CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 12712	**Date: July 11, 2024**
	Change Request 13693

SUBJECT: Accommodating 10-Digit Dollar Amounts on All Part A Medicare Summary Notices (MSNs)

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to update how 10-digit dollar amounts are displayed on all Part A Medicare Summary Notices (MSNs) so that the entire dollar amount can be shown in the Notes section.

EFFECTIVE DATE: January 1, 2025
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 6, 2025

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

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

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	21/10/10.3.6/Specifications for Section 3: Claims

III. FUNDING:

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

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-04	Transmittal: 12712	Date: July 11, 2024	Change Request: 13693

SUBJECT: Accommodating 10-Digit Dollar Amounts on All Part A Medicare Summary Notices (MSNs)

EFFECTIVE DATE: January 1, 2025
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 6, 2025

I. GENERAL INFORMATION

A. Background: The purpose of this Change Request (CR) is to accommodate 10-digit dollar amounts on all Part A Medicare Summary Notices (MSNs) by making use of the See Notes Below functionality on the MSN. Currently, large dollar amounts can cause printing errors on the MSN.

B. Policy: There are no policy implications.

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
13693.1	Contractors shall, for outpatient, home health, and hospice MSNs, in the Amount Charged, Medicare-Approved Amount, Amount Medicare Paid, and You May Be Billed columns, when service line level amounts exceed 8 digits, display asterisks in the 'grid portion' of the MSN with a reference to SEE NOTES BELOW. The full amount shall then be displayed in the note.					X				
13693.1.1	Contractors shall, in the Total for Claim line, for outpatient, home health, and hospice MSNs, in the Amount Charged, Medicare-Approved Amount, Amount Medicare Paid, and You May Be Billed columns, when line level amounts exceed 8 digits, display "See Notes" in the					X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	"grid portion" of the MSN with a reference to SEE NOTES BELOW. The full amount shall then be displayed in the note.									
13693.1.2	Contractor shall increase the limit of notes for line items and claim level from 6 to 9.					X				

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	None					

IV. SUPPORTING INFORMATION

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

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

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

V. CONTACTS

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

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

and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 0

10.3.6 - Specifications for Section 3: Claims

(Rev. 12712; Issued:07-11-24; Effective:01-01-25; Implementation: 01-06-25)

A. Section Title

POSITION

This subsection contains information of a fixed size. It is fixed in width but may vary in overall length.

The content area begins (0″, 0.22″), 7 points from the baseline of the content described above under the Headers for Other Pages subsection. It is full-page or 540 points in width and variable in height.

figure 10.3.6.A

FORMATTING

[GR 2.1] black rule

[TH 2] section header

DYNAMIC RULES

The language in this section varies for different members of the extended family of MSNs. See the specific content specifications below for details.

When there is a combined MSN for Part A, order the claims as follows:

- Part A Inpatient
- 'B of A'
- Home Health
- Hospice

When there is a combined MSN for Part B or DME, order the claims as follows:

- Assigned
- Unassigned

PART A INPATIENT SPECIFICATIONS

CONTENT

Your Inpatient Claims for Part A (Hospital Insurance)

HOSPICE SPECIFICATIONS

CONTENT

Your Hospice Claims for Part A (Hospital Insurance)

HOME HEALTH SPECIFICATIONS

CONTENT

Your Home Health Claims for Part A (Hospital Insurance)

PART B ASSIGNED AND DME ASSIGNED SPECIFICATIONS

CONTENT

Your Claims for Part B (Medical Insurance)

PART B UNASSIGNED AND DME UNASSIGNED SPECIFICATIONS

CONTENT

Your Unassigned Claims for Part B (Medical Insurance)

'B OF A' SPECIFICATIONS

CONTENT

Your Outpatient Claims for Part B (Medical Insurance)

B. Definitions of Columns

GLOBAL SPECIFICATIONS

POSITION

The subsection usually begins (0″, 0.94″) or 28 points from the baseline of the Section Title subsection. The content area is full-page or 540 points in width but is divided into two columns, each column 259 points in width with 22 point gutter in between. The height is variable, depending on the length of the content, which is determined by the member of the extended family to which the MSN belongs. The left column should always be longer than the right column. If a definition is split between the columns, there should be at least two lines on both left and right columns.

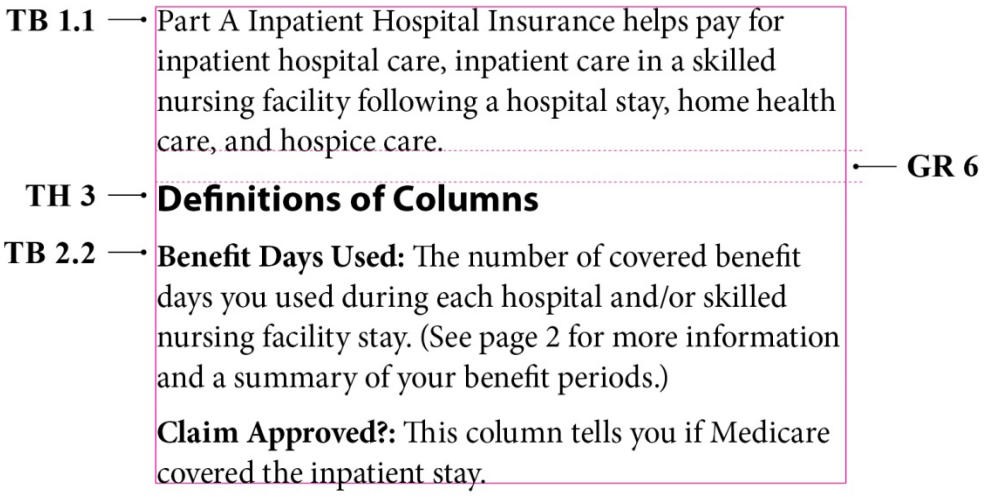


figure 10.3.6.B

FORMATTING

[TB 1.1] first paragraph and body text of subsequent paragraphs

[GR 6] space between paragraph

[TH 3] column-definition title

[GR 6] space between paragraph

[TB 1.2] definition terms, through colon [TB 1.1] definition

NOTE: The column header is bolded with the rest of the type usually in regular Roman text. There are a few instances where there may be additional bolded words within the body text.

DYNAMIC RULES

The language in this section differs for each member of the extended family of MSNs. See the specific content specifications below for details.

PART A INPATIENT SPECIFICATIONS

CONTENT

Part A Inpatient Hospital Insurance helps pay for inpatient hospital care, inpatient care in a skilled nursing facility following a hospital stay, home health care, and hospice care.

Definitions of Columns

Benefit Days Used: The number of covered benefit days you used during each hospital and/or skilled nursing facility stay. (See page 2 for more information and a summary of your benefit periods.)

Claim Approved?: This column tells you if Medicare covered the inpatient stay.

Non-Covered Charges: This is the amount Medicare didn't pay.

Amount Medicare Paid: This is the amount Medicare paid your inpatient facility.

Maximum You May Be Billed: The amount you may be billed for Part A services can include a deductible, coinsurance based on your benefit days used, and other charges.

For more information about Medicare Part A coverage, see your "Medicare & You" handbook.

HOSPICE SPECIFICATIONS

CONTENT

Part A Hospital Insurance helps pay for inpatient hospital care, inpatient care in a skilled nursing facility following a hospital stay, home health care, and hospice care.

Definitions of Columns

Service Approved?: This column tells you if Medicare covered the hospice service.

Amount Provider Charged: This is your provider's fee for this service.

Medicare-Approved Amount: This is the amount a provider can be paid for a Medicare service. It may be less than the actual amount the provider charged. Your provider has agreed to accept this amount as full payment for covered services. Medicare usually pays 80% of the Medicare-approved amount.

Amount Medicare Paid: This is the amount Medicare paid the provider. This is usually 80% of the Medicare-approved amount.

Maximum You May Be Billed: This is the total amount the provider is allowed to bill you. This is usually $0, but can include copayments for outpatient prescription drugs, as well as 5% of the Medicare- approved amount for inpatient respite care. If you have Medicare Supplement Insurance (Medigap policy) or other insurance, it may pay all or part of this amount.

HOME HEALTH SPECIFICATIONS

CONTENT

Part A Hospital Insurance helps pay for inpatient hospital care, inpatient care in a skilled nursing facility following a hospital stay, home health care, and hospice care.

Definitions of Columns

Service Approved?: This column tells you if Medicare covered the home health service.

Amount Provider Charged: This is your provider's fee for this service.

Medicare-Approved Amount: This is the amount a provider can be paid for a Medicare service. It may be less than the actual amount the provider charged. Your provider has agreed to accept this amount as full payment for covered services. Medicare usually pays 80% of the Medicare-approved amount.

Amount Medicare Paid: This is the amount Medicare paid the provider. This is usually 80% of the Medicare-approved amount.

Maximum You May Be Billed: This is the total amount the provider is allowed to bill you. This is usually $0. For durable medical equipment, it can include 20% of the Medicare-approved amount. If you have Medicare Supplement Insurance (Medigap policy) or other insurance, it may pay all or part of this amount.

PART B ASSIGNED SPECIFICATIONS

CONTENT

Part B Medical Insurance helps pay for doctors' services, diagnostic tests, ambulance services, and other health care services.

Definitions of Columns

Service Approved?: This column tells you if Medicare covered this service.

Amount Provider Charged: This is your provider's fee for this service.

Medicare-Approved Amount: This is the amount a provider can be paid for a Medicare service. It may be less than the actual amount the provider charged. Your provider has agreed to accept this amount as full payment for covered services. Medicare usually pays 80% of the Medicare-approved amount.

Amount Medicare Paid: This is the amount Medicare paid your provider. This is usually 80% of the Medicare-approved amount.

Maximum You May Be Billed: This is the total amount the provider is allowed to bill you, and can include a deductible, coinsurance, and other charges not covered. If you have Medicare Supplement Insurance (Medigap policy) or other insurance, it may pay all or part of this amount.

PART B UNASSIGNED SPECIFICATIONS

CONTENT

Medicare claims may be assigned or unassigned. Your claims below are **unassigned** - meaning the provider hasn't agreed to accept the Medicare-approved amount as payment in full.

Do Unassigned Claims Cost More? Maybe. A provider who doesn't accept assignment may charge you up to 15% over the Medicare-approved amount. This is known as the **limiting charge**. You may have to pay this amount, or it may be covered by another insurer.

For a list of providers that always accept Medicare assignment, visit www.medicare.gov/physician or call 1-800-MEDICARE (1-800-633- 4227). You may save money by choosing providers who accept assignment.

Definitions of Columns

Service Approved?: This column tells you if Medicare covered the service.

Amount Provider Charged: This is your provider's fee for this service.

Medicare-Approved Amount: This is the amount a provider can be paid for a Medicare service. Since your provider hasn't agreed to accept assignment, you might be charged up to 15% more than this amount. Medicare usually pays 80% of the Medicare-approved amount.

Medicare Paid You: When a provider doesn't accept assignment, Medicare pays you directly. You'll usually get 80% of the Medicare-approved amount.

Maximum You May Be Billed: This is the total amount the provider is allowed to bill you and can include a deductible, coinsurance, and other charges not covered. If you have Medicare Supplement Insurance (Medigap policy) or other insurance, it may pay all or part of this amount.

'B OF A' SPECIFICATIONS

CONTENT

Part B Medical Insurance helps pay for outpatient care provided by certified medical facilities, such as hospital outpatient departments, renal dialysis facilities, and community health centers.

Definitions of Columns

Service Approved?: This column tells you if Medicare covered the outpatient service.

Amount Facility Charged: This is the facility's fee for this service.

Medicare-Approved Amount: This is the amount a facility can be paid for a Medicare service. It may be less than the actual amount the facility charged. The facility has agreed to accept this amount as full payment for covered services. Medicare usually pays 80% of the Medicare-approved amount.

Amount Medicare Paid: This is the amount Medicare paid the facility. This is usually 80% of the Medicare-approved amount.

Maximum You May Be Billed: This is the total amount the facility is allowed to bill you, and can include a deductible, coinsurance, and other charges not covered. If you have Medicare Supplement Insurance (Medigap policy) or other insurance, it may pay all or part of this amount.

DME ASSIGNED SPECIFICATIONS

CONTENT

Part B Medical Insurance helps pay for durable medical equipment and other health care services.

Definitions of Columns

Item/Service Approved?: This column tells you if Medicare covered this item or service.

Amount Supplier Charged: This is your supplier's fee for this item or service.

Medicare-Approved Amount: This is the amount a supplier can be paid for a Medicare item or service. It may be less than the actual amount the supplier charged. Your supplier has agreed to accept this amount as full payment for covered items or services. Medicare usually pays 80% of the Medicare-approved amount.

Amount Medicare Paid: This column shows the amount Medicare paid the supplier. This is usually 80% of the Medicare-approved amount.

Maximum You May Be Billed: This is the total amount the supplier is allowed to bill you, and can include a deductible, coinsurance, and other charges not covered. If you have Medicare Supplement Insurance (Medigap policy) or other insurance, it may pay all or part of this amount.

DME UNASSIGNED SPECIFICATIONS

CONTENT

Medicare claims may be assigned or unassigned. Your claims below are **unassigned** - meaning the supplier hasn't agreed to accept the Medicare-approved amount as payment in full.

Do Unassigned Claims Cost More? Maybe. A supplier who doesn't accept assignment may charge you up to 15% over the Medicare-approved amount. This is known as the **limiting charge**. The limiting charge applies only to certain Medicare-covered services and doesn't apply to some supplies and durable medical equipment. You may have to pay this amount, or it may be covered by another insurer.

For a list of suppliers that always accept Medicare assignment, visit www.medicare.gov/supplier or call 1-800-MEDICARE (1-800-633- 4227). You may save money by choosing suppliers who accept assignment.

Definitions of Columns

Service Approved?: This column tells you if Medicare covered the item or service.

Amount Provider Charged: This is your supplier's fee for this item or service.

