for this fiscal period.
Total Deductible Amount (2-005-TS319)	Sum of cash deductible amounts for this provider, for this batch or for this type of bill summary, for this fiscal period.
Total Denied Charges (2-005-TS308)	Total claim denied charge amounts for this provider, for this type of bill summary, for this fiscal period.
Total Discharges (2-007-TS211)	Sum of discharges for this provider for this type of bill summary, for this fiscal period.
Total Disproportionate Share Amount (2-007-TS204)	Sum of operating disproportionate share amounts for this provider, for this type of bill summary, for this fiscal period.
Total DRG Amount (2-007-TS201)	Total of claim level DRG amounts for this provider, for this type of bill summary, for this fiscal period.
Total Federal-Specific Amount (2-007-TS202)	Total of federal-specific DRG amounts for this provider, for this type of bill summary, for this fiscal period.

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Total Gramm-Rudman Reduction (2-005-TS312)	Total of Gramm-Rudman reduction amounts for this provider, for this type of bill summary, for this fiscal period or for this batch.
Total HCPCS Allowable Amount (2-005-TS318)	Sum of claim HCPCS payable amounts for this provider, for this type of bill summary, for this fiscal period.
Total HCPCS Submitted Charges (2-005-TS317)	Sum of submitted HCPCS charges for the line items billed by this provider, for this type of bill summary, for this fiscal period.
Total Hospital-Specific Amount (2-007-TS203)	Total hospital-specific DRG amounts for this provider, for this type of bill summary, for this fiscal period.
Total Indirect Medical Education Amount (2-007-TS206)	Total of indirect teaching amounts for this provider, for this type of bill summary, for this fiscal period.
Total Interest Included (2-005-TS310)	Total of interest included amounts for this provider, for this type of bill summary, for this fiscal period or for this batch.
Total MSP Pass-Through (2-007-TS215)	Sum of claim MSP pass-through amounts for this provider for this type of bill summary for this fiscal period for this transmission.
Total MSP Patient Liability Met (2-005-TS321)	Sum of Medicare secondary payer patient liability met by patients for Medicare secondary payer for this provider, for this type of bill summary, for this fiscal period.
Total MSP Payer Amount (2-005-TS313)	Sum of Medicare secondary payer(s) amounts for this provider, for this type of bill summary for this fiscal period.
Total Noncovered Charges (2-005-TS307)	Sum of claim noncovered charge <del>amounts</del> for this provider, for this type of bill summary, for this fiscal period.

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Total Noncovered Days (2-007-TS214)	Sum of non-covered days for this provider, for this type of bill summary, for this fiscal period.
Total Outlier Days (2-007-TS207)	Sum of outlier days for this provider, for this type of bill summary, for this fiscal period.
Total Patient Reimbursement (2-005-TS322)	Total of patient refund amounts for this provider for this type of bill summary, for this fiscal period.
Total PIP Adjustment (2-005-TS324)	Total value of provider payments for Periodic Interim Payment (PIP claims for this provider, for this type of bill summary, for this fiscal period.
Total PIP Claims (2-005-TS323)	Total number of Periodic Interim Payment claims for this provider, for this type of bill summary, for this fiscal period.
Total PPS Capital FSP DRG Amount (2-007-TS217)	Sum of PPS-capital federal specific DRG amount s for this provider, for this type of bill summary, for this fiscal period.
Total PPS Capital HSP DRG Amount (2-007-TS218)	Sum of PPS-capital hospital specific DRG amount s for this provider, for this type of bill summary, for this fiscal period.
Total PPS DSH DRG Amount (2-007-TS219)	Sum of PPS disproportionate share of DRG amount s for this provider, for this type of bill summary, for this fiscal period.
Total Professional Component (2-005-TS320)	Sum of professional component amounts for this provider for this type of bill summary for this fiscal period.
Total Provider Payment (2-005-TS309)	Sum of provider payment amounts for this provider, for this type of bill summary, for this fiscal period.
Total Submitted Charges (2-005-TS305)	Sum of submitted charge amounts for this provider, for this fiscal period.

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Trace Type Code (1-040-TRN01)	Qualifies trace number appearing in next element.
Trace Number/Check Number (1-040-TRN02)	Unique number to identify each EFT payment transaction. (For non-EFT transactions, can be the unique MICR paper check number or the voucher number from a non-payment remittance.)
Transaction Set Control Number (1-010-ST02, 3-020-SE02)	The unique identification number within a transaction.
Transaction Segment Count (3-020-SE01)	A tally of all segments in the transaction set, including the ST and SE segments.
Type of Bill Frequency (2-010-CLP09)	Third digit of type of bill code.
Type of Bill Summary (2-005-TS302, 2-010-CLP08)	First two digits of type of bill code. A code which identifies the type of facility where services were performed.