Medicare-Approved Amount: This is the amount a supplier can be paid for a Medicare item or service. It may be less than the actual amount the supplier charged. Since your supplier hasn't agreed to accept assignment, you might be charged more than this amount (see "Do Unassigned Claims Cost More" to your left). Medicare usually pays 80% of the Medicare-approved amount.

Medicare Paid You: When a supplier doesn't accept assignment, Medicare pays you directly. You'll usually get 80% of the Medicare-approved amount.

Maximum You May Be Billed: This is the total amount the supplier is allowed to bill you and can include a deductible, coinsurance, and other charges not covered. If you have Medicare Supplement Insurance (Medigap policy) or other insurance, it may pay all or part of this amount.

For more information about Medicare assignment, see your "Medicare & You" handbook.

C. Claim Header

GLOBAL SPECIFICATIONS

This subsection contains the name and contact information for the provider and/or referrer of each claim. It also lists the date (or dates) of service for the claim. See Exhibit 2.5 for multiple examples of this section, showing provider and contact information variations among extended family members. See Exhibit 2.6 for multiple examples of claim headers indicating multiple dates of service.

The sort order for claims is determined by the date of service listed in this section. Claims should be listed by earliest date of service, using the first date of service in a given claim.

For multiple claims with the same earliest date of service, the claims are sorted chronologically by last date of service.

For multiple claims with the same first and last date of service, the claims are sorted alphabetically by billing facility name, provider last name, or supplier name.

For multiple claims with the same first and last date of service and the same billing provider, the claims are sorted by Maximum You May be Billed Amount, with the claim with the lowest amount listed first.

POSITION

This subsection is full-page or 540 points in width and starts 19 points below the definitions of columns. The height is variable, depending on the length of the content, which may be three or four lines high.

Indent in 8 points all around for content area. Note: Space after the black rule should be 8 points, rather than the typical 6 points specified in the style sheet.

The facility/provider/supplier line has a maximum of 40 characters, same as on page 1 on the ‘Facility/Provider/Supplier List’ subsection. The phone number has a maximum of 30 characters, to include area code and/or any international numbers for U.S. territories. The address line has a maximum of 80 characters. If the address exceeds the maximum character limit, truncate the second address line to fit the address in one line. The referred or ordering provider line also has a maximum of 40 characters.

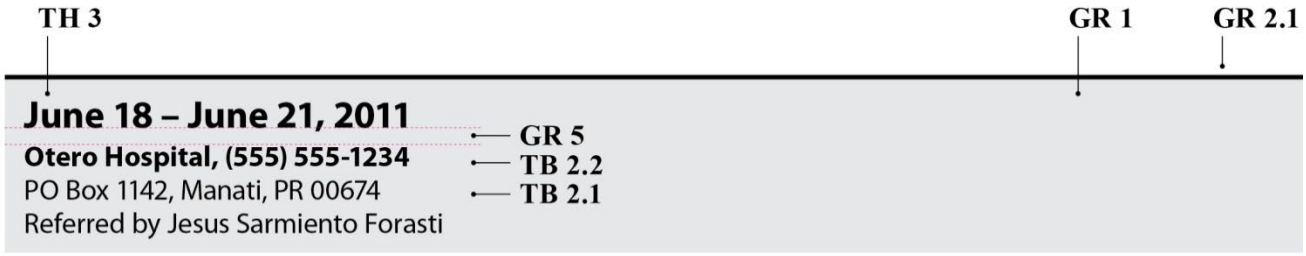


figure 10.3.6.C

PART A INPATIENT, HOSPICE, HOME HEALTH AND 'B OF A' SPECIFICATIONS

FORMATTING

[GR 1] gray fill

[GR 2.1] black rule

[TH 4] Claim Service Date

[GR 5] space after text

[TB 2.2] facility/provider name and telephone number

[TB 2.1] facility/provider address

[TB 2.1] referring provider

DYNAMIC RULES

The content in this section is nearly entirely dynamically generated. It includes the following content elements:

Date(s) of Service

The date of service is listed with a spelled-out month, numeric day, and complete numeric year (e.g., October 15, 2021).

If a single claim includes multiple dates of service, list the first and last date of service for the claim, separated by an en-dash; insert spaces to either side of the en-dash.

If both the first and last dates are within the same calendar year, drop the year from the first date (e.g., October 15 - November 3, 2021). If the dates are in different calendar years, keep the year in both dates (e.g., October 15, 2021 - January 3, 2022).

Facility Name

Print the complete name of the inpatient facility, hospice facility or provider, or home health provider that filed the claim for services.

Facility Phone Number

Print the facility or provider's 10-digit phone number, preceded by a comma to separate it from the facility or provider name. Enclose the area code within parentheses. Insert a dash between the third and fourth digit of the local phone number.

If available, print the phone number associated with the billing department of the facility or provider that filed the claim for services. If a specific billing contact number is not available, print the primary phone number for the facility or provider. If no phone number for the facility or provider is available, suppress this content element and its preceding comma.

Facility Address

Print the facility or provider's street address, city, state abbreviation, and ZIP code +4. Insert a comma between the street address and city, and between the city and state abbreviation.

If available, print the physical address of the facility or provider. If the physical address is not available, print the mailing or billing address for the facility or provider. If no address for the facility or provider is available, suppress this content element.

Referring Provider

If the beneficiary was referred by a provider, print the provider's full name here, preceded by the phrase "Referred by". When printing a degree suffix (e.g., M.D.) with a name, place a period after the "M" and after the "D." Referring physician name and any suffix should be separated by a comma.

CONTENT

{Date(s) of Service}

{Facility/Provider Name}, {10-digit phone number for facility/provider}

{Facility/Provider Street Address} {Facility/Provider State} {Facility/Provider ZIP+4}

Referred by {Provider Title} {Provider Given Name} {Provider Middle Initial} {Provider Family Name}

PART B (ASSIGNED AND UNASSIGNED) SPECIFICATIONS

FORMATTING

[GR 1] gray fill

[GR 2.1] black rule

[TH 4] Claim Service Date

[GR 5] space after text

[TB 2.2] provider name and telephone number

[TB 2.1] provider practice name and address

[TB 2.1] referring provider

DYNAMIC RULES

The content in this section is nearly entirely dynamically generated. It includes the following content elements:

Date(s) of Service

The date of service is listed with a spelled-out month, numeric day, and complete numeric year (e.g., October 15, 2021).

If a single claim includes multiple dates of service, list the first and last date of service for the claim, separated by an en-dash; insert spaces to either side of the en-dash.

If both the first and last dates are within the same calendar year, drop the year from the first date (e.g., October 15 - November 3, 2021). If the dates are in different calendar years, keep the year in both dates (e.g., October 15, 2021 - January 3, 2022).

Provider Name

Print the complete name of the provider that filed the claim for services. When printing a degree suffix (e.g., M.D.) with a name, place a period after the "M" and after the "D." The name and any suffix should be separated by a comma.

Provider Phone Number

Print the provider's 10-digit phone number, preceded by a comma to separate it from the provider name. Enclose the area code within parentheses. Insert a dash between the third and fourth digit of the local phone number.

If available, print the phone number associated with the billing department of the provider that filed the claim for services. If a specific billing contact number is not available, print the primary phone number for the provider. If no phone number for the provider is available, suppress this content element and its preceding comma.

Provider Practice Name and Address

If applicable, print the name of the practice or facility associated with the provider. Print the provider's street address, city, state abbreviation, and zip code +4. Insert a comma between the practice name, street address and city, and between the city and state abbreviation.

Whenever possible, the address that is printed should be the physical address of the provider. If the physical address is not available, use the mailing or billing address for the provider. If no address for the provider is available, suppress this content element.

Referring Provider

If the beneficiary was referred to the provider by another provider, print the referring provider's full name here, preceded by the phrase "Referred by". When printing a degree suffix (e.g., M.D.) with a name, place a period after the "M" and after the "D." Referring provider name and any suffix should be separated by a comma.

CONTENT

{Date(s) of Service}

{Provider Title}{Provider Given Name}{Provider Middle Initial}{Provider Family Name} {, Provider Suffix}, {10-digit phone number for provider}

{Provider Practice Name}{Provider Street Address}{ Provider State}{ Provider ZIP+4}

Referred by {Provider Title}{Provider Given Name}{Provider Middle Initial}{Provider Family Name}

DME (ASSIGNED AND UNASSIGNED) SPECIFICATIONS

FORMATTING

[GR 1] gray fill

[GR 2.1] black rule

[TH 4] Claim Service Date

[GR 5] space after text

[TB 2.2] supplier name and telephone number

[TB 2.1] supplier practice name and address and any referring/ordering provider

DYNAMIC RULES

The content in this section is nearly entirely dynamically generated. It includes the following content elements:

Date(s) of Service

The date of service is listed with a spelled-out month, numeric day, and complete numeric year (e.g., October 15, 2021).

If a single claim includes multiple dates of service, list the first and last date of service for the claim, separated by an en-dash; insert spaces to either side of the en-dash.

If both the first and last dates are within the same calendar year, drop the year from the first date (e.g., October 15 - November 3, 2021). If the dates are in different calendar years, keep the year in both dates (e.g., October 15, 2021 - January 3, 2022).

Supplier Name

Print the complete name of the supplier that filed the claim for services. If the supplier is a physician, when printing a degree suffix (e.g., M.D.) with the name, place a period after the "M" and after the "D." The name and any suffix should be separated by a comma.

Supplier Phone Number

Print the supplier 10-digit phone number, preceded by a comma to separate it from the supplier name. Enclose the area code within parentheses. Insert a dash between the third and fourth digit of the local phone number.

If available, print the phone number associated with the billing department of the supplier that filed the claim for services. If a specific billing contact number is not available, print the primary phone number for the supplier. If no phone number for the supplier is available, suppress this content element and its preceding comma.

Supplier Address

Print the supplier's street address, city, state abbreviation, and ZIP code +4. Insert a comma between the practice name, street address and city, and between the city and state abbreviation.

If available, print the physical address of the supplier. If the physical address is not available, print the mailing or billing address for the supplier. If no address for the supplier is available, suppress this content element.

Ordering Provider

If the beneficiary's supplies were ordered by a provider, print the ordering provider's full name here, preceded by the phrase "Ordered by". When printing a degree suffix (e.g., M.D.) with a name, place a period after the "M" and after the "D." Ordering physician name and any suffix should be separated by a comma. If the NPI submitted on the claim is not on file, use the name as shown on the claim. Suppress the "Ordered by" line if not able to identify the doctor. For A/B MACs (B), if the ordering physician is the same as any performing physician on the claim, suppress the ordering physician line. If the NPI submitted on the claim is not on the A/B MAC (B)'s file, suppress the "Ordered by" line.

CONTENT

{Date(s) of Service}

{Supplier Name}, {10-digit phone number for supplier}

{Supplier Street Address}{Supplier State}{Supplier ZIP+4}

Ordered by {Provider Title} {Provider Given Name}{Provider Middle Initial}{Provider Family Name}

D. Claim Column Titles

The language used for the column headers differs for each member of the extended family of MSNs. See the specific content specifications below for details.

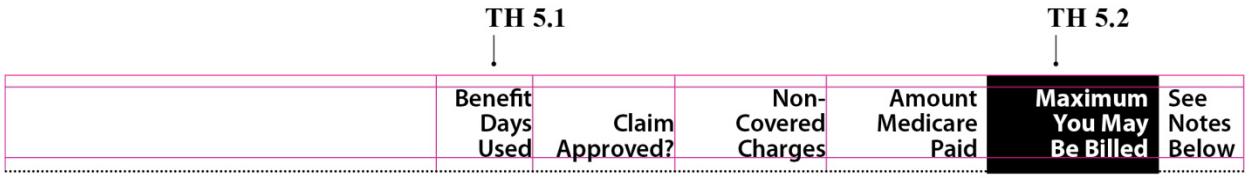


figure 10.3.6.D1

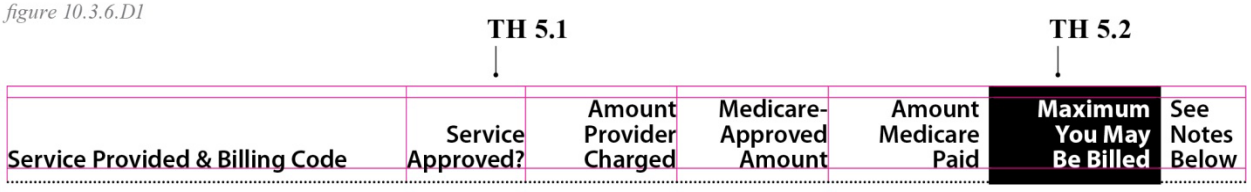


figure 10.3.6.D2

PART A INPATIENT SPECIFICATIONS

POSITION/FORMATTING

This subsection is directly after the claims header subsection. It is full-page or 540 points in width and 42.25 points in height. Content should have 5 points of space from top and 7 points of space from the bottom. There are seven columns with varying widths. All content is to be bottom aligned. See figure 10.3.6.D1 and Exhibit 1.1 for reference.

Listed below are widths and formatting for each column:

Column 1: 188 points wide, no content

Column 2: 42 points wide, [TH 5.1] right aligned

Column 3: 62 points wide, [TH 5.1] right aligned

Column 4: 66 points wide, [TH 5.1] right aligned

Column 5: 71 points wide, [TH 5.1] right aligned with 5 point indent

Column 6: 73 points wide, [TH 5.2] right aligned with 3.5 point intent, white text on black fill and [GR 2.2] on both sides of the column

Column 7: 38 points wide, [TH 5.1] left aligned with 5 point indent

DYNAMIC RULES

n/a - the content in this subsection is static.

CONTENT

(blank)

Benefit Days Used

Claim Approved?

Non-Covered Charges

Amount Medicare Paid

Maximum You May Be Billed

See Notes Below

HOSPICE AND HOME HEALTH SPECIFICATIONS

POSITION/FORMATTING

This subsection is directly after the claims header subsection. It is full-page or 540 points in width and 42.25 points in height. Content should have 5 points of space from the top and 7 points of space from the bottom. There are seven columns with varying widths. All content is to be bottom aligned. See figure 10.3.6.D2, Exhibit 1.3, and Exhibit 1.4 for reference.

Listed below are widths and formatting for each column:

Column 1: 174 points wide, [TH 5.1] left aligned

Column 2: 52 points wide, [TH 5.1] right aligned

Column 3: 66 points wide, [TH 5.1] right aligned

Column 4: 66 points wide, [TH 5.1] right aligned

Column 5: 71 points wide, [TH 5.1] right aligned with 5 point indent

Column 6: 73 points wide, [TH 5.2] right aligned with 3.5 point intent, white text on black fill and [GR 2.2] on both sides of the column

Column 7: 38 points wide, [TH 5.1] left aligned with 5 point indent

DYNAMIC RULES

The content in this subsection is static.

CONTENT

Quantity & Service Provided

Service Approved?

Amount Provider Charged

Medicare-Approved Amount

Amount Medicare Paid

Maximum You May Be Billed

See Notes Below

PART B ASSIGNED SPECIFICATIONS

POSITION/FORMATTING

This subsection is directly after the claims header subsection. It is full-page or 540 points in width and 42.25 points in height. Content should have 5 points of space from the top and 7 points of space from the bottom. There are seven columns with varying widths. All content is to be bottom aligned. See figure 10.3.6.D2, Exhibit 1.5 for reference.

Listed below are widths and formatting for each column:

Column 1: 174 points wide, [TH 5.1] left aligned

Column 2: 52 points wide, [TH 5.1] right aligned

Column 3: 66 points wide, [TH 5.1] right aligned

Column 4: 66 points wide, [TH 5.1] right aligned

Column 5: 71 points wide, [TH 5.1] right aligned with 5 point indent

Column 6: 73 points wide, [TH 5.2] right aligned with 3.5 point intent, white text on black fill and [GR 2.2] on both sides of the column

Column 7: 38 points wide, [TH 5.1] left aligned with 5 point indent

DYNAMIC RULES

The content in this subsection is static.

CONTENT

Service Provided & Billing Code

Service Approved?

Amount Provider Charged

Medicare-Approved Amount

Amount Medicare Paid

Maximum You May Be Billed

See Notes Below

PART B UNASSIGNED SPECIFICATIONS

POSITION/FORMATTING

This subsection is directly after the claims header subsection. It is full-page or 540 points in width and 42.25 points in height. Content should have 5 points of space from the top and 7 points of space from the bottom. There are seven columns with varying widths. All content is to be bottom aligned. See figure 10.3.6.D2 and Exhibit 1.6 for reference.

Listed below are widths and formatting for each column:

Column 1: 174 points wide, [TH 5.1] left aligned

Column 2: 52 points wide, [TH 5.1] right aligned

Column 3: 66 points wide, [TH 5.1] right aligned

Column 4: 66 points wide, [TH 5.1] right aligned

Column 5: 71 points wide, [TH 5.1] right aligned with 5 point indent

Column 6: 73 points wide, [TH 5.2] right aligned with 3.5 point intent, white text on black fill and [GR 2.2] on both sides of the column

Column 7: 38 points wide, [TH 5.1] left aligned with 5 point indent

DYNAMIC RULES

n/a - the content in this subsection is static.

CONTENT

Service Provided & Billing Code

Service Approved?

Amount Provider Charged

Medicare-Approved Amount

Medicare Paid You

Maximum You May Be Billed

See Notes Below

'B OF A' SPECIFICATIONS

POSITION/FORMATTING

This subsection is directly after the claims header subsection. It is full-page or 540 points in width and 42.25 points in height. Content should have 5 points of space from the top and 7 points of space from the bottom. There are seven columns with varying widths. All content is to be bottom aligned. See figure 10.3.6.D2 and Exhibit 1.2 for reference.

Listed below are widths and formatting for each column:

Column 1: 174 points wide, [TH 5.1] left aligned

Column 2: 52 points wide, [TH 5.1] right aligned

Column 3: 66 points wide, [TH 5.1] right aligned

Column 4: 66 points wide, [TH 5.1] right aligned

Column 5: 71 points wide, [TH 5.1] right aligned with 5 point indent

Column 6: 73 points wide, [TH 5.2] right aligned with 3.5 point intent, white text on black fill and [GR 2.2] on both sides of the column

Column 7: 38 points wide, [TH 5.1] left aligned with 5 point indent

DYNAMIC RULES

n/a - the content in this subsection is static.

CONTENT

Service Provided & Billing Code

Service Approved?

Amount Facility Charged

Medicare-Approved Amount

Amount Medicare Paid

Maximum You May Be Billed

See Notes Below

DME ASSIGNED SPECIFICATIONS

POSITION/FORMATTING

This subsection is directly after the claims header subsection. It is full-page or 540 points in width and 42.25 points in height. Content should have 5 points of space from the top and 7 points of space from the bottom. There are seven columns with varying widths. All content is to be bottom aligned. See figure 10.3.6.D2 and Exhibit 1.7 for reference.

Listed below are widths and formatting for each column:

Column 1: 174 points wide, [TH 5.1] left aligned

Column 2: 52 points wide, [TH 5.1] right aligned

Column 3: 66 points wide, [TH 5.1] right aligned

Column 4: 66 points wide, [TH 5.1] right aligned

Column 5: 71 points wide, [TH 5.1] right aligned with 5 point indent

Column 6: 73 points wide, [TH 5.2] right aligned with 3.5 point intent, white text on black fill and [GR 2.2] on both sides of the column

Column 7: 38 points wide, [TH 5.1] left aligned with 5 point indent

DYNAMIC RULES

n/a - the content in this subsection is static.

CONTENT

Quantity, Item/Service Provided & Billing Code

Item/Service Approved?

Amount Supplier Charged

Medicare-Approved Amount

Amount Medicare Paid

Maximum You May Be Billed

See Notes Below

DME UNASSIGNED SPECIFICATIONS

POSITION/FORMATTING

This subsection is directly after the claims header subsection. It is full-page or 540 points in width and 42.25 points in height. Content should have 5 points of space from the top and 7 points of space from the bottom. There are seven columns with varying widths. All content is to be bottom aligned. See figure 10.3.6.D2 and Exhibit 1.8 for reference.

Listed below are widths and formatting for each column:

Column 1: 174 points wide, [TH 5.1] left aligned

Column 2: 52 points wide, [TH 5.1] right aligned

Column 3: 66 points wide, [TH 5.1] right aligned

Column 4: 66 points wide, [TH 5.1] right aligned

Column 5: 71 points wide, [TH 5.1] right aligned with 5 point indent

Column 6: 73 points wide, [TH 5.2] right aligned with 3.5 point intent, white text on black fill and [GR 2.2] on both sides of the column

Column 7: 38 points wide, [TH 5.1] left aligned with 5 point indent

DYNAMIC RULES

n/a - the content in this subsection is static.

CONTENT

Quantity, Item/Service Provided & Billing Code

Item/Service Approved?

Amount Provider Charged

Medicare-Approved Amount

Medicare Paid You

Maximum You May Be Billed

See Notes Below

E. Claim Content Lines

The content in the claim lines is beneficiary-specific and also differs for each member of the extended family of MSNs. See the specific content specifications below for details.

POSITION

This subsection is directly after the claim column titles subsection. It is full-page or 540 points in width and has a variable height, depending on the number of service line items in the given claims. There are seven columns, corresponding to the column titles subsection. All content is top aligned.

PART A INPATIENT SPECIFICATIONS

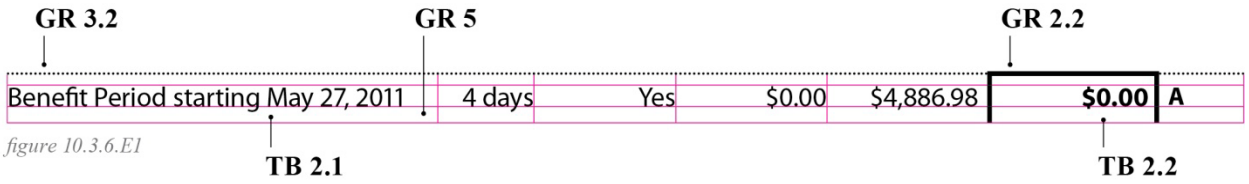


figure 10.3.6.E1

FORMATTING

[GR 3.2] dotted rule [GR 2.2] black rule

Column 1: [TB 2.1] benefit period, left aligned

Column 2: [TB 2.1] approved status, right aligned

Column 3: [TB 2.1] amount charged, right aligned

Column 4: [TB 2.1] amount approved t, right aligned

Column 5: [TB 2.1] amount paid, right aligned, with 5 point indent

Column 6: [TB 2.2] maximum, right aligned, with 3.5 point indent

Column 7: [TB 2.2] note indicator, left aligned, with 5 point indent

NOTE: When there is more than one service line, start with [GR 3.2] dotted rule to allow distinction between the services by the dotted rule.

The first line of column 6 will have [GR 2.2] on top and sides of the column. Subsequent lines will have [GR 2.2] on the sides only.

DYNAMIC RULES

The content in this section is nearly entirely dynamically generated. It includes the following content elements:

Description of Part A Inpatient Service

This column should contain the associated benefit-period start date. Language options include:

Benefit period starting {Month DD, YYYY}

The date of service is listed with a spelled-out month, numeric day, and complete numeric year (e.g., October 15, 2021).

If there is no active benefit period because the claims are rejected, leave this field blank.

Benefit Days Used

This column shows the number of benefit days used during the hospital or skilled nursing facility admission, it indicates that a claim did not use benefit days because all the beneficiary's benefit days for the given period have been exhausted, or there was no active benefit period because the claim was rejected. Language options include:

1 day

{#} days

none remain

none

See Exhibit 2.7 for an example of the "none remain" option.

Claim Approved?

This column indicates if a claim item was approved or denied. It also indicates if a claim was adjusted. Language options include:

Yes

NO

Yes - **adjusted**

NO - adjusted

See Exhibit 2.8 for an example of an adjusted claim (this example shows a Part B MSN, but it can be understood to also apply to other members of the extended family).

Non-Covered Charges

This column lists the amount of any claim charges that Medicare did not cover. Non-covered services will include beneficiary-liable as well as provider-liable charges. This figure may be up to eight digits long, including cents:

${###,###.##}

Insert a comma between the thousands' digit and the hundreds' digit of any four-figure or higher amount. Use $0.00 for zero**.**

Amount Medicare Paid

This column lists the amount that Medicare paid toward the claim. This figure may be up to eight digits long, including cents:

${###,###.##}

Insert a comma between the thousands' digit and the hundreds' digit of any four-figure or higher amount. Use $0.00 for zero**.**

Maximum You May Be Billed

This column lists the beneficiary's total liability for the claim item. This figure may be up to eight digits long, including cents:

${###,###.##}

Insert a comma between the thousands' digit and the hundreds' digit of any four-figure or higher amount. Use $0.00 for zero**.**

See Notes Below

This column displays indicators that refer to explanations listed in the Notes for Claims Above subsection, which is printed at the bottom of the page when applicable.

Note indicators use capital letters, and indicators should be printed in alphabetic order, with a comma without space preceding each indicator after the first indicator for a line (e.g., A,B,C). Show no more than three alphabetic indicators per line. If more than three indicators are required, print on the next line below. A maximum of five notes are allowed per service, so no more than five note indicators should ever be listed here.

If the same message is needed for more than one claim or service line on a single page, print the same alphabetic code each time the message is required on that page. If, however, that same message is required on a following page, use a new indicator letter in the appropriate alphabetical order for that page.

Continue alphabetical order from page to page - do not restart the alphabet on each new page.

If more than 26 alphabetic codes are needed, begin using lowercase alphabetic codes (e.g., a,b,c). If more than 52 alphabetic codes are needed, repeat using capital letters.

CONTENT

{Inpatient hospital benefit period starting Month DD, YYYY} [or] {Skilled nursing facility benefit period starting Month DD, YYYY}

1 day [or] {#} days [or] none remain

Yes [or] **NO** [or] Yes - **adjusted** [or] **NO - adjusted**

${###,###.##}

${###,###.##}

${###,###.##}

{NOTE INDICATOR(S)}

or

[blank]

none

Yes [or] **NO** [or] Yes - **adjusted** [or] **NO - adjusted**

${###,###.##}

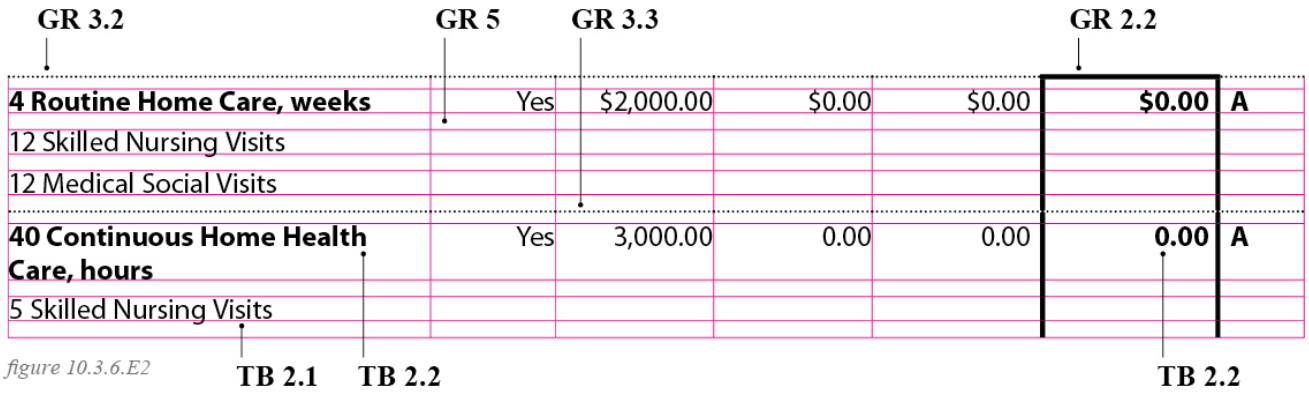
${###,###.##}

${###,###.##}

{NOTE INDICATOR(S)}

HOSPICE SPECIFICATIONS

See Exhibit 1.3 for layout reference.



FORMATTING

[GR 3.2] dotted line [GR 2.2] black rule

Column 1: [TB 2.2] quantity and level of care description, left aligned
or [TB 2.] quantity and service visit description, left aligned

Column 2: [TB 2.1] approved status for level of care, right aligned

Column 3: [TB 2.1] amount charged for level of care, right aligned

Column 4: [TB 2.1] amount approved for level of care, right aligned

Column 5: [TB 2.1] amount paid for level of care, right aligned, with 5 point indent

Column 6: [TB 2.2] maximum for level of care, right aligned, with 3.5 point indent

Column 7: [TB 2.2] note indicator for level of care, left aligned, with 5 point indent

NOTE: Columns 2 through 7 should be filled only for level of care. They should be left blank for service visit lines.

The first line of column 6 will have [GR 2.2] on top and sides of the column. Subsequent lines will have [GR 2.2] on the sides only.

NOTE: Between level of care and service visit lines, insert [GR 5] 7 point space in between the claim lines. There is no dotted line in between.

DYNAMIC RULES

The content in this section is entirely dynamically generated. It includes the following content elements:

Quantity & Service Provided

This column should contain the quantity or number of level of care provided, followed by the description of the level of care provided in bold. Then items below should contain the quantity or number of service visit provided, followed by the description of the service visit provided. There may be multiple service visit types per one level of care.

Whenever possible, the number of level of care and service visit provided should be expressed as a whole number, without decimal point or trailing zero (e.g. 2, <u>not</u> 2.0). Only if the number is a partial quantity, then include a decimal point and a fractional amount, rounded to the nearest tenth (e.g. 2.5, not 2.49). Use the most-recent level of care and service visit descriptions. Suppress the billing code.

Service Approved?

This column indicates if a claim item was approved or denied. It also indicates if a claim was adjusted. Language options include:

Yes

NO

Yes - **adjusted**

NO - adjusted

See Exhibit 2.8 for an example of an adjusted claim.

Amount Provider Charged

This column lists the amount of the charge the provider submitted. This figure field has a maximum of 11 characters, including cents:

${###,###.##}

Insert a comma between the thousands' digit and the hundreds' digit of any four-figure or higher amount. Use $0.00 for zero**.**

Medicare-Approved Amount

This column lists the amount that Medicare allows for the service. This field has a maximum of 11 characters, including cents:

${###,###.##}

Insert a comma between the thousands' digit and the hundreds' digit of any four-figure or higher amount. Use $0.00 for zero**.**

Amount Medicare Paid

This column lists the amount that Medicare paid toward the claim. This field has a maximum of 11 characters, including cents:

${###,###.##}

Insert a comma between the thousands' digit and the hundreds' digit of any four-figure or higher amount. Use $0.00 for zero**.**

Maximum You May Be Billed

This column lists the beneficiary's total liability for the claim item. This field has a maximum of 11 characters, including cents:

${###,###.##}

Insert a comma between the thousands' digit and the hundreds' digit of any four-figure or higher amount. Use $0.00 for zero**.**

See Notes Below

This column displays indicators that refer to explanations listed in the "Notes for Claims Above" subsection, which is printed at the bottom of the page when applicable.

Note indicators use capital letters, and indicators should be printed in alphabetic order, with a comma without space preceding each indicator after the first indicator for a line (e.g., A,B,C). Show no more than three alphabetic indicators per line. If more than three indicators are required, print on the next line below. A maximum of *nine* notes are allowed per service, so no more than *nine* note indicators should ever be listed here.

If the same message is needed for more than one claim or service line on a single page, print the same alphabetic code each time the message is required on that page. If, however, that same message is required on a following page, use a new indicator letter in the appropriate alphabetical order for that page.

Continue alphabetical order from page to page - do not restart the alphabet on each new page.

If more than 26 alphabetic codes are needed, begin using lowercase alphabetic codes (e.g., a,b,c). If more than 52 alphabetic codes are needed, repeat using capital letters.

CONTENT

{Level of care description}

{Service visit description}

Yes [or] **NO** [or] Yes - **adjusted** [or] **NO - adjusted**

${###,###.##}

${###,###.##}

${###,###.##}

${###,###.##}

{NOTE INDICATOR(S)}

HOME HEALTH SPECIFICATIONS

See Exhibit 1.4 for layout reference.

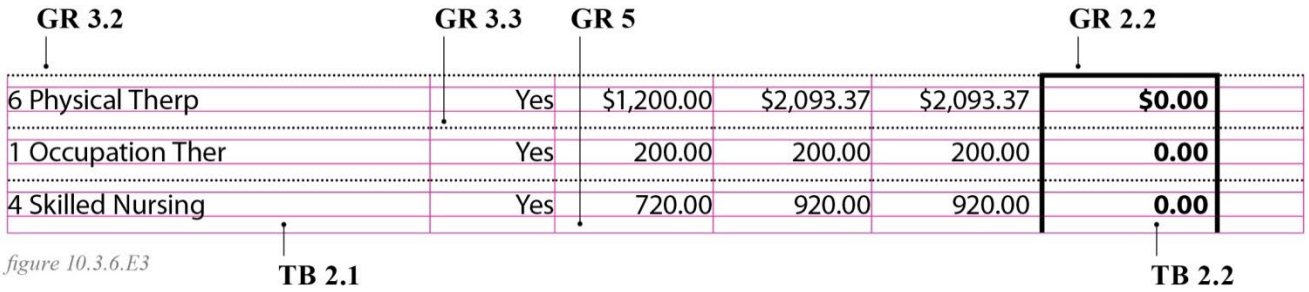


figure 10.3.6.E3

FORMATTING

[GR 3.2] dotted line [GR 2.2] black rule

Column 1: [TB 2.1] quantity and service description, left aligned

Column 2: [TB 2.1] approved status, right aligned

Column 3: [TB 2.1] amount charged, right aligned

Column 4: [TB 2.1] amount approved, right aligned

Column 5: [TB 2.1] amount paid, right aligned, with 5 point indent

Column 6: [TB 2.2] maximum, right aligned, with 3.5 point indent

Column 7: [TB 2.2] note indicator, left aligned, with 5 point indent

The first line of column 6 will have [GR 2.2] on top and sides of the column. Subsequent lines will have [GR 2.2] on the sides only.

NOTE: When there is more than one service line, format [GR 3.3] dotted rule 3 in between the claim lines.

NOTE: For multiple dates and/or providers subtitles, insert the following before corresponding service lines(s):

[TH 5.1] date or provider information

[GR 3.3] dotted rule 3

See Exhibit 2.6 for examples of claims with these various options for dynamic column subtitles.

DYNAMIC RULES

The content in this section is entirely dynamically generated. It includes the following content elements:

Quantity & Service Provided

This column should contain the quantity or number of services provided, followed by the description of the service provided.

Whenever possible, the number of services provided should be expressed as a whole number, without decimal point or trailing zero (e.g. 2, not 2.0). Only if the number is a partial quantity, then include a decimal point and a fractional amount, rounded to the nearest tenth (e.g. 2.5, not 2.49).

Use the most recent consumer-friendly HCPCS (level 1)/CPT service descriptions, which can be found on the CMS systems mainframe or at https://www.cms.gov/Medicare/Coding/MedHCPCSGenInfo/index.html. The service

description has a maximum of 100 characters. Suppress the rest if the description runs longer.

Service Approved?

This column indicates if a claim item was approved or denied. It also indicates if a claim was adjusted. Language options include:

Yes

NO

Yes - **adjusted**

NO - **adjusted**

See Exhibit 2.8 for an example of an adjusted claim.

Amount Provider Charged

This column lists the amount of the charge the provider submitted. This figure may be up to eight digits long, including cents:

${###,###.##}

Insert a comma between the thousands' digit and the hundreds' digit of any four-figure or higher amount. Use $0.00 for zero**.**

Medicare-Approved Amount

This column lists the amount that Medicare allows for the service. This figure may be up to eight digits long, including cents:

${###,###.##}

Insert a comma between the thousands' digit and the hundreds' digit of any four-figure or higher amount. Use $0.00 for zero**.**

Medicare Paid You

This column lists the amount that Medicare paid the beneficiary toward the unassigned claim. This figure may be up to eight digits long, including cents:

${###,###.##}

Insert a comma between the thousands' digit and the hundreds' digit of any four-figure or higher amount. Use $0.00 for zero**.**

Maximum You May Be Billed

This column lists the beneficiary's total liability for the claim item. This figure may be up to eight digits long, including cents:

${###,###.##}

Insert a comma between the thousands' digit and the hundreds' digit of any four-figure or higher amount. Use $0.00 for zero**.**

See Notes Below

This column displays indicators that refer to explanations listed in the Notes for Claims Above subsection, which is printed at the bottom of the page when applicable.

Note indicators use capital letters, and indicators should be printed in alphabetic order, with a comma without space preceding each indicator after the first indicator for a line (e.g., A,B,C). Show no more than three alphabetic indicators per line. If more than three indicators are required, print on the next line below. A maximum of *nine* notes are allowed per service, so no more than *nine* note indicators should ever be listed here.

If the same message is needed for more than one claim or service line on a single page, print the same alphabetic code each time the message is required on that page. If, however, that same message is required on a following page, use a new indicator letter in the appropriate alphabetical order for that page.

Continue alphabetical order from page to page - do not restart the alphabet on each new page.

If more than 26 alphabetic codes are needed, begin using lowercase alphabetic codes (e.g., a,b,c). If more than 52 alphabetic codes are needed, repeat using capital letters.

Multiple Dates and/or Providers Subtitles

If a single Part B claim includes services provided on multiple dates, or provided by individually named providers, or both, then a dynamic date, provider, or date and provider subtitle should be introduced into the claim body, separating the individual claim items into clusters by date, provider, or date and provider. See Exhibit 2.6 for examples of claims with these various options for dynamic column subtitles.

Any subtitle should run across the full width of the claim columns, but the dynamic content is placed only in the first column.

In the case of a dynamic date subtitle, the preference is for each individual day to be given a separate subtitle, with claim items grouped just by that one date. The date subtitle clusters should then be listed chronologically, earliest first. If the claims data for an item only includes a range, then that claim item can be listed under a range header, which should be sorted chronologically by its start date. The date format follows the same conventions outlined above in the Claim Header subsection.

In the case of separate providers listed for individual items within a claim, each provider should be named in a different subtitle, with associated claim items for that provider grouped underneath. The provider clusters should be listed alphabetically by provider last name or facility name. The provider format follows the same conventions outlined above in the Claim Header subsection.

If a single claim includes items with both different dates and different clusters, the items should be grouped first by date, then by provider, with each listed on a separate line.

CONTENT

{Service description} ({Revenue Code})

Yes [or] **NO** [or] Yes - **adjusted** [or] **NO** - **adjusted**

${###,###.##}

${###,###.##}

${###,###.##}

${###,###.##}

{NOTE INDICATOR(S)}

PART B ASSIGNED SPECIFICATIONS

See Exhibit 1.5 for layout reference.

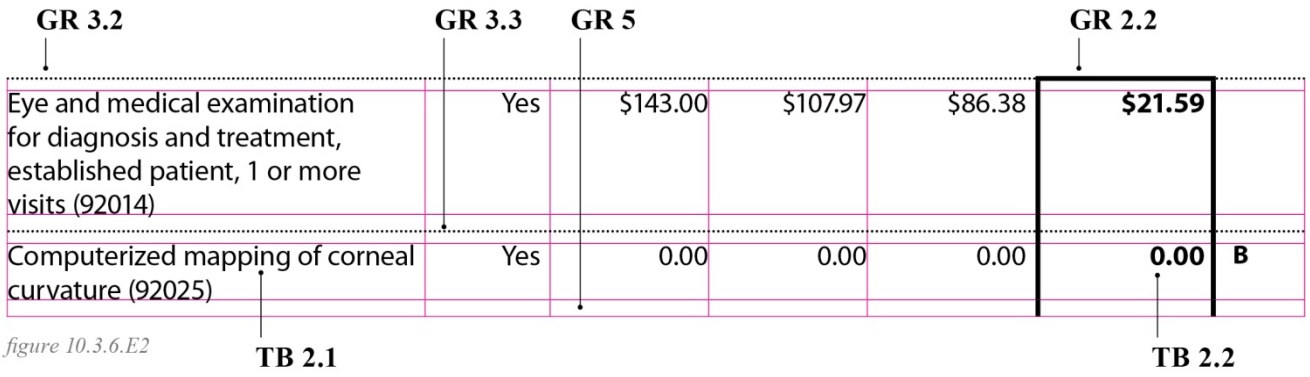


figure 10.3.6.E2

FORMATTING

[GR 3.2] dotted line [GR 2.2] black rule

Column 1: [TB 2.1] service description, left aligned

Column 2: [TB 2.1] approved status, right aligned

Column 3: [TB 2.1] amount charged, right aligned

Column 4: [TB 2.1] amount approved, right aligned

Column 5: [TB 2.1] amount paid, right aligned, with 5 point indent

Column 6: [TB 2.2] maximum, right aligned, with 3.5 point indent

Column 7: [TB 2.2] note indicator, left aligned, with 5 point indent

The first line of column 6 will have [GR 2.2] on top and sides of the column. Subsequent lines will have [GR 2.2] on the sides only.

NOTE: When there is more than one service line, format [GR 3.3] dotted rule 3 in between the claim lines.

NOTE: For multiple dates and/or providers subtitles, insert the following before corresponding service lines(s):

[TH 5.1] date or provider information

[GR 3.3] dotted rule 3

See Exhibit 2.6 for examples of claims with these various options for dynamic column subtitles.

DYNAMIC RULES

The content in this section is entirely dynamically generated. It includes the following content elements:

Service Provided & Billing Code

This column should contain the description of the service provided and, in parentheses, the billing code for that service, followed by any modifier code and modifier descriptor.

Use the most recent consumer-friendly HCPCS (level 1)/CPT service descriptions, which can be found on the CMS systems mainframe or at https://www.cms.gov/Medicare/Coding/MedHCPCSGenInfo/index.html. The service description has a maximum of 100 characters. Suppress the rest if the description runs longer.

For the revenue code, use standard abbreviations provided by the National Uniform Billing Committee without changing the wording.

The revenue code may have up to four 2-character modifier codes, followed by 2 modifier descriptors. The modifier descriptors have a maximum of 30 characters.

If a procedure code modifier is present in any of the four modifier fields on the claim detail, the following Modifier Descriptors will print:

Modifier	English	Spanish
80, 81, 82	Assistant surgeon	Cirujano asistente
26	Professional charge	Cargo profesional
TC	Technical charge	Cargo técnico
RR	Rental	Renta
NR	Purchase	Compra
RP	Replacement/repair	Reemplazo/arreglo
55	Care after operation	Cuidado despues de operación
56	Care before operation	Cuidado antes de la operación
MS	Maintenance/service	Mantenimiento/servicio
SG	Surgery Center fee	Cargo del centro de cirugía

NOTE: When a specialty 59 provider submits a claim with modifiers RP, NR, RR and SG the Modifier Descriptors on the Medicare Summary Notice will be suppressed as they are not applicable to the services provided.

Keep current practice of listing modifier code and modifier descriptors.

Service Approved?

This column indicates if a claim item was approved or denied. It also indicates if a claim was adjusted. Language options include:

Yes

NO

Yes - **adjusted**

NO - adjusted

See Exhibit 2.8 for an example of an adjusted claim.

Amount Provider Charged

This column lists the amount of the charge the provider submitted. This figure may be up to eight digits long, including cents:

${###,###.##}

Insert a comma between the thousands' digit and the hundreds' digit of any four-figure or higher amount. Use $0.00 for zero**.**

Medicare-Approved Amount

This column lists the amount that Medicare allows for the service. This figure may be up to eight digits long, including cents:

${###,###.##}

Insert a comma between the thousands' digit and the hundreds' digit of any four-figure or higher amount. Use $0.00 for zero**.**

Amount Medicare Paid

This column lists the amount that Medicare paid toward the claim. This figure may be up to eight digits long, including cents:

${###,###.##}

Insert a comma between the thousands' digit and the hundreds' digit of any four-figure or higher amount. Use $0.00 for zero**.**

Maximum You May Be Billed

This column lists the beneficiary's total liability for the claim item. This figure may be up to eight digits long, including cents:

${###,###.##}

Insert a comma between the thousands' digit and the hundreds' digit of any four-figure or higher amount. Use $0.00 for zero**.**

See Notes Below

This column displays indicators that refer to explanations listed in the Notes for Claims Above subsection, which is printed at the bottom of the page when applicable.

Note indicators use capital letters, and indicators should be printed in alphabetic order, with a comma without space preceding each indicator after the first indicator for a line (e.g., A,B,C). Show no more than three alphabetic indicators per line. If more than three indicators are required, print on the next line below. A maximum of five notes are allowed per service, so no more than five note indicators should ever be listed here.

If the same message is needed for more than one claim or service line on a single page, print the same alphabetic code each time the message is required on that page. If, however, that same message is required on a following page, use a new indicator letter in the appropriate alphabetical order for that page.

Continue alphabetical order from page to page - do not restart the alphabet on each new page.

If more than 26 alphabetic codes are needed, begin using lowercase alphabetic codes (e.g., a,b,c). If more than 52 alphabetic codes are needed, repeat using capital letters.

Multiple Dates and/or Providers Subtitles

If a single Part B claim includes services provided on multiple dates, or provided by individually named providers, or both, then a dynamic date, provider, or date and provider subtitle should be introduced into the claim body, separating the individual claim items into clusters by date, provider, or date and provider. See Exhibit 2.6 for examples of claims with these various options for dynamic column subtitles.

Any subtitle should run across the full width of the claim columns, but the dynamic content is placed only in the first column.

In the case of a dynamic date subtitle, the preference is for each individual day to be given a separate subtitle, with claim items grouped just by that one date. The date subtitle clusters should then be listed chronologically, earliest first. If the claims data for an item only includes a range, then that claim item can be listed under a range header, which should be sorted chronologically by its start date. The date format follows the same conventions outlined above in the Claim Header subsection.

In the case of separate providers listed for individual items within a claim, each provider should be named in a different subtitle, with associated claim items for that provider grouped underneath. The provider clusters should be listed alphabetically by provider last name or facility name. The provider format follows the same conventions outlined above in the Claim Header subsection.

If a single claim includes items with both different dates and different clusters, the items should be grouped first by date, then by provider, with each listed on a separate line.

CONTENT

{Service description} ({Revenue Code})

Yes [or] **NO** [or] Yes - **adjusted** [or] **NO** - **adjusted**

${###,###.##}

${###,###.##}

${###,###.##}

${###,###.##}

{NOTE INDICATOR(S)}

PART B UNASSIGNED SPECIFICATIONS

See figure 10.3.6.E2 or Exhibit 1.7 for layout reference.

FORMATTING

[GR 3.2] dotted line [GR 2.2] black rule

Column 1: [TB 2.1] service description, left aligned

Column 2: [TB 2.1] approved status, right aligned

Column 3: [TB 2.1] amount charged, right aligned

Column 4: [TB 2.1] amount approved, right aligned

Column 5: [TB 2.1] amount paid, right aligned, with 5 point indent

Column 6: [TB 2.2] maximum, right aligned, with 3.5 point indent

Column 7: [TB 2.2] note indicator, left aligned, with 5 point indent

The first line of column 6 will have [GR 2.2] on top and sides of the column. Subsequent lines will have [GR 2.2] on the sides only.

NOTE: When there is more than one service line, format [GR 3.3] dotted rule 3 in between the claim lines.

NOTE: For multiple dates and/or providers subtitles, insert the following before corresponding service lines(s):

[TH 5.1] date or provider information

[GR 3.3] dotted rule 3

See Exhibit 2.6 for examples of claims with these various options for dynamic column subtitles.

DYNAMIC RULES

The content in this section is entirely dynamically generated. It includes the following content elements:

Service Provided & Billing Code

This column should contain the description of the service provided and, in parentheses, the billing code for that service, followed by any modifier code and modifier descriptor.

Use the most recent consumer-friendly HCPCS (level 1)/CPT service descriptions, which can be found on the CMS systems mainframe or at https://www.cms.gov/Medicare/Coding/MedHCPCSGenInfo/index.html. The service description has a maximum of 100 characters. Suppress the rest if the description runs longer.

For the revenue code, use standard abbreviations provided by the National Uniform Billing Committee without changing the wording.

The revenue code may have up to four 2-character modifier codes, followed by 2 modifier descriptors. The modifier descriptors have a maximum of 30 characters.

If a procedure code modifier is present in any of the four modifier fields on the claim detail, the following Modifier Descriptors will print:

Modifier	English	Spanish
80, 81, 82	Assistant surgeon	Cirujano asistente
26	Professional charge	Cargo profesional
TC	Technical charge	Cargo técnico
RR	Rental	Renta
NR	Purchase	Compra
RP	Replacement/repair	Reemplazo/arreglo
55	Care after operation	Cuidado despues de operación
56	Care before operation	Cuidado antes de la operación
MS	Maintenance/service	Mantenimiento/servicio
SG	Surgery Center fee	Cargo del centro de cirugía

NOTE: When a specialty 59 provider submits a claim with modifiers RP, NR, RR and SG the Modifier Descriptors on the Medicare Summary Notice will be suppressed as they are not applicable to the services provided.

Keep current practice of listing modifier code and modifier descriptors.

Service Approved?

This column indicates if a claim item was approved or denied. It also indicates if a claim was adjusted. Language options include:

Yes

NO

Yes - **adjusted**

NO - adjusted

See Exhibit 2.8 for an example of an adjusted claim.

Amount Provider Charged

This column lists the amount of the charge the provider submitted. This figure may be up to eight digits long, including cents:

${###,###.##}

Insert a comma between the thousands' digit and the hundreds' digit of any four-figure or higher amount. Use $0.00 for zero**.**

Medicare-Approved Amount

This column lists the amount that Medicare allows for the service. This figure may be up to eight digits long, including cents:

${###,###.##}

Insert a comma between the thousands' digit and the hundreds' digit of any four-figure or higher amount. Use $0.00 for zero**.**

Medicare Paid You

This column lists the amount that Medicare paid the beneficiary toward the unassigned claim. This figure may be up to eight digits long, including cents:

${###,###.##}

Insert a comma between the thousands' digit and the hundreds' digit of any four-figure or higher amount. Use $0.00 for zero**.**

Maximum You May Be Billed

This column lists the beneficiary's total liability for the claim item. This figure may be up to eight digits long, including cents:

${###,###.##}

Insert a comma between the thousands' digit and the hundreds' digit of any four-figure or higher amount. Use $0.00 for zero**.**

See Notes Below

This column displays indicators that refer to explanations listed in the Notes for Claims Above subsection, which is printed at the bottom of the page when applicable.

Note indicators use capital letters, and indicators should be printed in alphabetic order, with a comma without space preceding each indicator after the first indicator for a line (e.g., A,B,C). Show no more than three alphabetic indicators per line. If more than three indicators are required, print on the next line below. A maximum of five notes are allowed per service, so no more than five note indicators should ever be listed here.

If the same message is needed for more than one claim or service line on a single page, print the same alphabetic code each time the message is required on that page. If, however, that same message is required on a following page, use a new indicator letter in the appropriate alphabetical order for that page.

Continue alphabetical order from page to page - do not restart the alphabet on each new page.

If more than 26 alphabetic codes are needed, begin using lowercase alphabetic codes (e.g., a,b,c). If more than 52 alphabetic codes are needed, repeat using capital letters.

Multiple Dates and/or Providers Subtitles

If a single Part B claim includes services provided on multiple dates, or provided by individually named providers, or both, then a dynamic date, provider, or date and provider subtitle should be introduced into the claim body, separating the individual claim items into clusters by date, provider, or date and provider. See Exhibit 2.6 for examples of claims with these various options for dynamic column subtitles.

Any subtitle should run across the full width of the claim columns, but the dynamic content is placed only in the first column.

In the case of a dynamic date subtitle, the preference is for each individual day to be given a separate subtitle, with claim items grouped just by that one date. The date subtitle clusters should then be listed chronologically, earliest first. If the claims data for an item only includes a range, then that claim item can be listed under a range header, which should be sorted chronologically by its start date. The date format follows the same conventions outlined above in the Claim Header subsection.

In the case of separate providers listed for individual items within a claim, each provider should be named in a different subtitle, with associated claim items for that provider grouped underneath. The provider clusters should be listed alphabetically by provider last name or facility name. The provider format follows the same conventions outlined above in the Claim Header subsection.

If a single claim includes items with both different dates and different clusters, the items should be grouped first by date, then by provider, with each listed on a separate line.

CONTENT

{Service description} ({Revenue Code})

Yes [or] **NO** [or] Yes - **adjusted** [or] **NO - adjusted**

${###,###.##}

${###,###.##}

${###,###.##}

${###,###.##}

{NOTE INDICATOR(S)}

'B OF A' SPECIFICATIONS

See Exhibit 1.2 for layout reference.

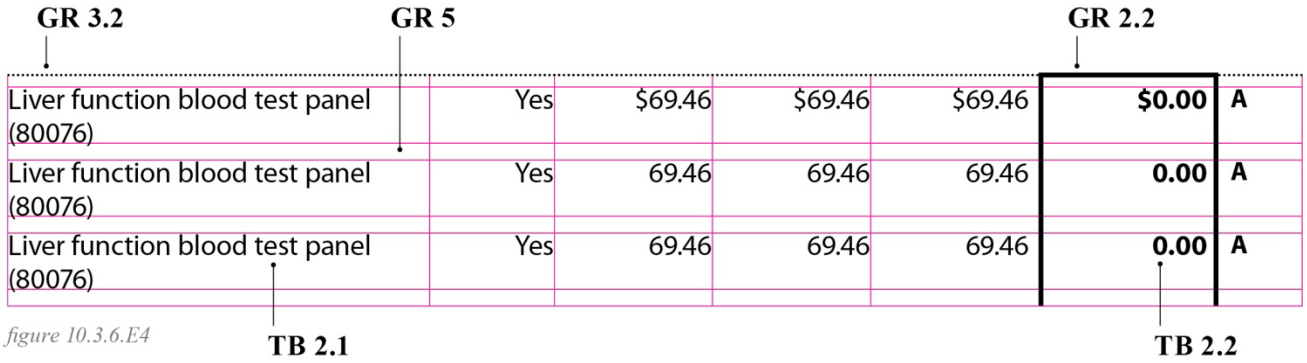


figure 10.3.6.E4

FORMATTING

[GR 3.2] dotted line [GR 2.2] black rule

Column 1: [TB 2.1] service description, left aligned

Column 2: [TB 2.1] approved status, right aligned

Column 3: [TB 2.1] amount charged, right aligned

Column 4: [TB 2.1] amount approved t, right aligned

Column 5: [TB 2.1] amount paid, right aligned, with 5 point indent

Column 6: [TB 2.2] maximum, right aligned, with 3.5 point indent

Column 7: [TB 2.2] note indicator, left aligned, with 5 point indent

The first line of column 6 will have [GR 2.2] on top and sides of the column. Subsequent lines will have [GR 2.2] on the sides only.

NOTE: When there is more than one service line, insert [GR 5] 7 point space in between the claim lines. There is no dotted line in between.

DYNAMIC RULES

The content in this section is entirely dynamically generated. It includes the following content elements:

Service Provided & Billing Code

This column should contain the description of the service provided and, in parentheses, the billing code for that service, followed by any modifier code and modifier descriptor.

Use the most recent consumer-friendly HCPCS (level 1)/CPT service descriptions, which can be found on the CMS systems mainframe or at https://www.cms.gov/Medicare/Coding/MedHCPCSGenInfo/index.html. The service description has a maximum of 100 characters. Suppress the rest if the description runs longer.

For the revenue code, use standard abbreviations provided by the National Uniform Billing Committee without changing the wording.

Service Approved?

This column indicates if a claim item was approved or denied. It also indicates if a claim was adjusted. Language options include:

Yes

NO

Yes - **adjusted**

NO - adjusted

See Exhibit 2.8 for an example of an adjusted claim (this example shows a Part B MSN, but it can be understood to also apply to other members of the extended family).

Amount Facility Charged

This column lists the amount of the charge the outpatient facility submitted. This figure may be up to eight digits long, including cents:

${###,###.##}

Insert a comma between the thousands' digit and the hundreds' digit of any four-figure or higher amount. Use $0.00 for zero**.**

Medicare-Approved Amount

This column lists the amount that Medicare allows for the service. This figure may be up to eight digits long, including cents:

${###,###.##}

Insert a comma between the thousands' digit and the hundreds' digit of any four-figure or higher amount. Use $0.00 for zero**.**

Amount Medicare Paid

This column lists the amount that Medicare paid toward the claim. This figure may be up to eight digits long, including cents:

${###,###.##}

Insert a comma between the thousands' digit and the hundreds' digit of any four-figure or higher amount. Use $0.00 for zero**.**

Maximum You May Be Billed

This column lists the beneficiary's total liability for the claim item. This figure may be up to eight digits long, including cents:

${###,###.##}

Insert a comma between the thousands' digit and the hundreds' digit of any four-figure or higher amount. Use $0.00 for zero**.**

See Notes Below

This column displays indicators that refer to explanations listed in the Notes for Claims Above subsection, which is printed at the bottom of the page when applicable.

Note indicators use capital letters, and indicators should be printed in alphabetic order, with a comma without space preceding each indicator after the first indicator for a line (e.g., A,B,C). Show no more than three alphabetic indicators per line. If more than three indicators are required, print on the next line below. A maximum of *nine* notes are allowed per service, so no more than *nine* note indicators should ever be listed here.

If the same message is needed for more than one claim or service line on a single page, print the same alphabetic code each time the message is required on that page. If, however, that same message is required on a following page, use a new indicator letter in the appropriate alphabetical order for that page.

Continue alphabetical order from page to page - do not restart the alphabet on each new page.

If more than 26 alphabetic codes are needed, begin using lowercase alphabetic codes (e.g., a,b,c). If more than 52 alphabetic codes are needed, repeat using capital letters.

CONTENT

{Service description} ({Revenue Code})

Yes [or] **NO** [or] Yes - **adjusted** [or] **NO** - **adjusted**

${###,###.##}

${###,###.##}

${###,###.##}

${###,###.##}

{NOTE INDICATOR(S)}

DME ASSIGNED SPECIFICATIONS

See Exhibit 1.7 for layout reference.

FORMATTING

[GR 3.2] dotted line [GR 2.2] black rule

Column 1: [TB 2.1] quantity and item/service description, left aligned

Column 2: [TB 2.1] approved status, right aligned

Column 3: [TB 2.1] amount charged, right aligned

Column 4: [TB 2.1] amount approved, right aligned

Column 5: [TB 2.1] amount paid, right aligned, with 5 point indent

Column 6: [TB 2.2] maximum, right aligned, with 3.5 point indent

Column 7: [TB 2.2] note indicator, left aligned, with 5 point indent

The first line of column 6 will have [GR 2.2] on top and sides of the column. Subsequent lines will have [GR 2.2] on the sides only.

NOTE: When there is more than one service line, insert [GR 5] 7 point space in between the claim lines. There is no dotted line in between.

NOTE: For multiple dates subtitle, insert the following before corresponding service lines(s):

[TH 5.1] date or provider information

[GR 5] space after

See Exhibit 2.6 for examples of claims with these various options for dynamic column subtitles.

DYNAMIC RULES

The content in this section is entirely dynamically generated. It includes the following content elements:

Quantity, Item/Service Provided & Billing Code

This column should contain the quantity or number of services provided, the description of the service provided and, in parentheses, the billing code for that service, followed by any modifier code and modifier descriptor.

Whenever possible, the number of services provided should be expressed as a whole number, without decimal point or trailing zero (e.g. 2, not 2.0). Only if the number is a partial quantity, then include a decimal point and a fractional amount, rounded to the nearest tenth (e.g. 2.5, not 2.49).

Use the most recent consumer-friendly HCPCS (level 1)/CPT service descriptions, which can be found on the CMS systems mainframe or at https://www.cms.gov/Medicare/Coding/MedHCPCSGenInfo/index.html. The service description has a maximum of 100 characters. Suppress the rest if the description runs longer.

Item/Service Approved?

This column indicates if a claim item or service was approved or denied. It also indicates if a claim was adjusted. Language options include:

Yes

NO

Yes - **adjusted**

NO - adjusted

See Exhibit 2.8 for an example of an adjusted claim (this example shows a Part B MSN, but it can be understood to also apply to other members of the extended family).

Amount Provider Charged

This column lists the amount of the charge the provider submitted. This figure may be up to eight digits long, including cents:

${###,###.##}

Insert a comma between the thousands' digit and the hundreds' digit of any four-figure or higher amount. Use $0.00 for zero**.**

Medicare-Approved Amount

This column lists the amount that Medicare allows for the service. This figure may be up to eight digits long, including cents:

${###,###.##}

Insert a comma between the thousands' digit and the hundreds' digit of any four-figure or higher amount. Use $0.00 for zero**.**

Amount Medicare Paid

This column lists the amount that Medicare paid toward the claim. This figure may be up to eight digits long, including cents:

${###,###.##}

Insert a comma between the thousands' digit and the hundreds' digit of any four-figure or higher amount. Use $0.00 for zero**.**

Maximum You May Be Billed

The first line of claim will have [GR 2.2] on top and sides of the column. Subsequent lines will have [GR 2.2] on the sides only.

This column lists the beneficiary's total liability for the claim item. This figure may be up to eight digits long, including cents:

${###,###.##}

Insert a comma between the thousands' digit and the hundreds' digit of any four-figure or higher amount. Use $0.00 for zero**.**

See Notes Below

This column displays indicators that refer to explanations listed in the Notes for Claims Above subsection, which is printed at the bottom of the page when applicable.

Note indicators use capital letters, and indicators should be printed in alphabetic order, with a comma without space preceding each indicator after the first indicator for a line (e.g., A,B,C). Show no more than three alphabetic indicators per line. If more than three indicators are required, print on the next line below. A maximum of five notes are allowed per service, so no more than five note indicators should ever be listed here.

If the same message is needed for more than one claim or service line on a single page, print the same alphabetic code each time the message is required on that page. If, however, that same message is required on a following page, use a new indicator letter in the appropriate alphabetical order for that page.

Continue alphabetical order from page to page - do not restart the alphabet on each new page.

If more than 26 alphabetic codes are needed, begin using lowercase alphabetic codes (e.g., a,b,c). If more than 52 alphabetic codes are needed, repeat using capital letters.

Multiple Dates Subtitles

If a single claim includes services provided on multiple dates, then a dynamic date subtitle should be introduced into the claim body, separating the individual claim items into clusters by date. See Exhibit 2.6 for examples of claims with these various options for dynamic column subtitles.

Any subtitle should run across the full width of the claim columns, but the dynamic content is placed only in the first column.

The preference is for each individual day to be given a separate subtitle, with claim items grouped just by that one date. The date subtitle clusters should then be listed chronologically, earliest first. If the claims data for an item only includes a range, then that claim item can be listed under a range header, which should be sorted chronologically by its start date. The date format follows the same conventions outlined above in the Claim Header subsection.

CONTENT

{Item or Service description} ({Revenue Code})

Yes [or] **NO** [or] Yes - **adjusted** [or] **NO** - **adjusted**

${###,###.##}

${###,###.##}

${###,###.##}

${###,###.##}

{NOTE INDICATOR(S)}

DME UNASSIGNED SPECIFICATIONS

See Exhibit 1.8 for layout reference.

FORMATTING

[GR 3.2] dotted line [GR 2.2] black rule

Column 1: [TB 2.1] quantity and item/service description, left aligned

Column 2: [TB 2.1] approved status, right aligned

Column 3: [TB 2.1] amount charged, right aligned

Column 4: [TB 2.1] amount approved, right aligned

Column 5: [TB 2.1] amount paid, right aligned, with 5 point indent

Column 6: [TB 2.2] maximum, right aligned, with 3.5 point indent

Column 7: [TB 2.2] note indicator, left aligned, with 5 point indent

The first line of column 6 will have [GR 2.2] on top and sides of the column. Subsequent lines will have [GR 2.2] on the sides only.

NOTE: When there is more than one service line, insert [GR 5] 7 point space in between the claim lines. There is no dotted line in between.

NOTE: For multiple dates subtitle, insert the following before corresponding service lines(s):

[TH 5.1] date or provider information

[GR 5] space after

See Exhibit 2.6 for examples of claims with these various options for dynamic column subtitles.

DYNAMIC RULES

The content in this section is entirely dynamically generated. It includes the following content elements:

Quantity, Item/Service Provided & Billing Code

This column should contain the quantity or number of services provided, the description of the service provided and, in parentheses, the billing code for that service, followed by any modifier code and modifier descriptor.

Whenever possible, the number of services provided should be expressed as a whole number, without decimal point or trailing zero (e.g. 2, not 2.0). Only if the number is a partial quantity, then include a decimal point and a fractional amount, rounded to the nearest tenth (e.g. 2.5, not 2.49).

Use the most recent consumer-friendly HCPCS (level 1)/CPT service descriptions, the long descriptions for level 2, which can be found on the CMS systems mainframe or at https://www.cms.gov/Medicare/Coding/MedHCPCSGenInfo/index.html. The service description has a maximum of 100 characters. Suppress the rest if the description runs longer.

Item/Service Approved?

This column indicates if a claim item was approved or denied. It also indicates if a claim was adjusted. Language options include:

Yes

NO

Yes - **adjusted**

NO - adjusted

See Exhibit 2.8 for an example of an adjusted claim (this example shows a Part B MSN, but it can be understood to also apply to other members of the extended family).

Amount Provider Charged

This column lists the amount of the charge the provider submitted. This figure may be up to eight digits long, including cents:

${###,###.##}

Insert a comma between the thousands' digit and the hundreds' digit of any four-figure or higher amount. Use $0.00 for zero**.**

Medicare-Approved Amount

This column lists the amount that Medicare allows for the service. This figure may be up to eight digits long, including cents:

${###,###.##}

Insert a comma between the thousands' digit and the hundreds' digit of any four-figure or higher amount. Use $0.00 for zero**.**

Medicare Paid You

This column lists the amount that Medicare paid the beneficiary toward the unassigned claim. This figure may be up to eight digits long, including cents:

${###,###.##}

Insert a comma between the thousands' digit and the hundreds' digit of any four-figure or higher amount. Use $0.00 for zero**.**

Maximum You May Be Billed

This column lists the beneficiary's total liability for the claim item. This figure may be up to eight digits long, including cents:

${###,###.##}

Insert a comma between the thousands' digit and the hundreds' digit of any four-figure or higher amount. Use $0.00 for zero**.**

See Notes Below

This column displays indicators that refer to explanations listed in the Notes for Claims Above subsection, which is printed at the bottom of the page when applicable.

Note indicators use capital letters, and indicators should be printed in alphabetic order, with a comma without space preceding each indicator after the first indicator for a line (e.g., A,B,C). Show no more than three alphabetic indicators per line. If more than three indicators are required, print on the next line below. A maximum of five notes are allowed per service, so no more than five note indicators should ever be listed here.

If the same message is needed for more than one claim or service line on a single page, print the same alphabetic code each time the message is required on that page. If, however, that same message is required on a following page, use a new indicator letter in the appropriate alphabetical order for that page.

Continue alphabetical order from page to page - do not restart the alphabet on each new page.

If more than 26 alphabetic codes are needed, begin using lowercase alphabetic codes (e.g., a,b,c). If more than 52 alphabetic codes are needed, repeat using capital letters.

Multiple Dates Subtitles

If a single claim includes services provided on multiple dates, then a dynamic date subtitle should be introduced into the claim body, separating the individual claim items into clusters by date. See Exhibit 2.6 for examples of claims with these various options for dynamic column subtitles.

Any subtitle should run across the full width of the claim columns, but the dynamic content is placed only in the first column.

The preference is for each individual day to be given a separate subtitle, with claim items grouped just by that one date. The date subtitle clusters should then be listed chronologically, earliest first. If the claims data for an item only includes a range, then that claim item can be listed under a range header, which should be sorted chronologically by its start date. The date format follows the same conventions outlined above in the Claim Header subsection.

CONTENT

{Service description} ({Revenue Code})

Yes [or] **NO** [or] Yes - **adjusted** [or] **NO - adjusted**

${###,###.##}

${###,###.##}

${###,###.##}

${###,###.##}

{NOTE INDICATOR(S)}

F. Claim Total Line

The Claim Total Line subsection is the default subsection to follow the Claim Content Lines subsection. If a single claim is splitting across pages, suppress this subsection and replace with the continuation footer instead. Each claim will have only one instance of claim total line. Reference section I. Breaking Claims - Continuation Footer for specifications regarding the alternate option.

POSITION

This subsection is directly after the claim content lines subsection with fixed content area. It is full-page or 540 points in width and 21 points in height. There are six columns. The five right-most columns correspond to the columns in the Claims Content Lines subsection; the first column, containing the claim number, is equivalent in width to the first and second columns in the Claims Content Lines subsection. All content is to be top aligned.

PART A INPATIENT SPECIFICATIONS

See Exhibit 1.1 for layout reference.

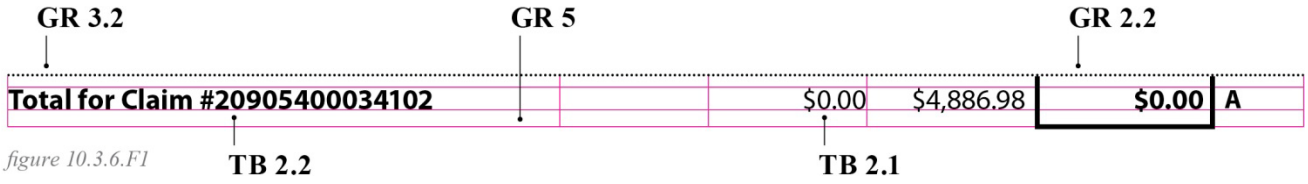


figure 10.3.6.F1

FORMATTING

[GR 3.2] dotted rule [GR 2.2] black rule

Columns 1-2: [TB 2.2] claim number, left aligned

Column 3: (blank)

Column 4: [TB 2.1] non-covered total, right aligned

Column 5: [TB 2.1] amount paid total, right aligned, with 5 point indent

Column 6: [TB 2.2] maximum total, right aligned, with 3.5 point indent

Column 7: [TB 2.2] note indicator, left aligned, with 5 point indent

NOTE: The first line of column 6 will have [GR 2.2] on both sides and the bottom of the column as a highlight.

DYNAMIC RULES

The content in this section is nearly entirely dynamically generated. It includes the following content elements:

Claim Number

This column lists the control number for the claim, preceded by a static text phrase:

Total for Claim #{Claim Number}

Insert dashes in the control number as indicated by the system.

Total of Non-Covered Charges

This column lists the sum of the line-item amounts above for any claim charges that Medicare did not cover. This figure may be up to eight digits long, including cents:

${###,###.##}

Insert a comma between the thousands' digit and the hundreds' digit of any four-figure or higher amount. Use $0.00 for zero**.**

Total Amount Medicare Paid

This column lists the sum of the line-item amounts above that Medicare paid toward the claim. This figure may be up to eight digits long, including cents:

${###,###.##}

Insert a comma between the thousands' digit and the hundreds' digit of any four-figure or higher amount. Use $0.00 for zero. If the field has more than 11 characters, replace with "see note" and list the amount in the notes.

Total Maximum You May Be Billed

This column lists the sum of the line-item amounts above showing the beneficiary's liability for the claim item. This figure may be up to eight digits long, including cents:

${###,###.##}

Insert a comma between the thousands' digit and the hundreds' digit of any four-figure or higher amount. Use $0.00 for zero. If the field has more than 11 characters, replace with "see note" and list the amount in the notes.

See Notes Below

This column displays indicators that refer to explanations listed in the "Notes for Claims Above" subsection, which is printed at the bottom of the page when applicable. See the description in the "Claim Content Lines" specifications for detailed instructions. A maximum of six notes are allowed per total line.

CONTENT

Total for Claim #{Claim Number}

${###,###.##}

${###,###.##}

${###,###.##}

{NOTE INDICATOR(S)}

HOSPICE AND HOME HEALTH SPECIFICATIONS

See Exhibit 1.3 and Exhibit 1.4 for layout reference.

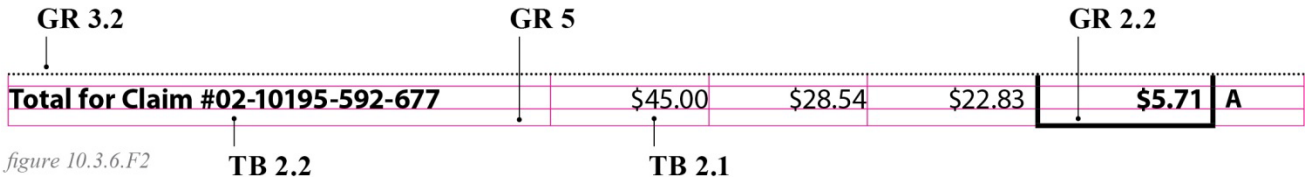


figure 10.3.6.F2

FORMATTING

[GR 3.2] dotted rule [GR 2.2] black rule

Columns 1-2: [TB 2.2] claim number, left aligned

Column 3: [TB 2.1] amount charged total, right aligned

Column 4: [TB 2.1] approved total, right aligned

Column 5: [TB 2.1] amount paid total, right aligned, with 5 point indent

Column 6: [TB 2.2] maximum total, right aligned, with 3.5 point indent

Column 7: [TB 2.2] note indicator, left aligned, with 5 point indent

NOTE: The first line of column 6 will have [GR 2.2] on top, bottom, and both sides of the column as a highlight.

DYNAMIC RULES

The content in this section is nearly entirely dynamically generated. It includes the following content elements:

Claim Number

This column lists the claim number for the claim, preceded by a static text phrase:

Total for Claim #{Claim Number}

Insert dashes in the claim number as indicated by the system.

Total Amount Provider Charged

This column lists the sum of the line-item amounts above of the charges the provider submitted. This figure may be up to eight digits long, including cents:

${###,###.##}

Insert a comma between the thousands' digit and the hundreds' digit of any four-figure or higher amount. Use $0.00 for zero. If the field has more than 11 characters, replace with "see note" and list the amount in the notes.

Total Medicare-Approved Amount

This column lists the sum of the line-items amounts above for what Medicare allows for the service. This figure may be up to eight digits long, including cents:

${###,###.##}

Insert a comma between the thousands' digit and the hundreds' digit of any four-figure or higher amount. Use $0.00 for zero. If the field has more than 11 characters, replace with "see note" and list the amount in the notes.

Total Amount Medicare Paid

This column lists the sum of the line-item amounts above for what Medicare paid toward the claim. This figure may be up to eight digits long, including cents:

${###,###.##}

Insert a comma between the thousands' digit and the hundreds' digit of any four-figure or higher amount. Use $0.00 for zero. If the field has more than 11 characters, replace with "see note" and list the amount in the notes.

Total Maximum You May Be Billed

This column lists the sum of the line-item amounts above showing the beneficiary's liability for the claim item. This figure may be up to eight digits long, including cents:

${###,###.##}

Insert a comma between the thousands' digit and the hundreds' digit of any four-figure or higher amount. Use $0.00 for zero. If the field has more than 11 characters, replace with "see note" and list the amount in the notes.

See Notes Below

This column displays indicators that refer to explanations listed in the "Notes for Claims Above" subsection, which is printed at the bottom of the page when applicable. See the description in the "Claim Content Lines" specifications for detailed instructions. A maximum of *nine* notes are allowed per total line.

CONTENT

Total for Claim #{Claim Number}

${###,###.##}

${###,###.##}

${###,###.##}

${###,###.##}

{NOTE INDICATOR(S)}

PART B ASSIGNED SPECIFICATIONS

See Figure 10.3.6.F2 and Exhibit 1.5 for layout reference.

FORMATTING

[GR 3.2] dotted rule [GR 2.2] black rule

Columns 1-2: [TB 2.2] claim number, left aligned

Column 3: [TB 2.1] amount charged total, right aligned

Column 4: [TB 2.1] approved total, right aligned

Column 5: [TB 2.1] amount paid total, right aligned, with 5 point indent

Column 6: [TB 2.2] maximum total, right aligned, with 3.5 point indent

Column 7: [TB 2.2] note indicator, left aligned, with 5 point indent

NOTE: The first line of column 6 will have [GR 2.2] on top, bottom, and both sides of the column as a highlight.

DYNAMIC RULES

The content in this section is nearly entirely dynamically generated. It includes the following content elements:

Claim Number

This column lists the claim number for the claim, preceded by a static text phrase:

Total for Claim #{Claim Number}

Insert dashes in the claim number as indicated by the system.

Total Amount Provider Charged

This column lists the sum of the line-item amounts above of the charges the provider submitted. This figure may be up to eight digits long, including cents:

${###,###.##}

Insert a comma between the thousands' digit and the hundreds' digit of any four-figure or higher amount. Use $0.00 for zero**.**

Total Medicare-Approved Amount

This column lists the sum of the line-items amounts above for what Medicare allows for the service. This figure may be up to eight digits long, including cents:

${###,###.##}

Insert a comma between the thousands' digit and the hundreds' digit of any four-figure or higher amount. Use $0.00 for zero**.**

Total Amount Medicare Paid

This column lists the sum of the line-item amounts above for what Medicare paid toward the claim. This figure may be up to eight digits long, including cents:

${###,###.##}

Insert a comma between the thousands' digit and the hundreds' digit of any four-figure or higher amount. Use $0.00 for zero**.**

Total Maximum You May Be Billed

This column lists the sum of the line-item amounts above showing the beneficiary's liability for the claim item. This figure may be up to eight digits long, including cents:

${###,###.##}

Insert a comma between the thousands' digit and the hundreds' digit of any four-figure or higher amount. Use $0.00 for zero**.**

See Notes Below

This column displays indicators that refer to explanations listed in the "Notes for Claims Above" subsection, which is printed at the bottom of the page when applicable. See the description in the "Claim Content Lines" specifications for detailed instructions. A maximum of six notes are allowed per total line.

CONTENT

Total for Claim #{Claim Number}

${###,###.##}

${###,###.##}

${###,###.##}

${###,###.##}

{NOTE INDICATOR(S)}

PART B UNASSIGNED SPECIFICATIONS

See figure 10.3.6.F2 or Exhibit 1.6 for layout reference.

FORMATTING

[GR 3.2] dotted rule [GR 2.2] black rule

Columns 1-2: [TB 2.2] claim number, left aligned

Column 3: [TB 2.1] amount charged total, right aligned

Column 4: [TB 2.1] approved total, right aligned

Column 5: [TB 2.1] amount paid total, right aligned, with 5 point indent

Column 6: [TB 2.2] maximum total, right aligned, with 3.5 point indent

Column 7: [TB 2.2] note indicator, left aligned, with 5 point indent

NOTE: The first line of column 6 will have [GR 2.2] on top, bottom, and both sides of the column as a highlight.

DYNAMIC RULES

The content in this section is nearly entirely dynamically generated. It includes the following content elements:

Claim Number

This column lists the claim number for the claim, preceded by a static text phrase:

Total for Claim #{Claim Number}

Insert dashes in the claim number as indicated by the system.

Total Amount Provider Charged

This column lists the sum of the line-item amounts above of the charges the provider submitted. This figure may be up to eight digits long, including cents:

${###,###.##}

Insert a comma between the thousands' digit and the hundreds' digit of any four-figure or higher amount. Use $0.00 for zero**.**

Total Medicare-Approved Amount

This column lists the sum of the line-items amounts above for what Medicare allows for the service. This figure may be up to eight digits long, including cents:

${###,###.##}

Insert a comma between the thousands' digit and the hundreds' digit of any four-figure or higher amount. Use $0.00 for zero**.**

Total Amount Medicare Paid You

This column lists the sum of the line-item amounts above for what Medicare paid the beneficiary toward the claim. This figure may be up to eight digits long, including cents:

${###,###.##}

Insert a comma between the thousands' digit and the hundreds' digit of any four-figure or higher amount. Use $0.00 for zero**.**

Total Maximum You May Be Billed

This column lists the sum of the line-item amounts above showing the beneficiary's liability for the claim item. This figure may be up to eight digits long, including cents:

${###,###.##}

Insert a comma between the thousands' digit and the hundreds' digit of any four-figure or higher amount. Use $0.00 for zero**.**

See Notes Below

This column displays indicators that refer to explanations listed in the "Notes for Claims Above" subsection, which is printed at the bottom of the page when applicable. See the description in the "Claim Content Lines" specifications for detailed instructions. A maximum of six notes are allowed per total line.

CONTENT

Total for Claim #{Claim Number}

${###,###.##}

${###,###.##}

${###,###.##}

${###,###.##}

{NOTE INDICATOR(S)}

'B OF A' SPECIFICATIONS

See Exhibit 1.2 for layout reference.

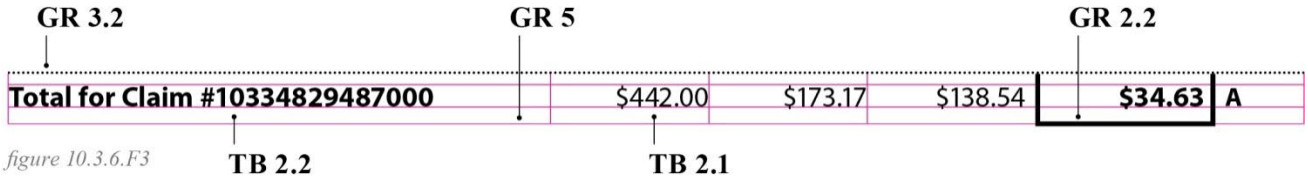


figure 10.3.6.F3

FORMATTING

[GR 3.2] dotted rule [GR 2.2] black rule

Columns 1-2: [TB 2.2] claim number, left aligned

Column 3: [TB 2.1] amount charged total, right aligned

Column 4: [TB 2.1] approved total, right aligned

Column 5: [TB 2.1] amount paid total, right aligned, with 5 point indent

Column 6: [TB 2.2] maximum total, right aligned, with 3.5 point indent

Column 7: [TB 2.2] note indicator, left aligned, with 5 point indent

NOTE: The first line of column 6 will have [GR 2.2] on top, bottom, and both sides of the column as a highlight.

DYNAMIC RULES

The content in this section is nearly entirely dynamically generated. It includes the following content elements:

Claim Number

This column lists the claim number for the claim, preceded by a static text phrase:

Total for Claim #{Claim Number}

Insert dashes in the claim number as indicated by the system.

Total Amount Facility Charged

This column lists the sum of the line-item amounts above of the charges the facility submitted. This figure may be up to eight digits long, including cents:

${###,###.##}

Insert a comma between the thousands' digit and the hundreds' digit of any four-figure or higher amount. Use $0.00 for zero. If the field has more than 11 characters, replace with "see note" and list the amount in the notes.

Total Medicare-Approved Amount

This column lists the sum of the line-items amounts above for what Medicare allows for the service. This figure may be up to eight digits long, including cents:

${###,###.##}

Insert a comma between the thousands' digit and the hundreds' digit of any four-figure or higher amount. Use $0.00 for zero. If the field has more than 11 characters, replace with "see note" and list the amount in the notes.

Total Amount Medicare Paid

This column lists the sum of the line-item amounts above for what Medicare paid toward the claim. This figure may be up to eight digits long, including cents:

${###,###.##}

Insert a comma between the thousands' digit and the hundreds' digit of any four-figure or higher amount. Use $0.00 for zero. If the field has more than 11 characters, replace with "see note" and list the amount in the notes.

Total Maximum You May Be Billed

This column lists the sum of the line-item amounts above showing the beneficiary's liability for the claim item. This figure may be up to eight digits long, including cents:

${###,###.##}

Insert a comma between the thousands' digit and the hundreds' digit of any four-figure or higher amount. Use $0.00 for zero. If the field has more than 11 characters, replace with "see note" and list the amount in the notes.

See Notes Below

This column displays indicators that refer to explanations listed in the "Notes for Claims Above" subsection, which is printed at the bottom of the page when applicable. See the description in the "Claim Content Lines" specifications for detailed instructions. A maximum of *nine* notes are allowed per total line.

CONTENT

Total for Claim #{Claim Number}

${###,###.##}

${###,###.##}

${###,###.##}

${###,###.##}

{NOTE INDICATOR(S)}

DME ASSIGNED SPECIFICATIONS

See figure 10.3.6.F3 or Exhibit 1.7 for layout reference.

FORMATTING

[GR 3.2] dotted rule [GR 2.2] black rule

Columns 1-2: [TB 2.2] claim number, left aligned

Column 3: [TB 2.1] amount charged total, right aligned

Column 4: [TB 2.1] approved total, right aligned

Column 5: [TB 2.1] amount paid total, right aligned, with 5 point indent

Column 6: [TB 2.2] maximum total, right aligned, with 3.5 point indent

Column 7: [TB 2.2] note indicator, left aligned, with 5 point indent

NOTE: The first line of column 6 will have [GR 2.2] on top, bottom, and both sides of the column as a highlight.

DYNAMIC RULES

The content in this section is nearly entirely dynamically generated. It includes the following content elements:

Claim Number

This column lists the claim number for the claim, preceded by a static text phrase:

Total for Claim #{Claim Number}

Insert dashes in the claim number as indicated by the system.

Total Amount Supplier Charged

This column lists the sum of the line-item amounts above of the charges the supplier submitted. This figure may be up to eight digits long, including cents:

${###,###.##}

Insert a comma between the thousands' digit and the hundreds' digit of any four-figure or higher amount. Use $0.00 for zero**.**

Total Medicare-Approved Amount

This column lists the sum of the line-items amounts above for what Medicare allows for the item or service. This figure may be up to eight digits long, including cents:

${###,###.##}

Insert a comma between the thousands' digit and the hundreds' digit of any four-figure or higher amount. Use $0.00 for zero**.**

Total Amount Medicare Paid

This column lists the sum of the line-item amounts above for what Medicare paid toward the claim. This figure may be up to eight digits long, including cents:

${###,###.##}

Insert a comma between the thousands' digit and the hundreds' digit of any four-figure or higher amount. Use $0.00 for zero**.**

Total Maximum You May Be Billed

This column lists the sum of the line-item amounts above showing the beneficiary's liability for the claim item. This figure may be up to eight digits long, including cents:

${###,###.##}

Insert a comma between the thousands' digit and the hundreds' digit of any four-figure or higher amount. Use $0.00 for zero**.**

See Notes Below

This column displays indicators that refer to explanations listed in the Notes for Claims Above subsection, which is printed at the bottom of the page when applicable. See the description in the Claim Content Lines specifications for detailed instructions. Note that the Claim Total Line differs from the Claim Content Lines in regards to claim notes: A maximum of three notes are allowed per total line, rather than the five notes allowed for a content line. No more than three note indicators should ever be listed here.

CONTENT

Total for Claim #{Claim Number}

${###,###.##}

${###,###.##}

${###,###.##}

${###,###.##}

{NOTE INDICATOR(S)}

DME UNASSIGNED SPECIFICATIONS

See figure 10.3.6.F2 or Exhibit 1.8 for layout reference.

FORMATTING

[GR 3.2] dotted rule [GR 2.2] black rule

Columns 1-2: [TB 2.2] claim number, left aligned

Column 3: [TB 2.1] amount charged total, right aligned

Column 4: [TB 2.1] approved total, right aligned

Column 5: [TB 2.1] amount paid total, right aligned, with 5 point indent

Column 6: [TB 2.2] maximum total, right aligned, with 3.5 point indent

Column 7: [TB 2.2] note indicator, left aligned, with 5 point indent

NOTE: The first line of column 6 will have [GR 2.2] on top, bottom, and both sides of the column as a highlight.

DYNAMIC RULES

The content in this section is nearly entirely dynamically generated. It includes the following content elements:

Claim Number

This column lists the claim number for the claim, preceded by a static text phrase:

Total for Claim #{Claim Number}

Insert dashes in the claim number as indicated by the system.

Total Amount Supplier Charged

This column lists the sum of the line-item amounts above of the charges the supplier submitted. This figure may be up to eight digits long, including cents:

${###,###.##}

Insert a comma between the thousands' digit and the hundreds' digit of any four-figure or higher amount. Use $0.00 for zero**.**

Total Medicare-Approved Amount

This column lists the sum of the line-items amounts above for what Medicare allows for the item or service. This figure may be up to eight digits long, including cents:

${###,###.##}

Insert a comma between the thousands' digit and the hundreds' digit of any four-figure or higher amount. Use $0.00 for zero**.**

Total Amount Medicare Paid You

This column lists the sum of the line-item amounts above for what Medicare paid the beneficiary toward the claim. This figure may be up to eight digits long, including cents:

${###,###.##}

Insert a comma between the thousands' digit and the hundreds' digit of any four-figure or higher amount. Use $0.00 for zero**.**

Total Maximum You May Be Billed

This column lists the sum of the line-item amounts above showing the beneficiary's liability for the claim item. This figure may be up to eight digits long, including cents:

${###,###.##}

Insert a comma between the thousands' digit and the hundreds' digit of any four-figure or higher amount. Use $0.00 for zero**.**

See Notes Below

This column displays indicators that refer to explanations listed in the Notes for Claims Above subsection, which is printed at the bottom of the page when applicable. See the description in the Claim Content Lines specifications for detailed instructions. Note that the Claim Total Line differs from the Claim Content Lines in regards to claim notes: A maximum of three notes are allowed per total line, rather than the five notes allowed for a content line. No more than three note indicators should ever be listed here.

CONTENT

Total for Claim #{Claim Number}

${###,###.##}

${###,###.##}

${###,###.##}

${###,###.##}

{NOTE INDICATOR(S)}

G. Notes for Claims Above

This subsection is dynamically generated when any of the claim line items on the page has an explanatory note. Note that the notes are limited to only those claim items on each page. See Exhibit 2.9, Exhibit 2.10, Exhibit 2.11, and Exhibit 2.12 for multiple examples of the relationship between claims data and claim notes.

POSITION

This subsection is built dynamically from bottom up in relation to the claim section above. It is full-page or 540 points in width with a variable height depending on the content length. Indent in 16 points from the right margin to start notes text.

There should be a minimum of 12 points space between the top of this subsection and Claim Total Line subsection. If there is a continuation box, see next subsection, 10.3.6.I, for spacing specifications.

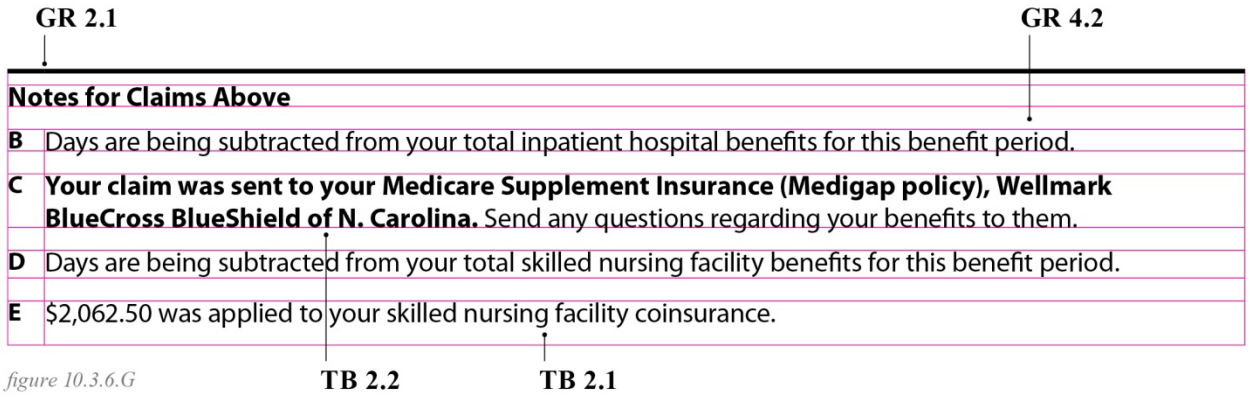


figure 10.3.6.G

FORMATTING

[GR 2] black rule

[TB 2.2] subsection header

[GR 4.2] space after

[TB 2.2] alphabetic note indicator(s) [TB 1.1] note body text

NOTE: If there are multiple notes, insert [GR 4.2] space before the note indicator and body text.

DYNAMIC RULES

This subsection is dynamically generated when any of the claim line items on the page is linked to an explanatory note. If there are no messages to be printed, suppress the entire Notes for Claims Above subsection. Do not print the Notes for Claims Above subsection without at least one complete message following it on the same page.

The section includes three elements:

Static Subsection Header

See the content section below for this language.

Note Indicator(s)

See the description in the Claim Content Lines specifications for detailed instructions on the generation of the alphabetic note indicators. Those instructions should be followed here, with the exception that each individual note indicator should be placed on a separate line.

List the note indicators in alphabetic order.

Identical notes should not be repeated. For example, even if the note indicator "F" appears on multiple occasions in the claim lines on the page, the F indicator and the explanatory note linked to F should only appear once in this section.

Explanatory Note

Each note indicator should be followed by an explanatory note relating to the claim data on the page. These explanatory notes are linked to the claim items in the system, and a complete list of the note text is available on the CMS website at: http://www.cms.gov/Medicare/Medicare-General-Information/MSN/index.html.

CONTENT

Notes for Claims Above

{Note Indicator(s)} {Explanatory Note(s)}

H. Continued Claims - Continuation Box

This section is dynamically generated when the claims continue on the next page or a claim is split across the page. See Exhibit 2.9, Exhibit 2.10, Exhibit 2.11, and Exhibit 2.12 for multiple examples of continuing claims.

POSITION

This element is fixed in size, 84 points in width and 18 points in height. The white type and glyph arrow are centered horizontally and vertically within the black filled box. The

horizontal position is fixed, but the vertical position is dynamic. The element is right aligned on top right of the Notes for Claims Above subsection.

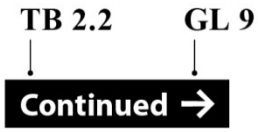


figure 10.3.6.H

FORMATTING

[TB 2.2] Continued [GL 9] arrow, right aligned, white on black fill

DYNAMIC RULES

If the claim above splits across pages, also include the continued footer at the bottom of the claim in addition to this element.

CONTENT

Continued [arrow glyph]

I. Breaking Claims - Continuation Footer

This section is dynamically generated when a claim is split across the page. When there is a split, include this subsection instead of the Claim Total Line subsection. The specifications of the columns are the same, dependent on MSN type, with dynamic claim number and static text. See Exhibit 2.9, Exhibit 2.10, Exhibit 2.11, and Exhibit 2.12 for multiple examples of continuing claims.

POSITION

This subsection is directly after the claim content lines subsection with fixed content area. It is full-page or 540 points in width and 21 points in height. There are six columns. The five right-most columns correspond to the column sizes in the Claims Content Lines subsection; the first column, containing the claim number, is equivalent in width to the first and second columns in the Claims Content Lines subsection. All content is to be top aligned.

figure 10.3.6.I

FORMATTING

[GR 3.2] dotted rule [GR 2.2] black rule

Columns 1-2: [TB 2.2] claim number, left aligned

Column 3: (blank)

Column 4: (blank)

Column 5: (blank)

Column 6: [TB 2.2] continued tag, right aligned, with 3.5 point indent

Column 7: (blank)

NOTE: There are no black rules to highlight Column 6 as the Claim Total Line subsection.

DYNAMIC RULES

Repeat at the bottom of the claim as needed if the Claim Total Line subsection is not on the page.

CONTENT

Claim #{Claim Number}

(continued)

J. Breaking Claims - Continuation Header

This section is dynamically generated when a claim is split across two or more pages. When there is a split, include this subsection on subsequent pages at the top of the page before continuing the claims followed by the Claim Column Titles subsection and Claim

Content Lines subsection. See Exhibit 2.9, Exhibit 2.10, Exhibit 2.11, and Exhibit 2.12 for multiple examples of continuing claims.

POSITION

This subsection is directly after the page header. It is fixed in size, full-page or 540 points in width and 25 points in height.

figure 10.3.6.J

FORMATTING

[GR 2.1] black rule

[TB 2.2] date / provider continued…

[GR 3.4] dotted rule w/ space before

DYNAMIC RULES

Repeat header on subsequent pages as needed if the Claim Total Line subsection is not on the page.

PART A INPATIENT AND'B OF A' SPECIFICATIONS

CONTENT

{Date of Service} / {Facility name} continued…

HOSPICE, HOME HEALTH AND PART B (ASSIGNED AND UNASSIGNED) SPECIFICATIONS

CONTENT

{Date of Service} / {Provider name} continued…

DME (ASSIGNED AND UNASSIGNED) SPECIFICATIONS

CONTENT

{Date of Service} / {Supplier name} continued…